Medical Review

2015 Social Services Conference
April 23, 2015

Doug Dammrose,MD
Idaho Medical Review, LLC

Outline

- Who is Idaho Medical Review, LLC?
- Why do Medical Review?
- Medical Review and the Statute
- Clinical Care and the Statute
  - Clinical Care/Payment/Episode of Care
  - 10 day
  - 31 day
  - Continued Care
  - Approved Services and the 6 Month Limit.
- Improving What We Do.

Idaho Medical Review, LLC

- Who are we?
  - 2 Board Certified physicians with over 80 years of collective clinical and health plan experience
  - 2 RNs with over 40 years of collective health plan experience
  - About 1500 Narrative style Medical Reviews 2014
  - About 1200 Abbreviated Reviews 2014
  - Application of Evidence Based Medicine
  - Experience with Commercial Insurance Review Criteria, and Coding Certification

Medical Review and the Statute

- Not specifically defined in the Statute
- It is a subset of Utilization Management such that the appraisal of "necessary medical services" should be performed by "medical professional", and historically this has been a physician.
- Prior to 2009, Counties could contract with independent medical reviewers to evaluate medical services for which payment was requested.
- In 2010 the IAC entered into a statewide contract with Idaho Medical Review, LLC
- In 2011 the CAT Board initiated and amended in 2013 a policy for medical review (www.idcounties.org – Medical_Review_Policy)

CAT Policy for Review

CAT Medical Review Policy

- All cases exceeding billed charges of $75,000 shall have a medical review done before county approval is completed.
- All 10-day apps must have med reviews, regardless of dollar amount.
- Send Medical Records as defined in the CAT transmittal form.

Utilization Management §31-3502(28)

The evaluation of medical necessity, appropriateness, and efficiency of the use of health care services, procedures and facilities and may include, but is not limited to, preadmission certification, the application of practice guidelines, continued stay review, discharge planning, case management, preauthorization of ambulatory procedures, retrospective review and claims review….Utilization management may also include the amount to be paid based on the application of the reimbursement rate to those medical services determined to be necessary medical services.

"Necessary Medical Services" §31-3502(18)

(a) Health care providers, exercising prudent clinical judgment, would provide to a person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms; (and)
(b) Are in accordance with generally accepted standards of medical practice; (and)
(c) Are clinically appropriate, in terms of type, frequency, extent, site and duration and are considered effective for the covered person's illness, injury or disease; (and)
(d) Are not provided primarily for the convenience of the person, physician or other health care provider; and
(e) Are the most cost-effective service or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury or disease.

This language is related to determination of payment for "medically necessary services". Determination is best made after a physician review of the clinical record.

Medically Necessary but not covered

- B. Necessary medical services shall not include the following:
- (a) Bone marrow transplants;
- (b) Organ transplants;
- (c) Elective, cosmetic and/or experimental procedures;
- (d) Services related to, or provided by, residential, skilled nursing, assisted living and/or shelter care facilities;
- (e) Normal, uncomplicated pregnancies, excluding caesarean section, and childbirth well-baby care;
- (f) Medicare copayments and deductibles;
- (g) Services provided by, or available to, an applicant from state, federal and local health programs;
- (h) Medicaid copayments and deductibles; and
- (i) Drugs, devices or procedures primarily utilized for weight reduction and complications directly related to such drugs, devices or procedures.

Emergency §31-3502(18)

- 12) "Emergency service" means a service provided for a medical condition in which sudden, serious and unexpected symptoms of illness or injury are sufficiently severe to necessitate or call for immediate medical care, including, but not limited to, severe pain, that the absence of **immediate medical attention** could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:
- (a) Placing the patient's health in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

Prudent person language

- People fear that symptoms may be a life threatening condition.
  - It is difficult to deny an ER visit for evaluation of a symptom that a person of average intelligence could view as life threatening
  - Repeated abuse for the same diagnosis may be deemed not necessary
- After the physician has evaluated the condition, the burden of emergent treatment rests with the physician and accepted guidelines for treatment

EMTALA - Stabilization

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in (1)(B) [pregnant woman who is having contractions], to deliver (including the placenta).

Appropriate transfer- facility with space and qualified personnel.

11

Physicians have not read the Statute with regard to Emergency

- Most oncology treatment plans are not emergent
- Many future cardiac procedures (bypass surgery, follow up stenting) can wait with medical management.
- Back surgery in the absence of progressive neurological symptoms can often wait.

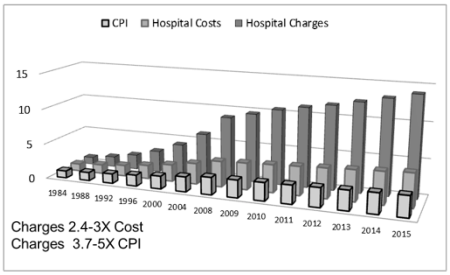
Why Is Medical Review Necessary?

Health Care: The Big Picture

- 31 of past 40 years health care costs increased greater than the economy as a whole
- Health Care costs are 18% of US GDP
- 30% increase in personal income in last decade eaten up by 76% increase in health care cost
- At least $750 B in waste

IOM: Best Care at Lower Cost

Hospital Charges to Cost/CPI



All Payer Data

Outcomes for multiple specific diagnoses AHRQ HCUP DATA 2012

Diagnosis	Admissions	LOS	Charges	Costs
Heart transplant or implant of heart assist system w mcc	4510	41.1	$865,204	$247,560
Heart transplant or implant of heart assist system w/o mcc	1120	22.5	$539,292	$150,740
Simple pneumonia & pleurisy w mcc	232,620	5.9	$38,227	$10,940
Simple pneumonia & pleurisy w cc	421,150	4.2	$24,232	$7,486
Simple pneumonia & pleurisy w/o cc/mcc	245,290	3.0	$16,224	$5,261
Appendectomy w/o complicated principal diag w cc	19,570	2.8	$36,506	$10,140
Appendectomy w/o complicated principal diag w/o cc/mcc	141,140	1.5	$27,990	$7,667

16

Financial Burden

- Burden on Counties-Property Tax Revenue
- Burden on State Budget-Competes with other General Fund Expenditures, i.e. Education etc.
- Incident Based Care without control on utilization or cost.

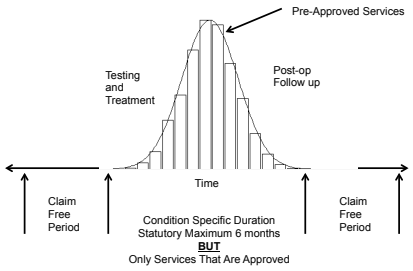
Why Do Medical Review?

- Be good stewards of tax dollars
- Strictly apply the Statute as it relates to payment for medical services to:
  - Strictly enforce the coverage defined in Statute
  - Eliminate Waste and Reduce Cost
    - Ineffective treatment
    - Excessive treatment
    - Harmful treatment

Clinical Care and the Statute

- "Necessary Medical Services" – For Payment
  - Patient-Not elective, coverage of last resort
  - MD-Most perceive what they do as medically necessary
- "Emergency"-Prudent Lay Person
- Clinical Care, Payment, and the Episode of Care
- The 10-Day
- The 31-Day
- Continuation of Care (Does it mean 6 months?)

Episode of Care-10 Day



Standardized Treatment Plans

Please describe all anticipated treatment in the format below. Include information about the planned surgery, home health care, rehabilitation services, therapy (physical, occupational, speech), diagnostic services, respiratory care, IV therapy, office visits and any other care related to this case. The information provided in this treatment plan will be used to determine medical necessity and the dates of service and/or frequency of treatment is required. **ABBREVIATIONS SUCH AS "TBD" "UNKNOWN" "FUTURE" OR "TO DISCHARGE" WILL BE CONSIDERED AS NON-RESPONSIVE AND MAY CAUSE THE TREATMENT PLAN TO BE INVALID.**

Type of Service	Provider	Procedure Code	Dates of Service FROM	Dates of Service TO	Estimated Charges
Pre-op/office visit					$
Radiology					$
Hospital					$
Physician Fees					$
Assistant Fees					$
Anesthesia					$
Pathology					$
Post-op office visit					$
Other:					$
Other:					$
Other:					$
TOTAL:					$

Outpatient: ___ Yes ___ No **If inpatient, what is the length of stay:** _____ days

Estimated date patient will be released for employment:

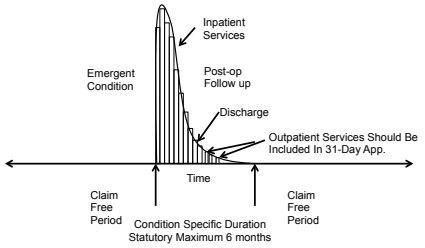
Will the patient be able to return to their present occupation? ___ Yes ___ No

List any restrictions:

Is patient a candidate for Social Security disability? ___ Yes ___ No

Additional comments:

Episode of Care-31Day



Standardize Review Questions

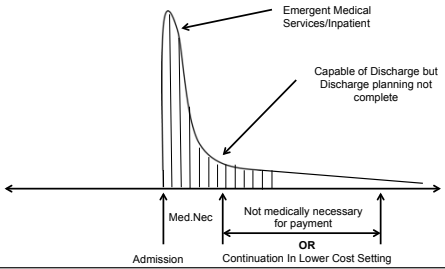
County is requesting your assistance in reviewing the attached medical records and hospital billing. The recipient was treated at St Elsewhere from 2/28/15 to 4/15/15 for liver failure, non Q wave myocardial infarction, thrombocytopenia and alcohol intoxication. The providers were given the opportunity to supply requested records. This review is based on the records supplied. Due to the extent of the charges the county believes that a case review is warranted and the county requests the following information be evaluated and provided:

1. Does it appear the patient has the current ability to work?
2. If not, does it appear patient will at some time in the future have the physical ability to work? If so, when and to what extent?
3. Does it appear the patient meets the criteria for disability under Social Security Guidelines?
4. Were/are the following requested service(s) necessary and emergent?
   a. St. Elsewhere ER/Inpatient 2/28/15 to 3/16/15 to include all physician and ancillary charges?
   b. 3/2/15 surgery for esophagogastroduodenoscopy to include all physician and ancillary charges?
   c. Outpatient level 4 follow up with St. Elsewhere on 3/20/15?
   d. Infusions related to endocarditis 3-17-15 to 3-31-15?
   e. Infusions related to endocarditis 4-1-15 to 4-15-15?

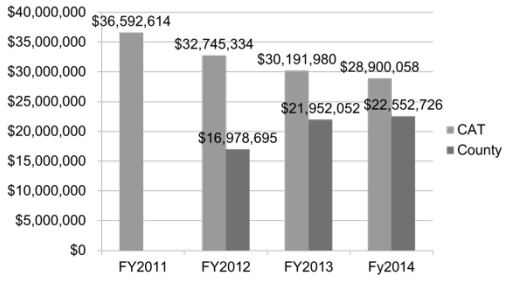
Your time and expertise in this matter is very much appreciated and we look forward to your response.

Sincerely,

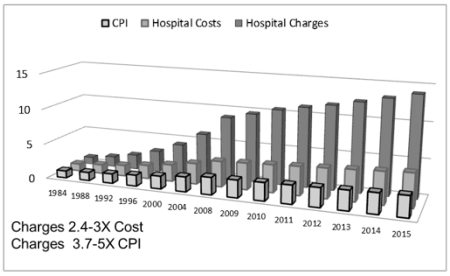
Episode of Care-31 day-Length of Stay



CAT Provider Payments



Hospital Charges to Cost/CPI



Improving What We Do

- Standardize Treatment Plan Requests
- Standardize Record Requests
- Standardize Report Formats

Improving consistency

- Specific Questions
  - Variation between reviewers can be reduced by being specific about the questions being asked regarding the applied for services
- Specific Records
  - Progress Notes
  - History and physical etc
  - Not just a letter.

Standardized Record Requests

- History and Physical Examination
- Operative Reports
- Dictated Radiology Reports
- Discharge Summary
- UB-04
- Detailed Bill

Summary

- Work with the CAT Board to avoid inconsistencies that could lead to loss of savings and risk for appeals.
- Facilitate tracking of costs of care and impact of cost containment measures.
- Demand treatment plans for elective care expected duration of care that follows an acute episode. Both physician and facility expected charges should be provided.
- All treatment plans and bills should have appropriate HCPCS and CPT codes provided.

30

Dialogue

- How can we make it easier for you?
- Questions?

DIALOGUE

- How is it going for you?
- What problems are you seeing?
- Can Medical Review be of more help to you?

Review of the Case

- What is the diagnosis?
- Does the treatment fit with the diagnosis?
- Could the same outcome be achieved with a simpler, lower cost test or treatment.
- The duration of care is subjected to two tests:
  - The point during the episode where the patient can clearly be treated at a lower level of care
  - Comparison of the diagnosis with national data for charges adjusted to the length of stay
- Duration of the outpatient care based on clinical guidelines and specific clinical details.(Ex. Oncology)

Case (continued)

- Does the patient have other coverage?
- Does the patient qualify for Social Security disability?
- Does the patient qualify for Medicaid under AABD?
- What is the “Clinical Episode of Care”