
Understanding your Medical Review

2017 Social Services Conference
April 20, 2017

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- 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
 - 1500 Narrative style Medical Reviews 2016
 - About 1200 Abbreviated Reviews 2016
 - Application of Evidence Based Medicine
 - Experience with Commercial Insurance Review Criteria, Review Criteria, and Coding Certification
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Idaho and the ACA

- One of 19 states without Medicaid expansion
- 106,000 enrolled for 2017 through YHI
- ~160,000 still uninsured
- ~78,000 in the gap
- All insurers with any significant exchange population had record loses
 - Unexpected pent up demand/inadequate healthy pool
 - Abuse of the system
 - Inadequate Cost Control

Managing the County Medically Indigent and Catastrophic Health Care Cost Programs

Apply the definitions in 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

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

Requesting Review

- Request **all** records from the facility for the dates of the application.
- Sort the records by date so that they are sequential.
- Separate out and scan to SCI only the following records:

Standardized Record Requests

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

Any additional records will be requested from the county based on the specific case prior to completion of the review

Medial Record Reviews: Best Submissions Practices

- Copy Melissa on all review requests
- Correct numbers into SCI
- Sequential records added complicates the review process(get all at once)
- PLEASE TRY TO AVOID MAIL Use SCI and limit to aforementioned records.
- Request starts at county but ends at CAT

Management of large volume records

- High cost of SCI storage makes limited SCI submissions necessary
- An example of a request from Susan Keck is a perfect way to handle such cases.
 - “Approximately 850 pages of secondary medical records, including hematology, coagulation, chemistry, point of care, physician orders, trauma flow sheets, admin assessment, daily focus assessment, etc., are on file and available if needed.”

Requesting Review (continued)

- In your email state any specific questions you have identified and desire for specific medical answers.
- “Rush” orders should be rare and the time frame you need to meet should be included and why. We work these cases every night and some weekends, therefore typically turn them around in 24-48 hours.

Reading and interpreting the Medical Review

- The Summary is to provide a synopsis of what happened to the patient. It may include dates and services that are not eligible for reimbursement.
- The pertinent information for the Board's decision is in the Opinion Section, and will outline in a "standardized" format the services, and dates that meet the statute for payment, based on medical necessity and emergent definitions.

Reading and interpreting

1. Have all other sources of payment been considered?
2. For this episode of care which services provided or requested are medically necessary and emergent as defined in the statute?
3. What is the recommended reimbursement for the services that defined as medically necessary and emergent?
4. Comparative Data (For Information Only)

Reading and interpreting (continued)

- Other resources for payment. We may feel that the patient appears to meet the Social Security criteria for disability. Because this could allow Medicaid coverage and avoid a future issue the patient should be referred for disability determination.
- We may identify an insurer or a resource like the VA that would be reference in this section.

Reading and interpreting (continued)

- Analysis of the bill may identify charges that are excessive (implants, pharmacy, etc).
- A portion of the entire stay may not be approved, and the unadjusted Medicaid rate should be applied to the only dates allowed.
- It is possible that continued stay but at a lower level of care should be reimbursed at a Swing bed/SNF rate.
- Comparative data is given to facilitate understanding of the charges compared to national norms.

Analysis of UB04 and bill detail

AMERICAN FALLS ID 83211 2082211493				Q	Q	Q	Q	Q	Q
42 INX CD	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 DRG CODE	46 DRG DATE	47 DRG RATE	48 DRG RATE	49 DRG RATE	50 DRG RATE	51 TOTAL CHARGES
0200	ICU ROOM		4588.50		1				4588.50
0200	ICU/CCU BASE RATE		2619.75		2				5239.50
0200	>12 HOUR ICU STAY TRANSFE		2084.26		1				2084.25
0250	ENOXAPARIN				49				1983.42
0251	ESOMEPRAZOLE MAGNESIUM				69				1408.91
0258	LR 1L				2				185.64
0270	CUFF, BP, DISP LG ADULT L				97				1507.13
0271	TUBING U-CONNECT				13				208.06
0510 CLINIC					10				0.00
8034001508	PHQ_Rx_123	01/09/2017	SODIUM CHLORIDE 0.9 % (flush)	A4218	2	8.25			16.50
6034000040	ARR_201701	01/10/2017	ENOXAPARIN	J1650	4	28.49			113.96
6034000040	ARR_201701	01/10/2017	ENOXAPARIN	J1650	4	28.49			113.96
8034001490	ARR_201701	01/10/2017	methy/PREDNISolone SODIUM SUCC	J2930	1	100.77			100.77
6034001001	ARR_201701	01/11/2017	OPREMERZOLAMINE HCL		1	2.40			2.40
6034001926	ARR_201701	01/11/2017	ESOMEPRAZOLE MAGNESIUM		1	19.42			19.42
8034002352	ARR_201701	01/11/2017	INSULIN LISPRO (HumaLOG)	J1815	1	31.65			31.65

5 doses of esomeprazole for about \$100 not \$1,408

4 doses of enoxaparin for about \$456 not \$1983

Reading and interpreting (Continued)

- 90 day global period
 - A **global period** is a **period** of time starting with a **surgical** procedure and ending some **period** of time after the procedure. Many surgeries have a follow-up **period** during which charges for normal post-operative care are bundled into the **global surgery** fee

Response to the provider

- It is not necessary to provide the medical review to the facility. It is only necessary to describe that the records have been reviewed and services were or were not eligible for payment under the statute.
- The medical review should be provided to the provider **only** if the original decision is being appealed for a determination that was felt not to be medically necessary, and the review is requested as part of the appeal.

Managing an appeal from the provider

- Only provide the medical review if the appeal is related to medical necessity, not if the the denial is another reason, such as, timely filing.
- IF the provider asks for a peer to peer after a denial of payment, and they are planning an appeal, I will do the peer to peer in the hope that we can avoid an appeal hearing.
- Involve me early in the appeal and provide me specifics. Arrange time with the prosecutor to develop the best defense.

Example of successful peer to peer

- We had denied outpatient department long-term antibiotics since it was not the lowest cost setting. OPD charges=\$22,000
- The facility appealed and had a letter from the discharging physician
- I contacted the local infusion company and the facility's home health department and found they could deliver the same treatment for about \$100/day or \$3,000.

Incremental Nursing Services

- Incremental nursing charges are represented by a range of revenue codes (230-234) used to request reimbursement for extraordinary, non-routine nursing care services in addition to the typical room and board charges. (National Uniform Billing Committee).
- This requires review to determine medical necessity of the documented nursing services in order to avoid erroneous denial of an appropriately applied code.
- If there was no extraordinary nursing service documented we would add: "The records provided do not support reimbursement for these codes."

QUESTIONS?