THE COMPLIANCE OF DENIALS AVOIDANCE AND APPEALS MANAGEMENT PROCESS:
JUST WHAT IS “MEDICAL NECESSITY”?

PRESENTER:

DR. BETTY BIBBINS, MD, BSN, CHC, CI-CDS, CPEHR, CPHIT
FOUNDER, CEO & EXECUTIVE PHYSICIAN EDUCATOR;
DOCUCOMP® LLC

OBJECTIVES

- Define Denial
- Identify the (lack of compliance) causes of denials
- Review the regulatory processes in denials
- Expand upon “Where do we go from here” – the Appeals process objectives & goals
DENIALS CATEGORIZATION

- Denials
- Underpayment
- Lost Revenue

DENIALS CATEGORIZATION (CONT’ D)

- Denial - A refusal to pay:
  - Provider not adhering to insurance company policies/procedures, or pending receipt of additional information
- Medical necessity denial
  - Information provided in the chart fails to support provided service was reasonable and necessary (meets the standard)
  - “Objective” versus “Subjective”
- Technical Denial
  - “Self Inflicted” denials
- Clinical validation denial (coding denials)
  - Clinical review of the case to see whether or not the patient truly possesses the conditions that were documented.
UNDERPAYMENTS

- **Underpayments**
  - Incorrect payment resulting from pricing inaccuracies or differences in contract interpretation
  - “Intentional” vs. “Oversight”
  - Inaccurate/inappropriate ChargeMaster price

LOST REVENUE

- **Lost Revenue**
  - Undetected Underpayments
  - Incorrect payment due to incomplete or inaccurate billing.
  - Charges or codes are missing from the bill and are thus never considered for payment
  - Inaccurate CPT codes
  - Missing or incorrect modifier
  - Inaccurate billing units
HARD DENIALS

- Denied claim for elective service without pre-authorization
- Denied days, service, or level of care for no concurrent authorization
- Denied as not financially responsible
  - Denied as not a covered service
- Denied charge/procedure as bundled
  - Denied for untimely submission

SOFT DENIALS

- Denied ER claim pending receipt of medical records
- Denied claim due to missing/inaccurate information
- Denied claim due to charge/coding issues
  - Denied charges pending receipt of itemized bill
- Denied drug/implant reimbursement pending receipt of invoice
  - Denied secondary payment pending receipt of primary EOB
CONTRIBUTING DENIAL FACTORS

- **Structure**
  - EHR systems
  - Staff core competencies, skill sets, knowledge bases
  - Job expectations commensurate with skills

- **Processes**
  - EHR systems
  - Patient care delivery flow
  - Preauthorization process and adherence
  - Charge capture inefficiencies
  - Documentation insufficiencies
  - Case management & utilization review model
  - Physician Advisor involvement
  - Coding and billing processes (DNFB vs. clinical coding accuracy - striking a balance)
  - Rebill auditing process and work flow

UNDERLYING DENIAL FACTORS
UNDERLYING DENIAL FACTORS (CONT’D)

- Outcomes
  - Inaccurate/Incomplete billing
  - Lack of timely claims follow up
    - Additional documentation requests
    - Insufficient documentation
  - Ineffective, inefficient appeals process
    - General processes, staff processes
    - Physician participation
    - Feedback loop continuous quality improvement processes
  - Aberrant DRG patterns
    - CDI program potential
  - CDI initiatives medical necessity denials

COMMON PROCESS INSUFFICIENCIES

- Registration process
  - Incorrect/inaccurate information
  - Serial vs. one time account
  - No prior authorization or incorrect CPT code authorized
  - No medical necessity check, inaccurate medical necessity check
  - Incomplete and inaccurate physician orders

- Service delivery
  - Inaccurate charge capture, human vs. systems initiated
  - Incomplete documentation
    - LCD, NCD, 3rd party payer requirements
    - Staff knowledge deficit
    - Lack of adherence to best practice standards of documentation
    - Ineffective and misdirected CDI initiatives
    - Lack of accountability and expectation
CMS – LCDS & NCDS

- **Common missing revenue cycle element**
  - Misunderstanding & misbelief
    - Covered diagnosis vs. other required elements

- **Overview LCD**
  - Abstract
  - Indications
  - Limitations of Coverage
  - ICD-10 codes that support medical necessity
  - Documentation requirements

**IMPORTANT LCD ELEMENTS**

- **NGS Medicare LCD Coverage Biologic Products for Wound Treatment and Surgical Interventions**

- **Indications**
  - Applied to wounds that have demonstrated a failed or insufficient response to no fewer than four weeks of conservative wound care measures. For initial applications of skin substitutes/replacements, a failed response to conservative measures is defined as an ulcer that has increased in size or depth or for which there has been less than 30% closure from baseline. For the purposes of this LCD, a chronic cutaneous ulcer is defined as a wound that has failed to proceed through an orderly and timely series of events to produce a durable structural, functional, and cosmetic closure. A burn wound is defined as a cutaneous wound induced by thermal, chemical, or electrical injury. An acute wound is of recent occurrence and usually traumatic in nature.
INDICATIONS

- Managed wounds should be clean and free of infection and are of reasonable size (at least 1.0 cm) and with adequate circulation/oxygenation to support tissue growth/wound healing as evidenced by physical examination (presence of acceptable peripheral pulses and/or Doppler toe signals and/or ABI of no less than 0.65).
- Management of chronic wounds should include treating the underlying condition and comorbidities, which might include optimizing blood glucose control in patients with diabetic ulcers, ensuring adequate nutrition status in debilitated patients, revascularization in patients with ischemic artery disease, and pain management.

INDICATIONS (CONT’ D)

- In addition to the type of dressing used in treating chronic wounds, several common principles apply to the management of most chronic wounds:
  - removal of dead and devitalized tissue which provides a nidus for bacterial infection (not colonization),
  - aggressive antibiotic treatment of peri wound and wound infections,
  - mechanical measures which may favorably alter local hemodynamics or ameliorate adverse physical forces, (Most common are offloading and debridement for diabetic ulcers and compression for venous ulcers) and
  - optimization of general nutrition.
LIMITATIONS OF COVERAGE

- Medicare would not expect to be billed (for CPT codes 15002/15004) in conjunction with application of skin substitutes/replacements as applied to chronic wounds. Minimal wound preparation is considered a part of the material application procedure.
- If a use is identified as not indicated by CMS or the FDA, or if it is determined, based on peer-reviewed medical literature, that a particular use of a product is not safe and effective, the indicated usage is not supported and therefore, the product is not covered for that indication.
- Regardless of the evidence supporting coverage for a particular use, payment may only be made if the use is reasonable and necessary for the treatment of the wound, burn, physiological or anatomic defect of the specific patient receiving the product.

LIMITATIONS OF COVERAGE (CONT" D)

- Services related to non-covered services are also not covered (e.g., application services).
- The automatic use of the CPT codes listed for the application of a particular product is inappropriate. The code selected should reflect the actual work involved in applying the product. This will be further defined in individual articles related to specific products.
DOCUMENTATION REQUIREMENTS

- The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

- The medical record documentation supporting medical necessity should be legible, maintained in the patient's medical record, and made available to Medicare upon request.

- Each claim must be submitted with ICD-10 CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD-10 CM codes will be returned.

DOCUMENTATION REQUIREMENTS (CONT’ D)

- The medical record documentation must confirm and support that all requirements set forth in the "Indications" section of this policy (and applicable article) have been satisfied with regards to the clinical characteristics of the ulcer, the presence of qualifying or disqualifying conditions, and the duration and intensity of pre-treatment conservative/conventional management.

- It is not just about the diagnosis limitations in use of medical necessity software!
DOCUMENTATION REQUIREMENTS (CONT’D)

- **Documentation of response or lack thereof**, requires measurement of the ulcer at baseline and following cessation of conservative or conventional management and must be included in the medical record. Documentation should also include measurement of the ulcer immediately prior to the placement of skin substitutes/replacements. A “failed response” is defined as an ulcer that has increased in size or depth, or for which there has been no change in baseline size or depth and no sign of improvement or indication that improvement is likely, such as granulation, epithelialization or progress toward closing.

- The medical record must document that wound treatments with skin substitutes/replacements are accompanied by appropriate wound dressing changes during the healing period and by appropriate compressive dressings during follow up, including, for neuropathic diabetic foot ulcers, appropriate steps to off load wound pressure during the follow up.

- The medical record documentation must clearly document the medical necessity and performance of the extent of site preparation procedures billed.

- Rationale for the selection of a biological product for surgical interventions in repair of anatomic defects or reconstruction work must be documented in the medical record and submitted to Medicare upon request.

PRODUCT WASTAGE DOCUMENTATION REQUIREMENTS

- **Product Wastage Documentation Requirements:**

  - Although a reasonable amount of product wastage is permitted, an exact amount of the tissue used per application should be documented in the patient’s medical record with:
    - Date and time.
    - Amount of product used.
    - Amount of product wasted.
    - The reason for the wastage.
WHAT REALLY MATTERS!

- **Clinical documentation**
  - Diagnoses
  - Context
  - Content
  - Clinical facts of the case

- **Assessment**
  - Diagnoses definitive/provisional
  - Clinical rationale
  - Thought Processes
  - Medical decision making

ROOT CAUSE OF DENIALS

- **Medical Necessity**
  - Documentation provided was **sufficient** to demonstrate there lacked a clear need for the service provided and/or at the level provided

- **Insufficient Documentation**
  - Claims are determined to have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary)
CHANGING THE FRAMEWORK

- Physician accountability and expectation
- Compelling argument for effective and complete documentation
- Different avenues for process improvement
- Goals and objective of CDI program
  - Outcomes Based vs Process improvement
  - Proactive vs. Reactive
  - Meaningful change vs. Training wheels
- Establishing standards of documentation
BRINGING PHYSICIANS INTO THE FOLD

- Preparation for the Merit-Based Incentive Payment System (MIPS) 2019
  - 4 Domains
  - Composite Performance Score
  - Positive & Downside Risk (2019 4% to +4% payment adjustment)
- CPC
  - Quality
  - Resource Use
  - Clinical Practice Improvement Activities
  - Advancing Care Information (Meaningful Use Evolution)

YEAR ONE PERFORMANCE CATEGORY WEIGHTS FOR MIPS

- Resource Use (10%)
- Clinical Practice Improvement Activities (15%)
- Quality (30%)
- Advancing Care Information (25%)
CDI MANDATE

- Capture all relevant diagnoses
  - Accurate SOI and ROM reporting
  - Payment vs. Non Payment ramifications
- Content and Context
  - Clinical facts of the case
  - Accurate representation and reporting of medical necessity
- Revenue Cycle Role
  - Achieving Potential
  - Communication of patient care

RELEVANCE OF DOCUMENTATION EFFECTIVENESS

- MIPS allows Medicare clinicians to be paid for providing high quality, efficient care through success in four performance categories
- Success predicated upon accurate and complete documentation
- Costs
  - Replaces the cost component of the Value Modifier Program (also known as Resource Use): The score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use more than 40 episode specific measures to account for differences among specialties
  - Total per capita cost measure, the MSPB measure, and several episode based measures
RELEVANCE OF DOCUMENTATION EFFECTIVENESS

- Quality
  - **Replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program:** Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.

CDI MANDATE

- **Effective communication of patient care**
- **Appropriate clinical documentation**
  - Provision of accurate, safe, and timely care
  - Consistent, congruent documentation throughout
  - Clinical facts of the case
  - Clinical judgment, reasoning, and thought processes
  - Minimized cut and paste
  - Paints clear picture of medical necessity
    - Admission
    - Continued Stay
PRACTICALLY SPEAKING

- **Documentation of Medical Necessity**
  - **Number, acuity, severity and duration** of problems addressed by physician
  - Extent to which comorbidities impact complexity in management of acute clinical conditions
  - Context of previous management of same conditions
  - Number of body areas and organ systems the physician must contend within clinical management
  - Challenges and complexity of arriving at a diagnosis (es) and development of a reasonable management action plan

MEDICAL RECORD CONTENT

- Medical Record Documentation and Content: The medical record must identify the patient, **support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care.** The medical record is sufficiently detailed and organized to enable:
  - The responsible practitioner to provide continuing care, determine later what the patient's condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment.
MEDICAL RECORD CONTENT (CONT’ D)

- A consultant to render an opinion after an examination of the patient and review of the health record.
- Another practitioner to assume care of the patient at any time.
- Retrieval of pertinent information required for utilization review and/or quality assurance activities.

KEY TO ESTABLISHING MEDICAL NECESSITY

- Accurately recorded
  - Chief complaint
  - History of Present Illness (HPI)
  - “Present” Illness versus “Past” Illness
  - Nature of presenting problem
- HPI - Chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present complaint
NATURE OF PRESENTING PROBLEM

- “A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter, with or without a diagnosis being established at the time of the encounter.”
- The CPT manual describes **five levels** of the severity of the NPP:
  - Minimal
  - Minor or self–limited
  - Low
  - Moderate
  - High

THE LEVELS

- **Minimal**: A problem that may not require the presence of the physician or other qualified healthcare professional
- **Self limited or minor**: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance
- **Low Severity**: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected
- **Moderate Severity**: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment
- **High Severity**: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment
HPI ELEMENTS

- **HPI-58 specific elements**
  - Location (example: left leg);
  - Quality (example: aching, burning, radiating pain);
  - Severity (example: 10 on a scale of 1 to 10);
  - Duration (example: started three days ago);
  - Timing (example: constant or comes and goes);
  - Context (example: lifted large object at work);
  - Modifying factors (example: better when heat is applied); and
  - Associated signs and symptoms (example: numbness in toes)
SPECIFICITY TRULY MATTERS

- **Documentation in the patient's medical record must be specific and unique to the patient encounter**
- **Statements such as 'Failed outpatient therapy' are simply not sufficient evidence of medical necessity for the admission or the surgery.**
- **Physician can include any clinical information desired in the medical record**
  - Only information relevant to the management of the patient's condition that is documented can be utilized for E & M billing assignment.

DENIALS AVOIDANCE

- Providing Physicians with Knowledge
- **Ordering...**
  - Right care
  - Right time
  - Right reason
  - Right setting
  - Right medical decision making
- **Right documentation**
DENIALS AVOIDANCE

TRANSFORMING CDI INITIATIVES

- Re-branding
- Re-formulating
- Re-engineering
- Re-focusing
- Re-vitalizing
REDIRECTING CDI

- Proactive vs. Reactive
- Collegial Physician Partnership
- Physician Patient Advocate
- Physician
  - Driven
  - Focused
  - Directed
- Right documentation for all the right reasons!
- Engaging Physicians
- EHRO process improvement structure

OUTPATIENT CDI DEVELOPMENT

- Identify and define goals and objectives
- Identify focus areas
  - High dollar low volume
  - Low dollar high volume
  - Service lines vs. Specific service
- **HCC Focused it is not!**
- Blood Pressure meds
  - Start low and go slow
- **Staff skill sets, core competencies and knowledgebase**
LASTLY

- Aligning Care Processes with Revenue Cycle Integrity
- Updating and process improvement Revenue cycle processes
- Capitalizing upon true improvement in documentation
- Documentation for:
  - Communication of patient care vs. Reimbursement
  - Medical decision making, thought processes, clinical judgment, problem solving skills
  - Clinical rational/clinical criteria
  - Patient care, what, where, why, what am I looking for or treating, what do I expect and what if
THANK YOU

Betty Bibbins, MD, BSN, CHC, CI-CDI, CPEHR, CPHIT
Founder & Chief Executive Physician Educator;
DocuComp® LLC

PO Box 190
Cape Charles, VA 23310-0190
Phone: 740-968-0472
Email: BibbinsMD@DocuCompLLC.com