Hyperbaric Medicine

'10 Tips to Receive and Keep Reimbursement'

Undersea and Hyperbaric Medical Society
Annual Scientific Meeting

Salt Lake City, June 27, 2008

www.baromedical.com/literature_review.asp

The Issues

- 'Medically necessary' interpretations
- Claims for unapproved uses
- Failure of coding compliance
- Documentation shortfalls
- Adverse determination appeals

No.1

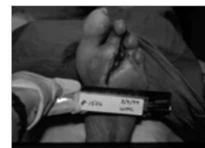
Complicated Toe Amputation Site Healing

Key to compliant course of clinical action/claim filing based on amputation type, in terms of intended closure

- *Open?*
- *Primary closure via approximation? Rarely employed*
- *Primary closure via rotational skin flap?*

Toe Amputation

Referral of a complicated open amputation



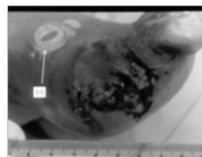
Correct coding is:
997.60 (amputation complication, unspecified), or
997.62 (if complicated by infection)

No Medicare indication for HBO therapy; no medically necessary code

The use of code 996.52 *'complicated flap'*, results in denials (commercial insurers) or repayment demands (Medicare)

Toe Amputation

Referral of a complication involving skin flap coverage



Correct code is 996.52 (skin flap complication) and supports an indication for HBO therapy

Best practice standards would dictate:
i. tcPO2 screening
ii. determination of flap complication etiology
iii. HBO started as soon as concerning signs appear

Wagner Grade 3 Lesion

Distal diabetic foot wound (Wagner 3); transmetatarsal amputation eliminates it, but post-op healing concerns

~ *coding this as a Wagner 3 is not recommended and difficult to defend*

~ *was the amputation closed with plantar skin? If yes, then treat and code as a compromised skin flap…996.52*

~ *otherwise, this is a amputation complication …997.60 of 997.62*

Use of 040.0 (gas gangrene) and 728.86 (nec fasc) for necrotic tissue likely to be rejected without supportive labs/x-rays and inpt. HBO

No.2

Compromised Skin Flap: Yes or No?

What exactly constitutes a skin flap; confusion and discussion in the hyperbaric setting…*not so for the plastic surgeon*

Common Problem Sites:

- Compromised BKA
- Dehisced saphenous vein donor site
- Dehisced abdominal incision

No.3

Osteomyelitis: When Chronic; When Refractory?

Common insurance standard definition:

Treatment response failure after surgical debridement and at least 6 weeks of antibiotics

Trailblazer Health Enterprises; LCD M-15A-R5: 11 / 2006

Common orthopaedic textbook definition: There is none!

Common infectious diseases textbook definition: The same!

Dorland's medical dictionary: Still the same

Ask an orthopedist: Chronic '6-8 weeks', Refractory 'failed an eradication attempt' (usually surgical)

Palmetto GBA Medicare FI

HBO Therapy Documentation; ID A9698: 8/01/2000

'It is occasionally noted that HBO starts the first day after the diagnosis (CROM) is made. This, by itself, is a good basis for making no Medicare payment …'

To assist appeals re: payment denial/repayment demand:

- Can you document standard care?
  - *~ and a protracted unsuccessful course?*
- How did the surgeon and ID docs code this case?
  - *~ 730.1x? …were they paid?*
- How did the hospital code this case?
  - *~ 730.1x? …was the hospital paid?*

No.4

Acute Peripheral Arterial Insufficiency

Frequently misapplied to LE problem wounds for the purpose of qualifying HBO therapy

~ uncommon dx; an outbreak of APAI when Medicare changed its HBO policy re: prep-preservation skin grafts

~ most were treated as outpatients for what is in fact was a chronic LE wound

Acute Peripheral Arterial Insufficiency

Coded as:

444.41* Upper extremity

444.21*/444.22*/444.81* Lower extremity

~ definition of 'acute'

~ examples

~ Medicare in-patient treatment expectation

** Medicare likely to deny payment if provided on outpatient basis*

Soft Tissue Radionecrosis (STRN)

No.5

Definition: Skin only vs. anything but bone?

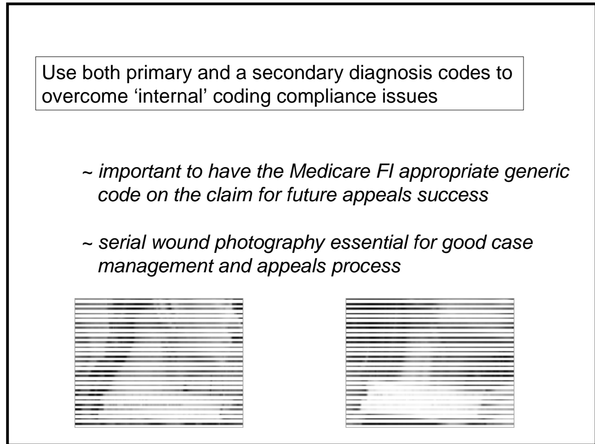
For commercial payors, confirm 'medical necessity' via pre-authorization

Coding issues: Highest degree of certainty

Medicare requires a generic code(s) 990 or 909.2*; regional FI dependent*

Anatomic Specific ICD-9 LENT Codes

Organ/Site	ICD-9 Code	ICD-9 Descriptor
Bladder	595.82	Radiation cystitis
Colon	558.1	Radiation enterocolitis
CNS	336.8	Radiation myelopathy
Dental caries	521.02	Radiation caries, into dentine
	521.03	Radiation caries, into pulp
	521.09	Other radiation caries
Larynx	476.0	Chronic laryngitis
	478.70	Unspecified disease of larynx
Lung	508.1	Radiation pulmonary injury
Mandible	526.89	Mandibular osteoradionecrosis
Oral cavity	528.8	Oral submucosal fibrosis/tongue
Rectum	569.2	Stenosis of rectum or anus
	569.3	Hemmorhage of rectum or anus
	569.41	Ulcer of rectum or anus
Skin/subcu.	692.82	Radiation dermatitis
Vagina	616.10	Post-radiation vaginitis



Critical Care Services/Codes

No. 6

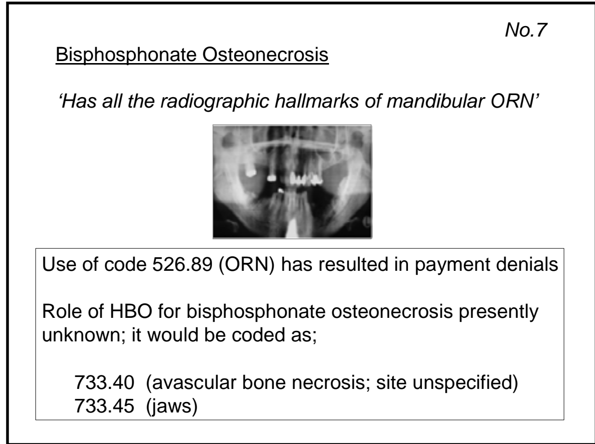
99291 and 99292 vs. 99183

Physician's direct delivery of care to the critically ill or the critically injured; vital organ system failures

- Central nervous system failure
- Circulatory failure; profound shock
- Renal, hepatic, metabolic or respiratory failure

Physician must give full time/attention to the patient; cannot provide services to any other

Claims for DCI; bill by the hour for MD attendance



Documentation Shortcomings

No.8

Palmetto GBA FI:
HBO Therapy Documentation; ID A9698: 8/01/2000

'There are three areas of concern in HBO documentation'

'Documentation needs to support the diagnosis'

'Attendance documentation needs to be individualized to the patient and specific to the disease process'

'More than one time annotated note necessary if treatment greater that 59 minutes'

Supporting the Diagnosis

There are several 'medically necessary' conditions in which HBO is used '*as an adjunct to conventional treatment*'

~ When Medicare requests supportive documentation they are anticipating that some of this material will identify concurrent 'standard care' events

i. CROM…records of surgery and antibiotic
ii. Radiation proctitis…record of diverting colostomy
iii. Radiation cystitis…records of instillations
iv. Necrotizing fasciitis…records of serial debridement

Supporting Physician Attendance

A common basis for Medicare repayment demands

'HBO # 35; I am in attendance during this treatment'

~ 'We are not in the business of disputing a physician's statements'

~ 'We do require minimal documentation, including some history, some physical assessment and some decision making'

-'not a cloned or generic checklist'

Documentation Shortcomings

The lower extremity wound

'The medical record must include, at a minimum, a wound's evaluation at least q 30 days during administration of HBO'

~ recommend this be undertaken and recorded weekly

' The medical record did not contain a clear and complete description of the wound'

~ current wound volume (dimensions and depth)

~ presence (extent) or absence of infection

~ presence (extent) or absence of non-viable tissue

Medicare Claim Filing and Appeals *No. 9*

No pre-approval process:

~ call to FI medical director; two different FI's

~ patients signs ABN where 'medically necessary' doubt exists

Provider must always file a claim if beneficiary receives services…failure to do so violates mandatory claims submission provision; could result in sanctions

Medicare Claim Filing and Appeals

Claim meets CMS/local FI standard…paid *
~ collect any co-insurance and patient deductible

Claim fails medical necessary standards…denied
~ appeal or collect full charges from patient if ABN signed, otherwise appeal

** post-payment review possibility*

Medicare Claim Filing and Appeals

Correct a claim or appeal a claim?

Denied vs. Rejected (reject message CO-16)

Provider options are to either;

RESUBMIT…REOPEN…APPEAL

Medicare Claim Filing and Appeals

RESUBMIT

Approach when a claim is rejected (CO-16)

Because of missing or incomplete information

~ *claim form incomplete*

~ *missing provider ID number*

~ *services are payable by another provider*

REOPEN

Approach to use when a claim rejected because of minor filing errors or omissions

Request that the FI reopen the claim in order to make necessary corrections

- ~ *add/delete modifier*
- ~ *change/correct referring physician ID*
- ~ *date of service correction*
- ~ *billed amount change*

'Reopen' process cannot be used to add services not previously submitted

APPEALS

Five appeal levels for addressing denial of 'medical necessity'

- Redeterminations
- Reconsiderations
- Administrative Law Judge
- Medicare Appeals Council
- Judicial review in U.S. Federal District Court

Redeterminations

First level of appeal, must be filed within 120 days from determination (denial) date

~ most common denial is 'not medically necessary

~ can be on letterhead (I prefer) in order to better argue the science and add references vs. Form CMS-20027

~ add data not previously able to submit

~ FI must reply within 60 days

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: ____
2. Medicare Number: ____
3. Description of Item or Service in Question: ____
4. Date the Service or Item was Received: ____
5. I do not agree with the determination of my claim. MY REASONS ARE: ____
6. Date of the initial determination notice ____
   (If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)
7. Additional Information Medicare Should Consider: ____
8. Requester's Name: ____
9. Requester's Relationship to the Beneficiary: ____
10. Requester's Address: ____
11. Requester's Telephone Number: ____
12. Requester's Signature: ____
13. Date Signed: ____
14. ☐ I have evidence to submit. (Attach such evidence to this form.)
    ☐ I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Reconsiderations

Second level of appeal; to appeal an 'Unfavorable' or 'Partially Favourable' response to your Redetermination request

~ *moves the review process from the FI and on to a 'Qualified Independent Contractor'. Involves a panel of physicians with 'appropriate clinical expertise'*

~ *must be received within 180 days of the date of the Redetermination decision*

~ *detailed and referenced decision for not medically necessary decisions within 60 days*

~ *usually limited to Part B denials*

Administrative Law Judge

Third level of appeal (Part B), often second level for Part A; dissatisfaction with the QIC decision;

~ *options exist for 'on the record' or 'in person'* *(better)*

~ *must be requested within 60 days of the QIC decision*

~ *ALJ guided less by absolute evidence hierarchy; more by relative degree of evidence* *(wound photography helpful!)*

~ *rulings: ALJ orders FI to remit full or partial payment or dismisses claim*

Administrative Law Judge

NCD's are not reviewable by an ALJ; only the LCD, which represents a 'clarification' of the NCD

~ *because 'clarification' requires interpretation there are regional differences in LCD,s*

Medicare Appeals Council

Provider (or CMS!) dissatisfied with AJG's decision

~ *final level of administrative appeal for all Part A,B,C and D*

~ *no MAC review available to provider if ALJ upholds dismissal by QIC*

~ *must appeal within 60 days of the ALJ decision*

~ *MAC can render a decision or decline to review*

Judicial Review: US Federal District Court

Final level of Medicare appeal, and following MAC decision

Commercial Insurer Appeals

Health insurance company specific, and even state-specific with the same company

Disease specific pre-authorization with written or verbal per agent name and time/date recorded database is key to appeal

Typically involve two types of appeals:

~ *adverse reimbursement and coding decisions*

~ *medically necessary/investigational coverage*

ORN Prophylaxis

No.10 Miscellaneous

Medically necessary insurance payment standard?

No…..Medicare

Yes…Cigna, Anthem BCBS, Wellpoint, Empire BCBS, Aetna

Coding expectation?

Cigna…

Anthem BCBS / Wellpoint / Empire BCBS…990

Aetna…526.89

ORN Prophylaxis

Attempts to claim from Medicare using a 'disease present' code (526.89…ORN, or 990…STRN) places providers at some risk

~ may be determined as a falsification of the medical record, filing false claim

~ despite tcPO2 findings of XRT portal hypoxia

ORN Prophylaxis

Seeking pre-authorization from commercial insurer that does not list this as medically necessary, cite:

~ standard elsewhere (major commercial payors)

~ NCI consensus statement

"Osteoradionecrosis is best managed with HBO therapy alone, or in conjunction with surgery…in high-risk patients, pre-extraction HBO therapy should be considered'

National Cancer Institute Monographs 1990:No. 9

ORN Prophylaxis

Seeking pre-authorization from commercial insurer that does not list this as medically necessary, cite:

~ standard elsewhere (major commercial payors)

*~ medical-legal precedent**

** State of Wisconsin Circuit Court; Waukesha County Case No. 88CV3384; February 26, 1990*

Mandibular Osteoradionecrosis

Referral from the oral surgeon with chief complaint of:

Complaint	ICD-9 Code
Jaw pain	526.9
Jaw necrosis	733.45
Alveolar ridge atrophy	525.2

Medically necessary ICD-9 Code for ORN…526.89

Arterial Insufficiency Ulcers

National Government Services, Inc. (FI x 25)

'Arterial insufficiency ulcers may be treated by HBO therapy if they are persistent after reconstructive surgery has restored large vessel function'

ICD-9 Code 707.1x

Coders will be compelled to add etiologic code 440.23 (atherosclerosis of the extremities with ulceration). Try to insist this be the secondary code

Issues with Part A vs. Part B difference re approved use!

Medicare Demand For Repayment

'The documentation does not document the availability of an ACLS team or ICU level of care services during HBO. No payment will be allowed for HBO without documentation that a trained emergency response team is available, and the setting provides the required availability of ICU services…'

Medicare Explanation Decision

Has the underwriter paid for previous similar care with such documentation?

Were other providers reimbursed for the same case, without the above documentation?