Claims Denial Management: What Are Third Party Payers *Really* Telling You about Your Documented Quality-of-Care and Compliance?

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CLINICAL MEDICINE UNDER SEIGE

- More than 42 million American Medicare beneficiaries.
- Medicare estimated to spend $61.5 billion to 875,000 doctors and other health care professionals next year.
- Due to overall Medicare spending above the SGR factor, cut in physician reimbursement mandated by statute again in 2007.
- August 8th, announced proposed cut of 5.1 percent across the board in Medicare payments for services provided by doctors to Medicare beneficiaries.

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LOOKING AHEAD….

- Without a change in Medicare reimbursement formula, reimbursement to physicians slated to be reduced 37% over 9 years.
- Physician Practice costs will increase by 22% over same time period.
- “Our current system of paying for physician services is simply not sustainable, from the point of view of taxpayers or Medicare beneficiaries.” (Dr. Mark B. McClellan, Administrator of CMS)

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QUALITY INITIATIVES ABOUND SETTING HEALTH CARE STANDARDS

- President Bush signed Executive Order on August 22, 2006 – “Transparency of America’s Health Care System”.
- Requires all providers of federally financed healthcare to adopt quality measurement tools and uniform standards.

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REQUIREMENTS INCLUDE

- Setting standards for care of specific health problems.
- Developing uniform methods of measuring Quality & Efficiency in healthcare, and public sharing of the outcomes for Physicians & Hospitals.
- Joining with the government standardize the requirements for information technology.
- Goal of the initiative:
  - "Reduce health care inflation while increasing the quality of medical services individuals receive".

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PAY-FOR-PERFORMANCE TAKES HOLD

- Goal of P4P:
  - Pay for volume with integration of quality vs. payment on basis of volume only.
  - Promote "**Efficiency**" in healthcare delivery.
  - Efficiency→→**Function of cost & quality outcomes.**
  - Improve care for as many Medicare beneficiaries as possible by as much as possible.
  - Reward both improvement & attainment- (Medpar Commission Comments to Proposed Rule June 6, 2006).

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VALUE BASED PURCHASING

- Current Medicare reimbursement system under Prospective Payment System (PPS):
  - Pay for services provided based upon number of complexity of services provided.
  - Little recognition of "Quality and 'Efficiency" in differentiating payment reimbursement.

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KEY TO SUCCESS OF VALUE BASED PURCHASING

- The importance of aligning hospital and physician incentives so that everyone will be working toward improving quality and providing appropriate care.
- Deficit Reduction Act requires Medicare to design and implement a P4P program for physician services by 2009.

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SOME SUGGESTED PERFORMANCE MEASURES

- NQF Measures
  - **Outcomes**
    - 30-day heart failure mortality
    - 30-day heart attack mortality
  - **Complications**
    - Urinary catheter- associated infection rate
    - Central line-associated blood stream infection rate
  - **Clinical**
    - Surgery patients with recommended venous thromboembolism prophylaxis ordered
- **The Importance of Risk Adjustment**

PHYSICIAN STRATEGY TO FACE P4P AND VALUE BASED PURCHASING

- Avoid the "Ostrich Approach":

  Ignore the issues faced in the business of medicine, hoping it will be considered a fad.
- Focus upon building, expanding and improving upon present medical record documentation techniques.
- "Implicit Medical Record Documentation" no longer suffices.

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Medical Descriptions **DO NOT APPLY TO MEDICAL INPATIENT RECORD DOCUMENTATION !**

Explicit Documentation A Must !!

DOCUMENTATION COMPLIANCE

- Documentation→→Captures and represents Physician Medical Decision Making.
- Physician Skill Set → Translating Medical Intellectual Capital into Signs & Symptoms
- Further patient work-up, Signs & Symptoms evolve into “Diagnoses” or “Suspected Diagnoses”
- Poor Quality = “Little or No Diagnoses” documented in the record

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DOCUMENTATION EXAMPLE #1

- Example of incomplete medical record documentation that fails to best capture Medical Decision Making and meet Medical Necessity for patient management:
  - Patient with known CAD and hypertension admitted to hospital with chest pain. MI diagnosed by EKG. Two days after admission, patient becomes short of breath, 40 mg Lasix IV ordered by physician
    - Physician Order- “Chest x-ray shows **pulmonary congestion,** 40 mg IV Lasix immediately
  - True S/I Documentation: “ 40 mg IV Lasix for **Heart Failure in patient** with echo shown EF 35% **post MI”.**

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DOCUMENTATION EXAMPLE #2

- Seventy two year old patient admitted from nursing home with sudden onset shortness of breath, tachycardia, Labs= **WBC 21.2, 20 bands, 102° T/124 P/28 RR**. History of stroke with residual dysphagia, PEG tube
- Presented to ED with above labs & vital signs. Has history of similar clinical presentation to ED 3 times in past 6 months. Was recently discharged from hospital with **Pneumonia** 1 month PTA.

DOCUMENTATION EXAMPLE #2a

- Chest X-ray read as infiltrate RLL
- Patient received **IV Rocephin** in ED, Continued on floor.
- **Hgb A1c** ordered on HD 3. **Results 9.6**
- **Clindamycin** added to antibiotic regimen HD 2.
- **Digoxin, Tegretol, Insulin** continued (outpatient meds).
- Diagnosis of **Pneumonia** made on day 1, treated over course of 5 days, patient discharged on day 6 back to nursing home.

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INAPPROPRIATE SI/IS FINAL DIAGNOSES FOR #2a

- Pneumonia
- Failure to Thrive
- Dysphagia
- S/P Stroke
- S/P PEG tube

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WHAT'S MISSING IN #2a?

- Specificity and completeness of documentation to adequately capture medical decision making and clinical management of patient
  - **Patient on three outpatient meds, no diagnoses documented. (Digoxin, Tegretol, Insulin)**
  - **Physician added sequential antibiotic, clinical - Rationale? (Rocephin, Clindamycin)**
  - **Physician ordered Hgb A1c - Clinical rationale and justification? (Never doc. DM)**

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SPECIFICITY IN DOCUMENTATION

- Final Diagnoses Considerations:
  - **Aspiration Pneumonia**
  - **Diabetes Type II, uncontrolled**
  - **Atrial Fibrillation**
  - **Seizure Disorder**
- **NO TELL**→ NO CREDIT
- No Credit→→ Inaccurate Reporting of potential morbidity, mortality, IS/SI.
- Don't Short Change the Capture of **Your** Quality of Care Provided.

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SPECIFICITY & COMPLETENESS REALLY COUNT

- Complete Medical Record Documentation:
  - Fundamental to establish Medical Necessity.
  - Necessary for establishing Severity-of-Illness, justifying Intensity-of-Services.
  - Required for accurate claims data reporting to 3rd party payers.
  - Used for aggregation of data, tracking and trending, and **Profiling.**

CLAIMS DATA DOWNSTREAM USES

- Third party payers using insurance claims data and other information to help Employers and Consumers analyze health care trends and evaluate care.
- Blue Health Intelligence de-identified health information on 79 million Blues members from 20 BCBC plans.
- Care Focused Purchasing - Employer driven project.
- Gather de-identified claims data, measure health care outcomes and costs, and provide results to Employers.

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CARE FOCUSED PURCHASING - PHYSICIAN FOCUSED

- Will provide employers with information on the Quality and Efficiency of health care among various **Hospitals and Physicians**.
- Initiative different than other projects to aggregate claims data to help measure health care quality because it will analyze both **Quality and Efficiency** at the individual Physician level.
- Provide information to Employers about **Costs and Quality** of individual Physicians.

BEST COMPLIANCE

- Focus Upon Complete & Accurate Medical Record Documentation – Inpatient & Ambulatory Care Settings.
- Strive to document Diagnoses….
- Transfer "Clinical Intellectual Capital" into words that can be translated into proper ICD-9 classifications.

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PERATIVE DOCUMENTATION TIPS for APPROPRIATE HOSPITAL SETTING COMPLIANCE

Avoid Signs & Symptoms as final Diagnoses

Don’t treat lab values, treat Diagnoses

Don’t leave the coders hanging with “Rule Out”.

Physician Order = Physician Diagnosis

List of Patient Medications = List of Patient Diagnoses

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IMPERATIVE PROGRESS NOTE DOCUMENTATION TIPS

- “History Of” = “History Of” occurred in Past.
- “Active but Stable” = Chronic Dz Controlled by Tx or Monitoring.
- Name that abnormal finding – “Hyponatremia” in place of “↓ Na^{+}”
- Strive for “Cause & Effect” relationships when documenting.
- Coders are not mind readers, nor are they Physicians!
- Golden Premise - “Why & For What”.

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OBSERVATION VS. INPATIENT ADMISSION-MAKE THE RIGHT DECISION

Observation Care

- Patient can be evaluated or treated within 24 hours
- Rapid improvement is anticipated for your patient within 24 hours
- Patient experiences postoperative events that require further monitoring (i.e., postoperative bleeding, pain management, intractable vomiting, delayed recovery from anesthesia)
  - If unsure, select observation care
    - (MPRO- Michigan QIO)

OBSERVATION VS. INPATIENT ADMISSION-MAKE THE RIGHT DECISION

Inpatient Care

Patient cannot be evaluated or treated within 24 hours

- Rapid improvement is not anticipated for the patient within 24 hours.

Medical Decision Making- Based upon the patient's clinicals in the ED after work-up and management, will the patient's condition require more than 24 hours to further work-up and discharge or does the patient require more than 24 hours?

"Surgical Abdomen" vs. "Vague abdominal pain"

InterQual Criteria as "Guide," supplemented with qualifying **physician medical decision making**, explicitly documented in record.

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The beginning………..