# Medical Record Reviews: Best Submission Practices

## 2016 Social Services Conference

April 20, 2016

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# Outline

- Idaho and the ACA
- Who is Idaho Medical Review, LLC?
- Medical Review and the Statute
- Clinical Care and the Statute
- Emergency Definition
- Continued Care
- Approved Services and the 6 Month Limit.
- Improving What We Do.

# Idaho and the ACA

- One of 19 states without Medicaid expansion
- 102,000 enrolled for 2016 through YHI
- 166,000 still uninsured
- 78,000 in the gap
- All insurers of any significant Exchange population had record loses
- Major problems
  - Unexpected pent up demand
  - Abuse of the system
  - Inadequate Cost Control

# Idaho Medical Review, LLC

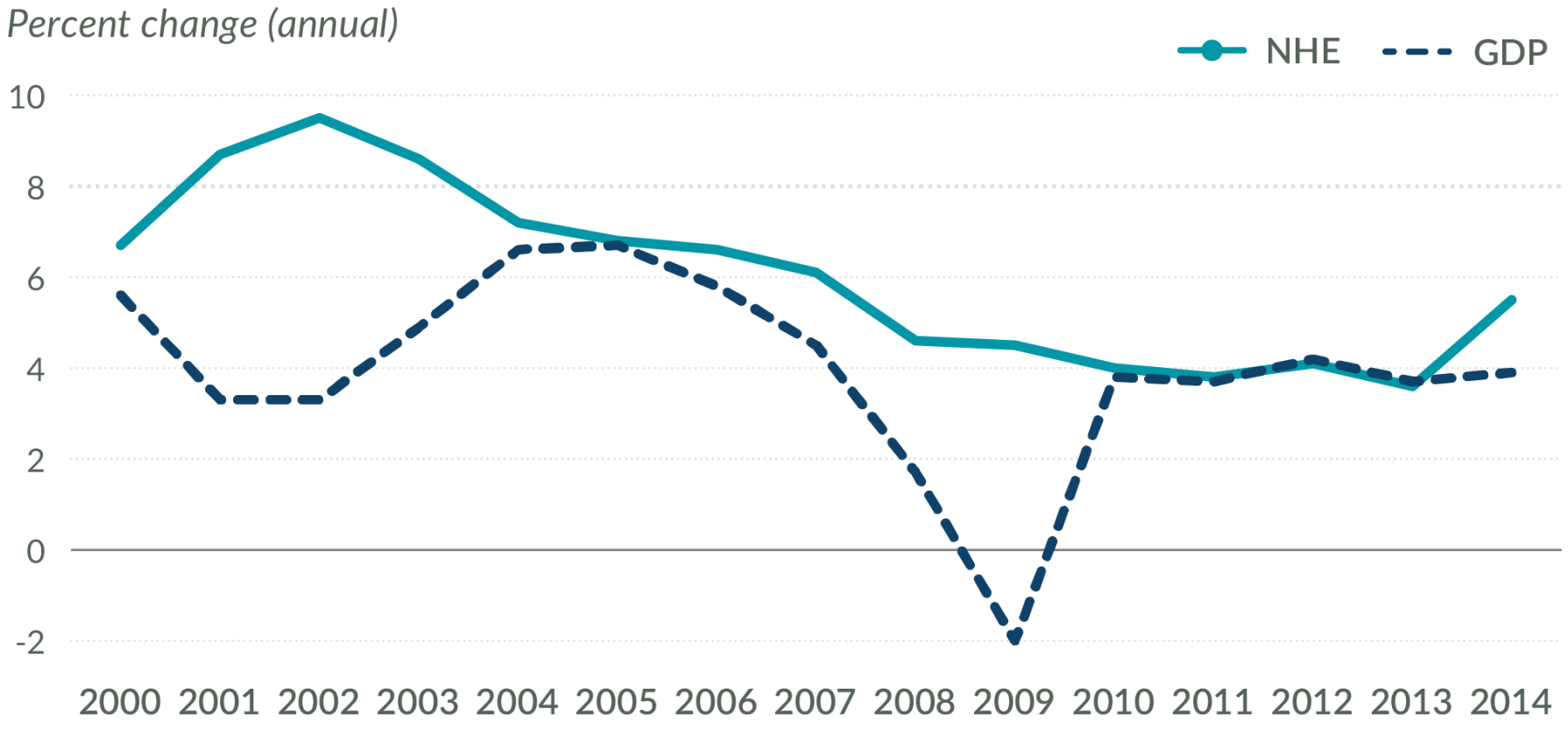
- Who are we?
  - 2 Board Certified physicians with over 80 years of collective clinical and health plan experience
  - 2 RNs with over 40 years of collective health plan experience
  - 1543 Narrative style Medical Reviews 2015
  - About 1200 Abbreviated Reviews 2015
  - Application of Evidence Based Medicine
  - Experience with Commercial Insurance Review Criteria, Review Criteria, and Coding Certification

# 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

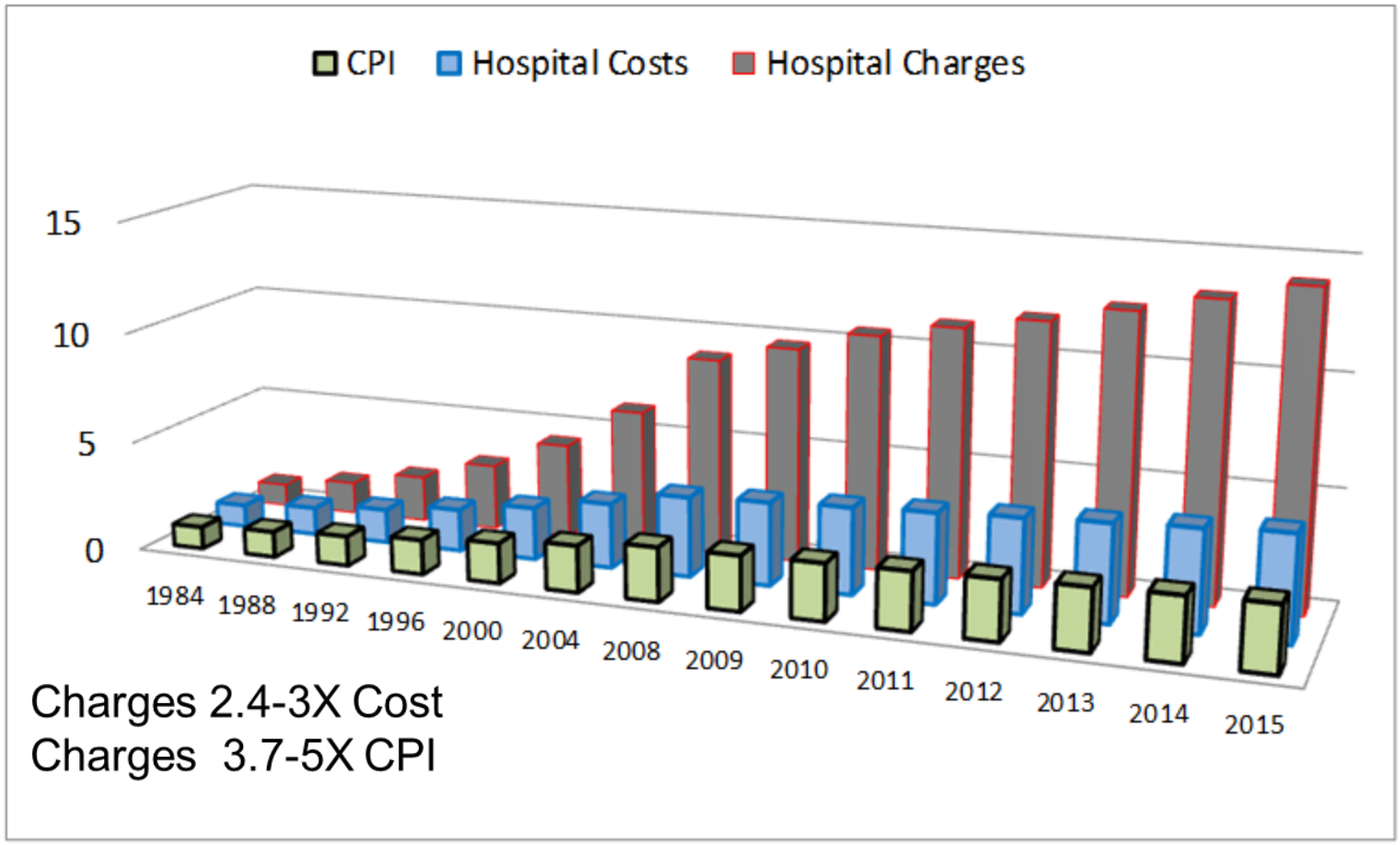
**IOM: Best Care at Lower Cost**

# Annual Health Spending Growth Slows to Rate of GDP Growth for Four Years (2010–13), But Rises in 2014

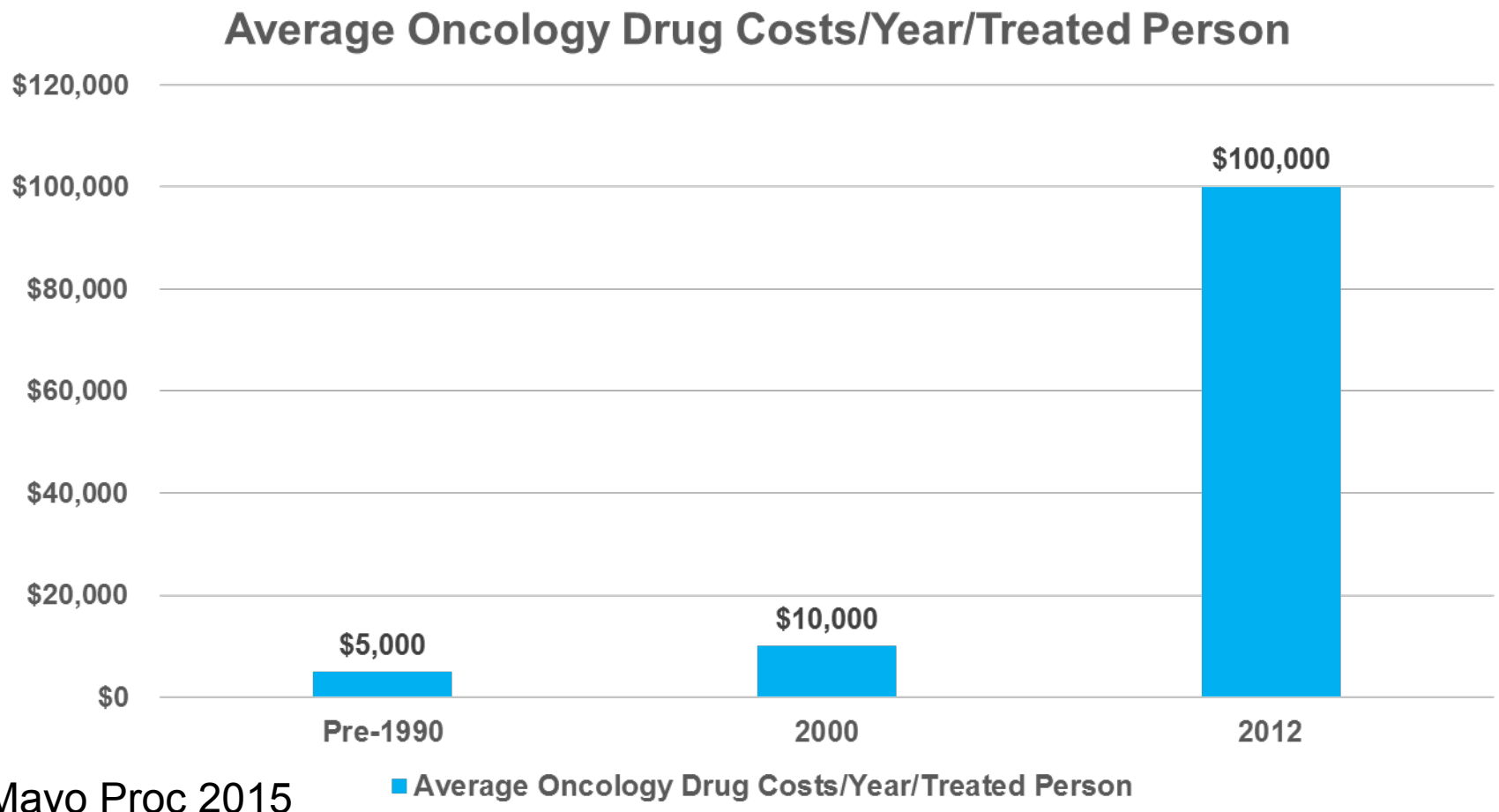



NHE = national health expenditures.
Source: Centers for Medicare and Medicaid Services, Historic and Projected National Health Expenditures. Updated July 2015.

# Hospital Charges to Cost/CPI



# Pharmacy Cost Inflation




Mayo Proc 2015

# 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

# Financial Burden

- Burden on Counties-Property Tax Revenue
- Burden on State Budget-Competes with other General Fund Expenditures, i.e. Education etc.

# 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.

# St. Lukes vs Twin Falls County

## Emergency vs Non-Emergent

- Fifth District Judge Butler determined
  - "Whether medical services are provided as an emergency or a non-emergency is only relevant as to the time within which to file an application."
  - "The only remaining determination for the obligated county is to approve those medical services which were "necessary medical services"

Somewhat circular argument and although the case was unique it raises concern about future determinations and continuation of care

# Stability/End of Emergency

- Most cost effective setting
  - Rehabilitation could be the most cost-effective setting
  - Continuation of the emergency
  - Twin Falls case

# 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.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# 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.

# 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 |

# All Payer Data

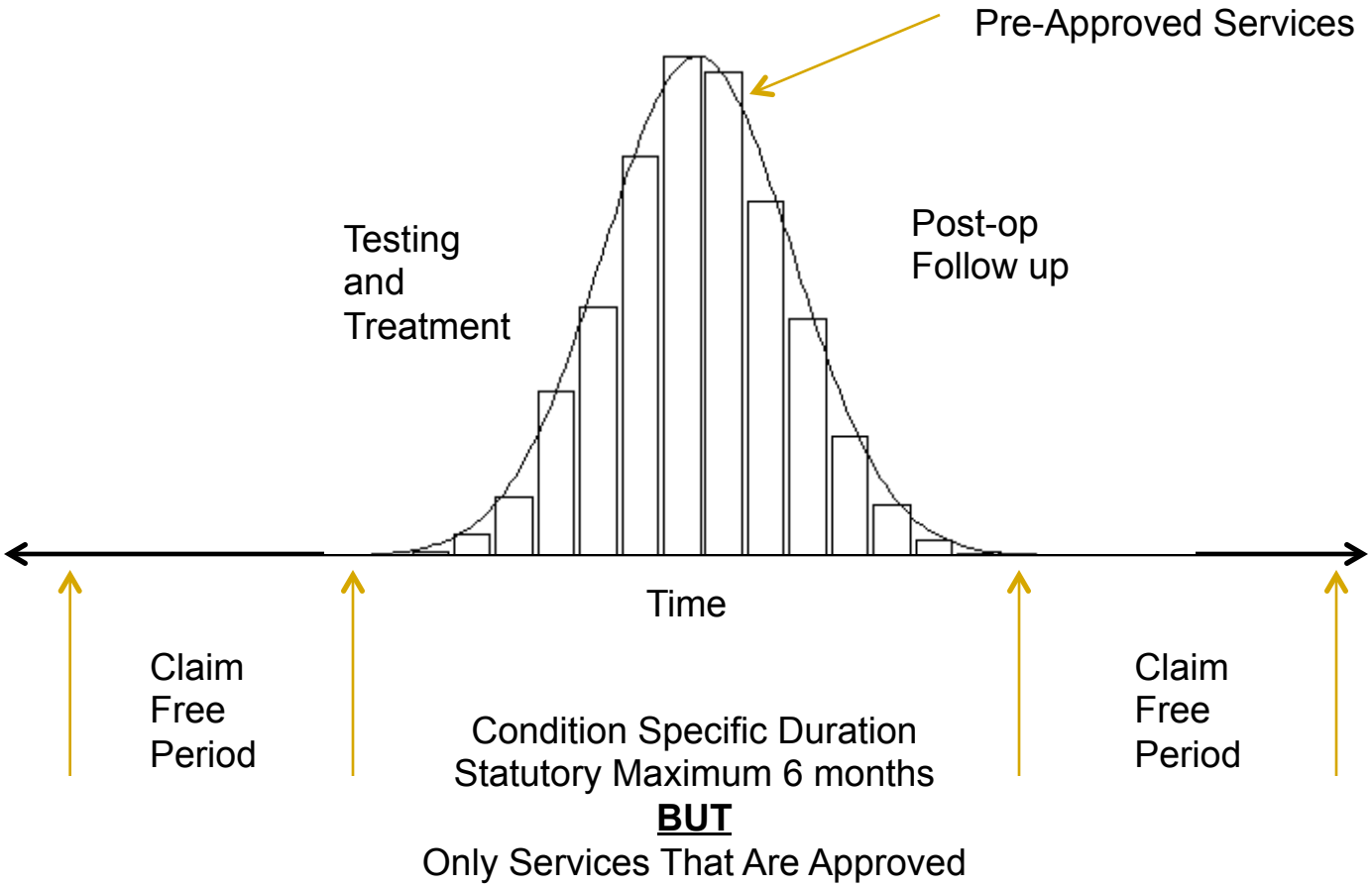
Outcomes for multiple specific diagnoses AHRQ HCUP 2013

| Diagnosis | Admissions | LOS | Charges | Costs |
|---|---|---|---|---|
| Heart transplant or implant of heart assist system w mcc | 5040 | 42.3 | $916,077 | $253,630 |
| Heart transplant or implant of heart assist system w/o mcc | 1135 | 22.1 | $570,082 | $154,501 |
| Simple pneumonia & pleurisy w mcc | 251,675 | 5.8 | $39,888 | $10,940 |
| Simple pneumonia & pleurisy w | 403,259 | 4.1 | $25,510 | $11,013 |
| Simple pneumonia & pleurisy w/o cc/ mcc | 217,675 | 3 | $17,586 | $5,537 |
| Appendectomy w/o complicated principal diag w cc | 17,655 | 2.8 | $39,223 | $10,401 |
| Appendectomy w/o complicated principal diag w/o cc/mcc | 117,440 | 1.5 | $30,562 | $7,957 |

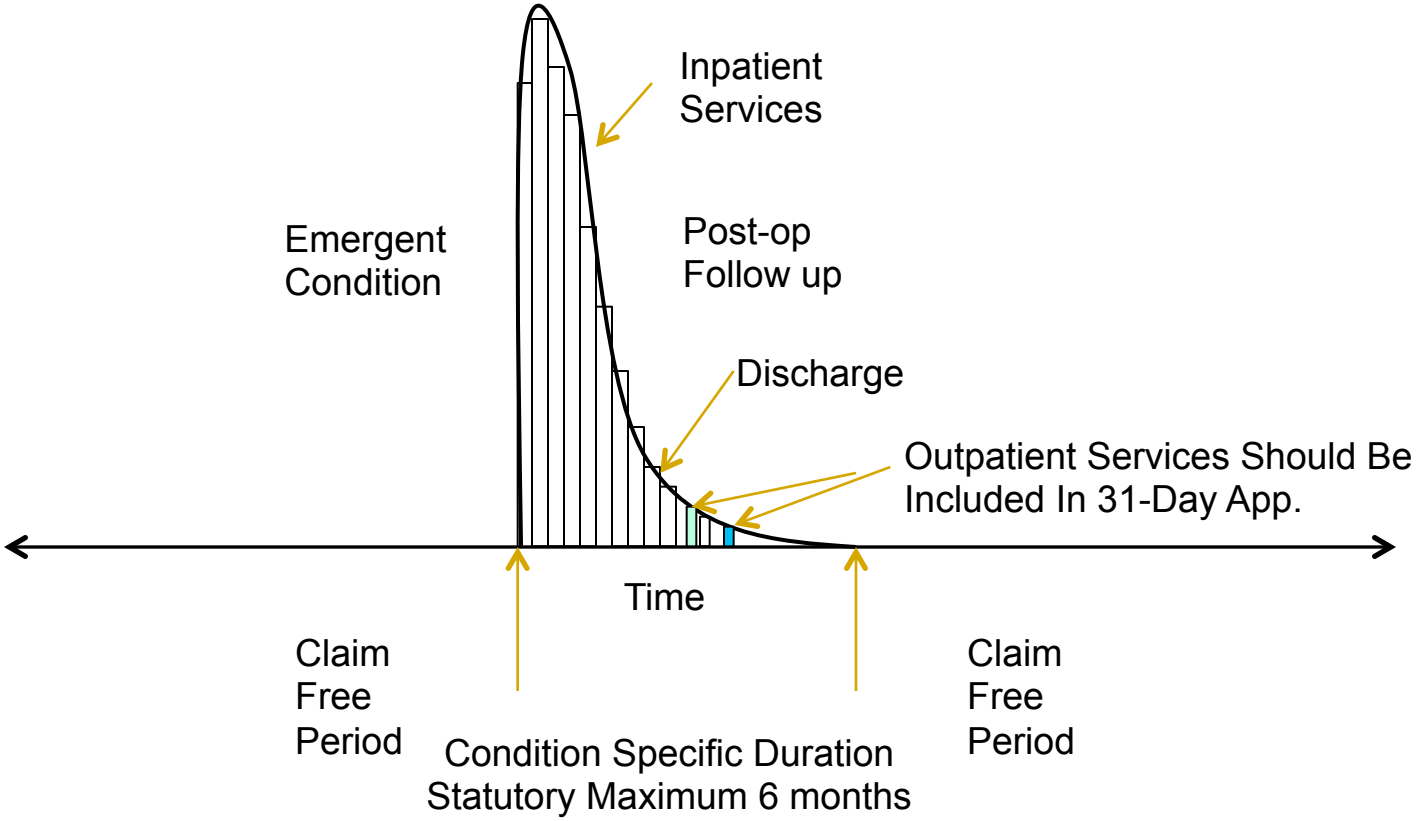
# Clinical Care and the Statute

- "Medically Necessary" – 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?)

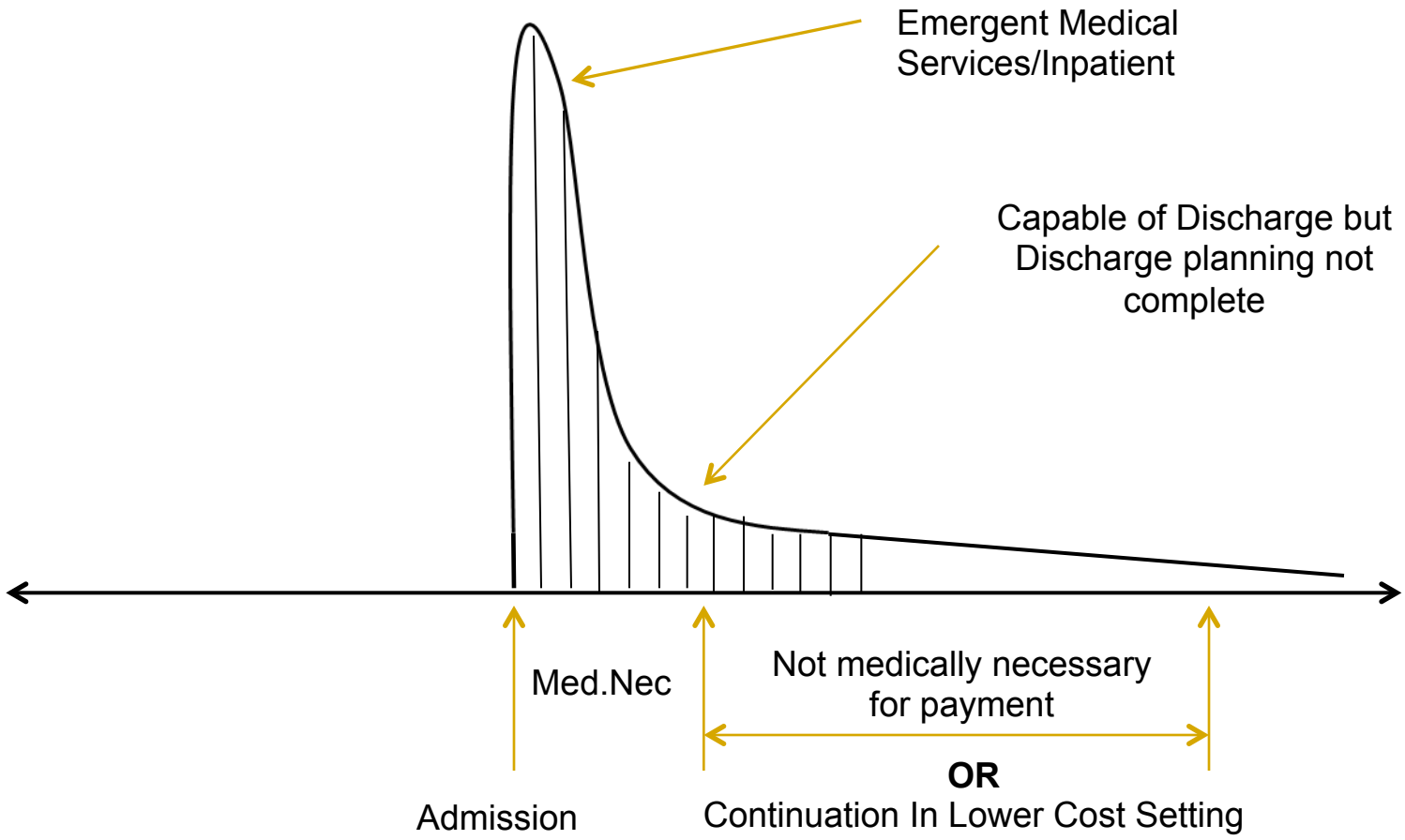
# Episode of Care-10 Day



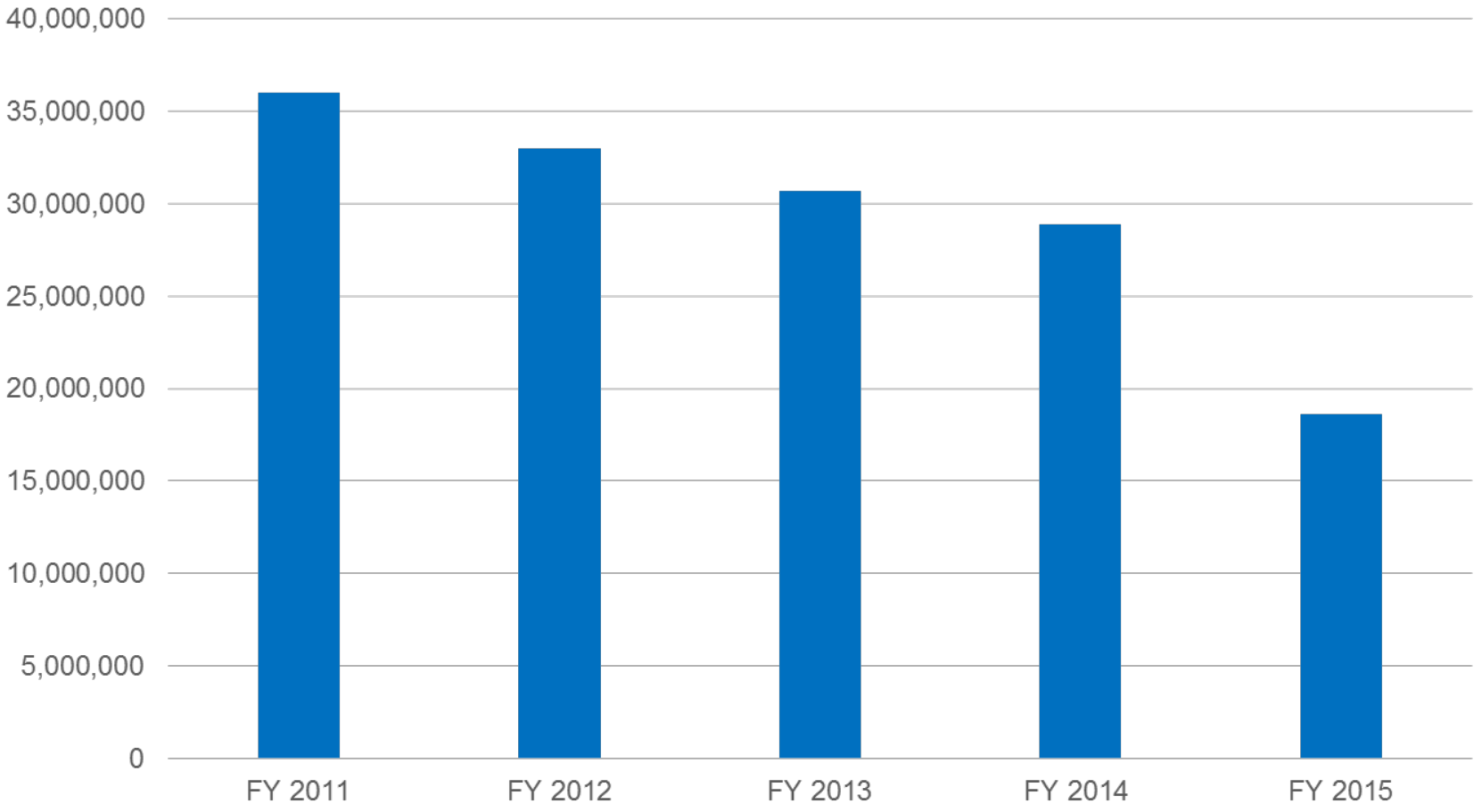
# Episode of Care-31Day



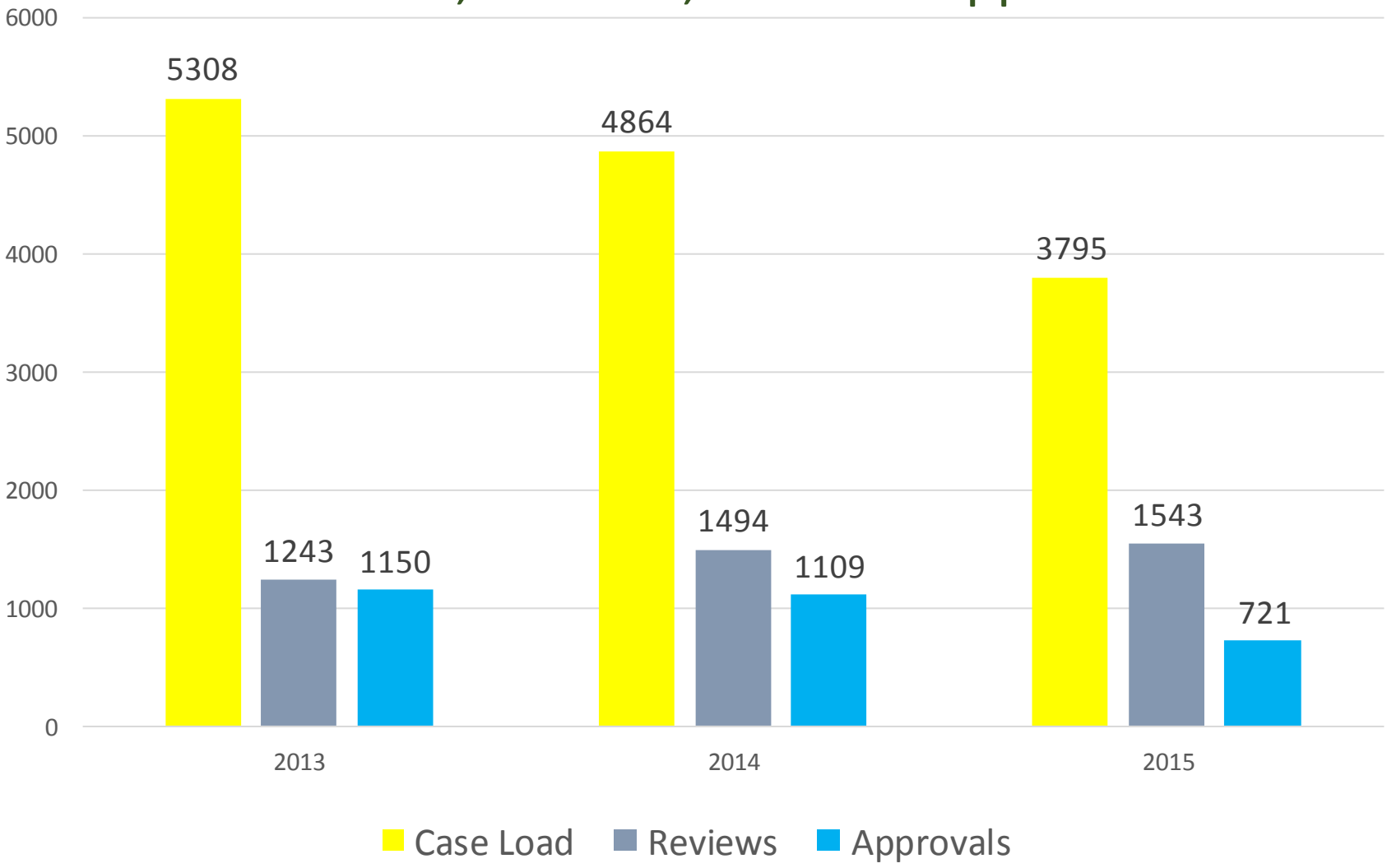
# Episode of Care-31 day-Length of Stay



# Five Year CAT Payments



# Case Load, Reviews, and CAT Approvals



# Impact

- Medical reviews – Since fiscal 2011, this program alone has saved over $18m in general funds; with a steady 35% annual increase in reviews.
- <.1% Appeals

# Improving What We Do

- Standardize Treatment Plan Requests
- Standardize Record Requests
- Standardize Report Formats
- Sequential records added complicates the review process(get all at once)
- NO MAIL. What you need to send.

# Standardized Record Requests

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

# Improving what we do (Continued)

- Copy Melissa on all review requests
- Correct numbers into SCI
- Sequential records complicates the review process(get all at once)
- When to release a review

# 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

# 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 | | Estimated Charges |
|---|---|---|---|---|---|
| | | | FROM | TO | |
| 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:

# 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,

# Future of Affordable Health Care

- Expand the number insured it only works if everyone is in.
- Control costs
  - Physician accountable for cost management
  - Pharmaceutical costs
- Reduce superfluous measurement of physicians
- Medicare will drive change with alternative payment methodologies. Private insurers will follow.  Pay for Value not Volume

# Questions?