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Meet the Presenter…

Doug Arrington
FNP, CMC, CHC, CHRC, CPC, CPC-H, CPMA
Faculty
Practice Management Institute

On the topic:
Auditing for Medical Necessity and Diagnosis Confirmation
Medical Necessity – Auditing and Diagnosis Confirmation

Doug Arrington, DNP, MSN, FNP, CMC, CPC, COC, CPMA, CHC, CHRC
Faculty - PMI

Objectives

- Describe what is Medical Necessity
- How is Medical Necessity measured, defined, and applied to healthcare services
- What are the resources to help get the healthcare services that are “needed”
- What are the clinical documentation requirements for Medical Necessity
- What to do – if things do not work the first time
- How to audit for Medical Necessity, clinical diagnostic clarity
What Is Medical Necessity

- Medical necessity is defined as accepted **health care services** and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.

- Source: CMS, United, MAC’s, other MCO’s websites

Important Distinction

- Everything beneficial to health, medically indicated for a patient, and medically necessary for coverage are linked but not equivalent.

- So, what is the healthcare provider to do?
- So, What about me – the patient?
- These are the primary individuals who are interested in this decision making process.
How Medical Necessity Works in Healthcare

• A coverage decision is a policy decision about types of health interventions provided to a population as part of the health benefit plan. What your health insurance plan provides coverage for.

• A medical necessity decision is about the appropriateness of a specific health treatment for a particular patient.

• Not all covered services are medically necessary; not all medically necessary treatments are covered.

• United, CMS, Cigna, other MCO’s

The Problem

• The criteria to define Medical Necessity is generally defined by:
  – Prevailing community standard
  – For the diagnosis and treatment of an illness
  – And its appropriateness

  – Only recently have insurance companies been required to publish their reimbursement policy guidelines – but not in all states and not all types of benefit plans

  – CMS, United, Cigna, other MCO’s
More Information

• The business matter of medicine is a continuum requiring a constant weighing of uncertainties and values. For example,
  – One antibiotic regimen may be medically comparable to and much less expensive than another, but with slightly higher risk of damage to hearing or to organs like kidneys or liver.
  – For a patient needing hip replacement, one prosthetic joint may be longer-lasting but far costlier than an alternative.
  – Of two equally effective drugs for hypertension, the costlier one may be preferable because it has fewer side effects; and a convenient once-a-day dosage – leading to increased patient compliance

Location, Location, Location

• The federal Medicare program for the elderly and disabled, for example, allegedly provides a uniform set of benefits to all enrollees, even though various companies act as the Medicare Administrative Contractor – pay for the health care services on behalf of this federal program.
• Yet in a study conducted by the General Accounting Office (2012), Medicare payment for a chest x-ray was 451 times more likely to be denied in Illinois than in South Carolina;
• Payment for a physician office visit was almost 10 times more likely to be denied in Wisconsin than in California; and
• Payment for real-time echocardiography was nearly 100 times more likely to be denied by Transamerica than by Blue Shield of California.
• So is that fair?
How Big Is this Problem - Denials?

- DME
- Elective Surgery
- Investigational and Experimental Treatments
- Preauthorization for selected diagnostic services
- Only about 8 percent of health care services – that means that 92 percent of the time – everything is okay. (Source: Stanford University – Health Policy – 1995 – Medical Necessity a fresh look)
- Communication with National Association of Insurance Commissioners – Denials or disputes frequently focus on Coverage Decisions – covered under the insurance plan versus the need or necessity of the health service.

So –

- Calling an intervention “necessary” usually means the health plan must cover it and that subscribers must pay for it in the price of the premium.
- Today, during the annual enrollment period, the healthcare consumer must make a choice that they have to “live with” for one year.
- What are the level of health services that I need for the next year?
Solution –

• For physicians and patients, the enhanced openness and clarity of evidenced guidelines-based benefit plans could relieve much of the rancor, dread, and gamesmanship that currently beleaguer health care services

• Patients want a solution to their health care problem – tell me clearly what is or is not covered

• Healthcare providers want to meet the patients expectations

Solution For All – 20 years old

• In 1995 (20 years ago), the health policy department at Stanford University attempted to develop a method of defining Medical Necessity, that was both - fair to the patient, to healthcare provider and to the health benefit plan
All in agreement –

• An health intervention is *medically necessary* if, as recommended by the treating physician and determined by the health plan’s medical director meets all of the following:

Medical Necessity –
A New Definition

• A health intervention is for the purpose of treating a medical condition;
• The most appropriate supply or level of service, considering potential benefits and harms to the patient;
• Is this a non covered or excluded health benefit? Cosmetic, oral surgery, refractory,
• Obtain ABN/Waiver of liability
More

- Known to be effective in improving health outcomes.
  - *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
  - *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
- For new interventions, effectiveness is determined by scientific evidence.
- For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and then by expert opinion.
- This is further clarified -

Further Clarification

- For existing interventions, the scientific evidence should be considered first, and to the greatest extent possible, should be the basis for determinations of medical necessity.
- If no scientific evidence is available, professional standards of care should be considered.
- If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion.
Accountable Care Act – “Obama Care”

• Post-ACA: will medical necessity still matter?
  – Key payment innovations give providers greater responsibility for costs of care
  – Bundled payments
  – ACOs and shared savings
  – Disease management

Resources – Scientific Support For Health Services

• Professional Medical Associations or Societies – For example The American Academy of Family Physicians
• Disease Specific Advocacy Groups – such as the American Diabetic Association
• All Provide Treatment guidelines to help health care providers and patients receive the type of health care services that are needed
American Academy of Family Physicians

- Chronic rhinosinusitis (CRS) and recurrent acute rhinosinusitis (RAR) should be distinguished from isolated episode of Acute bacterial rhinosinusitis (ABRS).
  
  - ABRS should be distinguished from acute rhinosinusitis due to viral respiratory infections and noninfectious conditions. ABRS should be diagnosed when signs and symptoms of acute rhinosinusitis (ARS) (purulent nasal drainage plus nasal obstruction, facial pain-pressure or both) persist without improvement for at least 10 days or if signs and symptoms worsen within 10 days after initial improvement.
  
  - Radiographic imaging should not be performed in patients with ARS unless a complication or alternative diagnosis is suspected.

What does this mean – for acute sinusitis

- The healthcare provider must document the clinical findings – stating in the history and physical exam that there has been at least a 10 day period of symptoms, that have not improved with Analgesics, intranasal steroids and/or nasal saline irrigation.

- Adults with uncomplicated ABRS should be either offered watchful waiting – (preferred) or prescribed antibiotic therapy – depending on risk factors and previous history if indicated. Patients undergoing watchful waiting should be prescribed antibiotics if their symptoms fail to improve after 7 days or worsen at any time.

- (Source: AAFP Website, Patient Care, Clinical Recommendations, Adult Sinusitis)
Resources

- Professional Associations – treatment guidelines – For example, the American Diabetes Association
  - Clinical Practice Recommendations
    - Clinical Practice Recommendations are based on a complete review of the relevant literature by a diverse group of highly trained clinicians and researchers.
    - After weighing the quality of evidence, from rigorous double-blind clinical trials to expert opinion, recommendations are drafted, reviewed, and submitted for approval to the Association’s Executive Committee; they are then revised on a regular basis, and subsequently published in the Association’s professional journal Diabetes Care.
    - Last Reviewed: October 17, 2013
    - Last Edited: August 21, 2015

Standards of Medical Care in Diabetes—2015: Summary of Revisions

- The ADA now recommends a premeal blood glucose target of 80–130 mg/dL, rather than 70–130 mg/dL, to better reflect new data comparing actual average glucose levels with A1C targets.

- To provide additional guidance on the successful implementation of continuous glucose monitoring (CGM), the Standards include new recommendations on assessing a patient’s readiness for CGM and on providing ongoing CGM support.
Application of the ADA Information

- Type 1 and Type 2 diabetics who are interested in continuous glucose monitoring readiness can be assessed using this resource. Then the assessment results can be submitted for benefit coverage (supporting documents) that the patient has been screened for readiness, their glycemic control, lifestyle, and medical management all support the need for and the medical necessity.
- Another strategy would be to call the insurance company and ask if a CGM is covered and what are the requirements for it to be covered? In some cases it may take the recommendation from an endocrinologist or dialectologist. In this case there is not even a need to fight the battle – make a referral out to a supporting specialist.

Status so far

- Discuss the problem with Medical Necessity
- Defined how Medical Necessity is currently defined
- Offered a new definition that helps the health care provider and ensure that each patient receives the necessary health care interventions based on clear criteria for medical necessity
- Provided resources for clinical treatment guidelines – that gives healthcare providers clear step by step info on diagnostics, physical assessment and treatment options which are supported by evidenced based (scientific) studies
Documentation – At a Minimum

- Type of healthcare problem(s)
- History – from onset to the present, how has it been treated, and how successful has this treatment been? Compliance issues – education, economic, lifestyle - define
- Exam Findings – end organ damage, eyes, nerves, skin, blood vessels. Effect of the disease process
- How bad is it? Mild, moderate, severe
- What other disease/condition is making it better or worse? Comorbidities

Rejection or Denial – Now What?

- Is this an expected rejection? ABN/Waiver of liability has been completed. Bill patient for services – down payment for services – or payment up front for services. Cosmetic, oral surgery, refractory, dental services
- Inform Patient that service has been rejected
- Review health plan website for appeal process.
Appeal – Who?

• A healthcare provider or the individual covered under a health benefit plan may appeal an adverse benefit coverage determination
• Reference sites are provided on the next slide.
• Make sure that you understand the steps necessary, and what information is required to appeal a determination

Health Plan Site Information -

• [http://www.bcbsil.com/provider/claims/claim_review.html](http://www.bcbsil.com/provider/claims/claim_review.html)
**Previous MCO experience**

- Both provider and patient appeal service at the same time – many times it is two different areas of a company and they may not know that each are appeal the determination
- What happens if upon appeal one is approved and one is upheld? What is a health plan to do?
- Get the team on the same page – essential – patient advocacy role

**Review Treatment Guidelines**

- Review Medical Specialty Association – print supporting documentation
- Disease specific societies/associations – print treatment guidelines
- State specific societies/associations – to reflect the local standard of care
- Request a same type specialist provider type review from the health benefit plan. This is a requirement most state insurance commissioner – Department of Insurance
Alternatives – after appeal process is not successful

• Secondary Coverage – do they provide coverage? May make their own independent decision – outside of COB.

• Reason for continued rejection – coverage, alternative treatment requirement(s) – failed conservative treatment. Meet criteria – reason for sound medical history, treatment, and response documentation

• Subrogation – liability coverage for services

• Fraud/Abuse history by patient

Reviewing the Medical Documentation -

• Diagnosis confirmation review
  - Supporting Documentation Collection
  - For each of the patient accounts included in the audit sample, obtain the following documentation:

  1. Copy of the test order or requisition
  2. Authentication of any verbal orders
  3. Notations on the test order of signs or symptoms presented by the patient
  4. Diagnosis noted on the test order
  5. Diagnostic test results
  6. Emergency department (ED) record for ED patients
  7. Copy of the claim forms - CMS 1500
  8. National coverage determinations (NCD) and applicable local coverage determinations (LCD) from the Medicare Administrative Contractor (MAC) – same for Managed Care Organizations
  9. Copies of any Advance Beneficiary Notice (ABN) or Notice of Exclusion from Medicare Benefits (NEMB) provided to and completed by the patient
Documenting Work & Identifying Deficiencies

1. Develop a test matrix (i.e., spreadsheet) to record presence or absence and correctness or incorrectness of data or process
2. For supporting documentation collected, enter whether information was obtained or not on the working spreadsheet
3. Where information is lacking, research cause for deficiency in the process
4. Identify ICD 9/10 codes for each diagnostic test selected in the sample patient accounts and determine whether the payment is in accordance with LCDs or NCDs (MCO Reimbursement Guidelines) – note on spreadsheet as compliant or not
5. Where no payable diagnosis code is identified, review the test order, test results, and the ED records to determine whether documentation supports assigning another covered diagnosis code
6. Also, where no covered diagnosis code is identified, determine whether an ABN was completed by the patient for the particular diagnostic test – specify compliance status on spreadsheet
7. If inadequate documentation appears to result in failing the test of “medical necessity”, discuss the information with the phy/hcp – note any exceptions and explanations on the spreadsheet
8. Investigate process deficiencies and recommend corrective action

Summary

- Medical Necessity – has not been clearly defined by health benefit plans, and healthcare providers have not always been clear in their clinical documentation
- When Evidenced Based guidelines are used to determine medical coverage and the “necessity” of a health service, the healthcare provider, consumer, and health benefit plan can clearly benefit
- There is no guessing as to what is required
Summary

- Auditing for Diagnosis/Medical Necessity provides the opportunity for a medical practice to identify opportunities to reduce practice administrative time, patient frustration, and the general headaches of everyday medical practice.
- This will result in increased customer satisfaction, decreased rejection requests, improved office moral, and a happy healthcare provider.

Questions?

Thank you for your attendance!


Contact information:
Doug Arrington  darrington@pmiMD.com