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Gaps in Clinical Policy Bulletins Put Commercial Claims at Risk

By Nina Youngstrom

When claims are denied by Medicare Advantage (MA) plans and commercial payers for total knee arthroscopy (TKA) or hyperbaric oxygen therapy (HBOT), hospitals should compare their documentation to the clinical policy bulletins for the procedures. It's possible that documentation for a requirement in the clinical policy bulletins, which set forth coverage criteria, is not in the hospital's medical records, and instead is in the physician's progress notes in his or her office. For example, only the progress notes may have documentation of failed conservative treatment, such as physical therapy, as required for TKA coverage, and only the progress notes may have wound classification, as required for HBOT.

Ensuring all the bases are covered in the multitude of clinical policy bulletins, including TKA and HBOT, will improve the odds of getting claims paid and overturning denials, said Denise Wilson, vice president of clinical audit and appeal services for AppealMasters in Towson, Maryland. "They're the first line of defense when appealing denials," she said.

Like Medicare's national and local coverage determinations, clinical policy bulletins are the coverage documents of MA plans and commercial payers. Typically written for outpatient services and procedures, they're specific to each payer. "Clinical policy bulletins outline the medical necessity for having a service or procedure performed," she explained. They're based on acceptable standards of medical care and defined as evidence-based medicine, such as a review of available studies. Auditors use them to determine whether medical records support claims submitted for services and procedures, Wilson said.