Denial Management: A Dosimetrist’s Role in a Successful Program

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Objectives

Discuss the concept of denial management
Understand the appeals process and timeline
Discuss the dosimetrist’s role in the appeals process
Review required documentation elements
Understand impact of lacking or incomplete documentation
Identify denial trends that may be avoidable

Terminology

• Rejection
  – Failure to meet specific criteria and data requirements on the claim form
  – Claim not received or processed
  – Make corrections and resubmit

• Denial
  – Refusal of an insurance company to pay for health care services obtained from a health care provider
  – Claim received and processed with a negative outcome
  – Submit appeal or redetermination
Medicare Appeals Process

Level 1
Redetermination by Medicare Administration Contractor (MAC)

Level 2
Reconsideration by Qualified Independent Contractor (QIC)

Level 3
Administrative Law Judge (ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)

Level 4
Review by Medicare Appeals Council

Level 5
Judicial review in US District Court

Timeline

Level 1
Request – 120 days
Decision – 60 days

Level 2
Request – 180 days
Decision – 60 days

Level 3
Request – 60 days
Decision – May be delayed due to volume

Level 4
Request – 60 days
Decision – 90 days if OMHA / 180 days if ALJ time expired without decision

Level 5
Request – 60 days
Decision – No statutory time limit
Industry Averages

Up to one-quarter of claims denied – Government Accountability Office (GAO)

Estimated 9% of hospital charges, representing $262 billion initially denied – Change Healthcare

Financial Impact

- For a typical health system, an average of $4.9 million per hospital is at risk due to denials
- Reworking denials cost approximately $118 per claim

Source: Change Healthcare Healthy Hospital Revenue Cycle Index
Denial Management

- Identify opportunities to correct issues that cause denials
- Classify denials for reason, cause or other factors
- Develop and implement strategies to appeal denials
- Ensure timelines are observed

Best Practice: Create A Multidisciplinary Team

Top 5 Claim Denials

- Coding Errors/Modifiers
- Evaluation and Management Services
- Medicare Secondary Payer
- Medical Necessity
- Duplicate Services

Source: A Celerian Group Company (CGS) J15 Medicare Administrative Contractor (MAC)
Documentation Requests

- Quantity / Frequency
- Repeat Procedure
- Pre-payment Review
- Post Payment Review
- Medical Necessity For Modality

Medicare Learning Network

INSUFFICIENT DOCUMENTATION ERRORS

Reviewers determine that claims have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, or were medically necessary). Reviewers also place claims into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

Insufficient documentation errors identified by the CERT RC may include:

- Incomplete progress notes (for example, unsigned, undated, insufficient detail)
- Unauthenticated medical records (for example, no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer, an electronic signature without the electronic record protocol or policy that documents the process for electronic signatures)
- No documentation of intent to order services and procedures (for example, incomplete or missing signed order or progress note describing intent for services to be provided)
Radiation Oncology Review

- Comprehensive Error Rate Testing (CERT) conducted special study of 77301 and 77300
- Included complex review
- Study identified improper payment rate was significantly higher than many other specialty services

CERT Findings

Insufficient Documentation Caused All of the Improper Payments

All of the improper payments were due to insufficient documentation. There were no claims with medical necessity errors or incorrect coding errors in the special study.

Insufficient documentation means that something was missing from the medical records. For example, the medical record was missing one or more of the following:

- No radiation therapy plan was submitted;
- The documentation submitted did not adequately describe the service defined by the HCPCS code;
- The correct date of service;
- A physician's signature; and/or
- A signature log or attestation for an ineligible signature.
Radiation Oncology Example 1

Insufficient Documentation – Missing Signatures

A radiation oncologist billed for HCPCS 77301 and 77300, and for multi-leaf collimator devices for IMRT, therapeutic radiology simulation-aided field setting, therapeutic radiology treatment planning (complex), and IMRT treatment delivery for three dates of service. The submitted documentation included notes for three dates of service different from those billed, an unsigned and undated treatment plan, an undated histogram, a Computed Tomography (CT) scan report, an unsigned fine needle aspiration report, an unsigned operative report, and a breast Magnetic Resonance Imaging (MRI) report. There was no documentation of complex treatment devices (irregular blocks, special shields, compensators, wedges, molds, or cast), and there was no verification of treatment setup and delivery. No signature attestation statement was received from either the radiation oncologist or the radiation physicist and no other medical records were submitted despite a request for additional documentation. This claim was scored as an insufficient documentation error.

Radiation Oncology Example 2

Insufficient Documentation – Missing Order, Intent to Order, and Dosimetry Calculation

A radiation oncologist billed for HCPCS 77301. The documentation received included CT images, a cumulative dose volume histogram, a treatment plan report, and an unsigned IMRT plan summary/calculation for the date of service billed. The billing provider did not submit an authenticated copy of the treating physician’s progress notes to document the order/intent to order radiation therapy prior to billed date of service, nor did the billing provider submit an authenticated copy of the dosimetry calculation for date of service. No other medical records were submitted despite a request for additional documentation. This claim was scored as an insufficient documentation error.
Radiation Oncology Example 3

“Radiation Therapy listed among the top 10 errors by type of service, with a projected error rate of 42.7%.”

Case #5: Treatment Records, Treatment Plans, and Orders

Submitted CPT code:

- 77427: Radiation treatment management x5.

Records submitted:

- Chemotherapy records
- Lab results
- Physician’s note (not signed)
- Discharge Instructions
- Upon second request, the following additional records were submitted: follow-up note; end of treatment summary; consultation note; multiple CT results; pathology results; colonoscopy results; and EGD results.


Financial Impact

- 2015 improper payment rate for radiation oncology – 9.6%
  - 0.3% of overall Medicare FFS improper payment rate
  - $137 million projected improper payment for radiation oncology for 2015

Source: Medicare Quarterly Provider Compliance Newsletter
January 2017
**Common Workflow Issues**

- Staff responsibility, lack of team approach
- Access to the complete medical record
- Knowledge of radiation oncology procedures
- Not looking for trends or patterns
- Lack of communication
- Unsuccessful initial appeal and/or write off

**Dosimetrist’s Input**

- Access to the radiation oncology medical record
- Knowledge of the electronic medical record functionality and reports
- Knowledge of the service performed
- Understand the techniques, equipment/software used and documentation elements
Required Documentation

- Beneficiary and Date of Service
- Physician order
- Written documentation of clinical treatment planning, signed and dated by MD
- Legible radiation therapy records/procedure reports for dates of service
- Dosimetry calculation records
- Record of patient condition before, during and after to support medical necessity…

https://med.noridianmedicare.com/web/jfb/specialties/radiation-oncology/radiation-therapy-documentation-requirements

Does Documentation Support?

Who?

How?

What?

Why?

When?
Dosimetry Planning

Isodose Planning

- Isodose Plan
- Beam Modifiers

3D Radiotherapy Plan

- 3D Planning
- Beam Modifiers
- Basic Dosimetry Calculations

IMRT Planning

- IMRT Plan
- IMRT Device
- Fluence Maps
- Secondary Calculations

Recommended Documentation:

- Physician visit(s), e.g. consults & follow ups
- Clinical treatment planning note
- Order for planning and devices
- Dosimetry plan with physician and physics signatures
- DRR or documentation of each beam modification device
3D Conformal

3D Plan
- 77295
Beam Modifiers
- 77332-77334
Basic Dosimetry Calculations
- 77300

Recommended Documentation:
- Physician visit(s)
- Clinical treatment planning note
- Order for planning, calculations and devices
- Dosimetry plan including physician and physics signatures
- DVH including target volume(s) and critical structure(s)
- DRR or documentation of each beam modification device

IMRT Planning

IMRT Plan
- 77301
IMRT Device
- 77338
Secondary Calculations
- 77300

Recommended Documentation:
- Physician visit(s)
- Clinical treatment planning note
- Order for planning, calculations, devices
- Statement of medical necessity over other forms of treatment
- Goals and dose constraints
- Dosimetry plan including physician and physics signatures
- Secondary MU calculations
- Fluence distributions recomputed in a phantom or equivalent methodology…
IMRT Calculations

- Documentation of independent calculation separate from the treatment planning system
- Requires physician approval

CPT® Assistant, November 2009; page 3:

After the plan is complete, in a separate process, the physicist must perform basic dose calculations on each of the modulated beams. This evaluation is reported with code 77380, Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, XDF, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician. These patient-specific monitor unit computations verify through a second (independent of treatment planning computer) dose calculation method that the computer has correctly performed the treatment planning calculations.

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Respiratory Motion Management

- 77293 Respiratory motion management simulation
- Documentation elements:
  - Order
  - Documentation of work at the time of simulation
  - Evidence of work performed during planning

Complete documentation is essential when reporting an add-on code. Documentation should include both the medical necessity of reporting CPT code 77293 as well as the work that the code describes was done. The documentation needs to be more extensive than just part of the simulation note since it is part of the isodose planning process. Physicians should work with their staff to ensure that proper documentation has been completed. Since the work that is included in 77293 occurs over several days and it involves the therapists, the dosimetrist, the physicist, and the physician, the information that could support the code would appear in several documents. The simulation note would also document physician review of respiratory motion management set-up and use at the time of simulation. The treatment plan document would indicate that the physician created an ITV that covered the largest volume in all phases of respiratory motion. Add-on codes are to be billed separately in addition to the primary procedure code. This code is only charged once per 3-D or IMRT plan and should be reported on the same day as the primary planning code (77295 or 77291).

Tips & Tricks

- Label or tabulate submitted documentation
- Highlight or add comments
- Utilize appropriate verbiage and terminology
- Clear titles or headers for procedure notes
- Review all documentation for required signatures
  - Signature log if illegible
  - Attestation statement for missing signatures
  - Screen capture of EMR
Avoiding Future Denials

• Check for required authorization for treatment technique
• Communicate technique changes or replanning
• Utilize correct diagnosis
  – Highest level of specificity
  – Metastatic versus primary disease
  – Informational codes, e.g. previous treatment
• Submit appropriate procedure coding and quantities

Questions