Appeal Strategies

Learning from appeal experiences to guide compliance

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Overview

- Areas of auditor focus, admissions pre-October 1, 2013
- Areas of auditor focus, admissions on or after October 1, 2013

In *every* ALJ hearing, it is necessary to:

- Successfully and properly frame the issue under review
  - Using the appropriate standards, establish the reasons why the claim meets CMS coverage criteria
- Address issues raised by medical reviewers
- Confront issues raised on cross-examination

Framing the Issue

- Admissions Pre- October 1, 2013: Frame the issue to focus on Medicare Benefit Policy Manual, Ch. 1, § 10
  - MBPM is based on a 24-hour benchmark: "Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more and treat other patients on an outpatient basis."
    - No "presumption of coverage" tied to 24-hour benchmark
    - However, note that the 2014 IPPS Final Rule "clarifies" that, "Our previous guidance also provided for a 24-hour benchmark, instructing physicians that, in general, beneficiaries who need to stay at the hospital less than 24 hours should be treated as outpatients, while those requiring care greater than 24 hours may usually be treated as inpatients."
- Documentation!

Framing the Issue

- Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 6, § 6.5.2

  Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay. See Pub. 100-02, chapter 1, §10 for further detail on what constitutes an appropriate inpatient admission.

Framing the Issue

- **Relationship between MBPM and MPIM**
  - *See In the case of Spokane Washington Hospital Company, LLC d/b/a Deaconess Hospital* (M-12-1005), decided June 19, 2012;
  - *See In the case of King's Daughters Medical Center* (M-12-1231), decided June 26, 2012
  - **Significantly, some Recovery Auditors and Medicare Administrative Contractors fail to even cite the MBPM in issuing decisions.**

Areas of auditor focus
Admissions Pre-October 1, 2013

- Improper focus on the nature of the services provided
  - *Recovery auditor:* "Outpatient services in the hospital billed as acute hospitalization."
  - *Redetermination reviewer:* "It is my determination that these services could have been rendered on an outpatient or observation level of care."
  - *Reconsideration reviewer:* "The services that the beneficiary received were not high acuity services."

Areas of auditor focus
Admissions Pre-October 1, 2013

- Statutory, Regulatory and CMS Sub-regulatory Definition of "**Inpatient Hospital Services**"
  - 42 U.S.C. § 1395x (b)
  - 42 C.F.R. § 409.10
  - Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 1, § 1

Subject to the conditions, limitations, and exceptions set forth in this subpart, the term "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- Bed and board.
- Nursing services and other related services.
- Use of hospital or CAH facilities.
- Medical social services.
- Drugs, biologicals, supplies, appliances, and equipment.
- Certain other diagnostic or therapeutic services.
- Medical or surgical services provided by certain interns or residents-in training.
- Transportation services, including transport by ambulance…

Areas of auditor focus
Admissions Pre-October 1, 2013

- Cross Examination
  - Which of the services provided can be furnished safely and effectively **only** on an inpatient basis?
  - Which of the procedures performed cannot be completed in 24 hours or more?

Areas of auditor focus
Admissions Pre-October 1, 2013

- Use of Commercial Screening Tools
  - At least one Medicare Administrative Contractor routinely based claim denials on InterQual criteria.
  - Although alone, compliance with commercial screening tools is unlikely to serve as the sole basis for a favorable ALJ decision, it should be argued that such criteria cannot only be used as a sword (and not also as a shield).
    - Compliance with commercial screening tools should be included with reconsideration submission and argued at ALJ hearing.
  - Waiver of Liability / Provider without Fault implications

- For admissions on or after October 1, 2013, use of commercial screening tools is less relevant, but remains helpful to demonstrate that a patient needed care in the hospital setting at a given point in time.

Areas of auditor focus
Admissions Pre-October 1, 2013

- Example of misapplication of CMS criteria at

The records did not support more intensive monitoring or extended nursing or physician care that would require an inpatient stay. Observation hospital care rather than inpatient admission was appropriate for [redacted]. The requirements for observation care, appropriate for this patient, are the same as for inpatient care with the exception that inpatient care is considerably more intense in terms of resource utilization (e.g., ICU/CCU) and/or duration (commonly more than two days), entailing more extensive resource utilization.

  - Improperly based denial on intensity of services rendered (e.g., reference to ICU/CCU); and
  - Failed to apply published CMS criteria re: 24-hour benchmark; instead, the MAC applied its own, internal and unpublished criteria - "duration (commonly more than two days)"

Areas of auditor focus
Admissions Pre-October 1, 2013

- Example of misapplication of CMS criteria at

Upon review of the information sent, as a Palmetto GBA independent contractor, I agree with the findings of the Recovery Audit Contractor. It is my determination that these services could have been rendered on an outpatient or observational level of care. The beneficiary's short hospital stay was uneventful and he was discharged two days later. These services could have been billed at the appropriate outpatient level of care. Therefore, Palmetto GBA is unable to deliver a favorable decision.

  - Improper denial based solely on retrospective review of the patient's hospital course (e.g., "stay was uneventful")
    - *See* Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 1, § 10 (regarding QIO review):

    In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

  - This example is taken from an appeal of a 49 hour hospital stay

Areas of auditor focus
Admissions Pre-October 1, 2013

- Example of misapplication of CMS criteria at Reconsideration (Note: 62 hour hospital stay):

None of the services that the beneficiary received during the hospital stay could be defined as high acuity care. None of the testing done yielded results that prompted urgent or complex intervention. The presenting symptoms did not recur. No clinical events were noted to have necessitated more intensive monitoring, or any escalation in the beneficiary's level of care.

The beneficiary completed the evaluation and treatment regimen implemented by the medical team, and was discharged to follow up in the outpatient setting. The documentation provided failed to support that Medicare criteria for inpatient admission were met. Therefore, the denial is upheld.

- Decision improperly based on "level" of hospital rendered: No "High acuity care;" No "escalation in the beneficiary's level of care"
- Decision improperly based on retrospective review of patient's hospital course

Areas of auditor focus
Admissions Pre-October 1, 2013

- Example of misapplication of CMS criteria at Reconsideration:

In consideration for the acuity of care rendered during the admission, the level of intensity at which monitoring occurred, the complexity of decision making and the non-urgent pace at which care was provided, medical documentation did not support that Medicare inpatient criteria were met.

- This rationale may gain momentum for medical reviews of claims with admissions on or after October 1, 2013 (i.e., "the non-urgent pace at which care was provided")

Emerging areas of auditor focus Admissions Pre-October 1, 2013

- Watch for Medical review contractors attempting to inappropriately apply new regulations to pre-October 1, 2013 admissions

Emerging areas of auditor focus Admissions On or After October 1, 2013

http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html

•Probe and educate

•Purposes:

- Identify claims that are non-compliant with the 2014 IPPS Final Rule;
- Issue (pre-payment) denials for improper claims for payment; and
- Educate providers about the 2014 IPPS Final Rule

Emerging areas of auditor focus
Admissions On or After October 1, 2013

http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html

•Probe and educate

•For inpatient admissions between 10/1/2013 and 3/31/2015:

– CMS will direct the Medicare review contractors to apply the 2-midnight presumption – i.e., contractors should not select Medicare Part A IP claims for review *for the purposes of determining whether IP status was appropriate* if the IP stay spanned 2 midnights from the time of formal admission

Emerging areas of auditor focus Admissions On or After October 1, 2013

- MACs may still review Part A IP claims crossing 2 midnights following the formal admission for purposes unrelated to patient status:
  - (1) To ensure the services provided were medically necessary;
  - (2) To ensure that the hospitalization was medically necessary;
  - (3) To validate provider coding and documentation;
  - (4) When a CERT Contractor is directed to review such claims;
  - (5) If directed by CMS or other entity to review such claims.

Per the Final Rule at p. 50951: "We note that it was not our intent to suggest that a 2-midnight stay was presumptive evidence that the stay at the hospital was necessary; rather, only that **if** *the stay was necessary, it was appropriately provided as an inpatient stay… [S]ome medical review is always necessary…"*

- Claims with evidence of systemic gaming, abuse or delays in the provision of care in an attempt to surpass the 2 midnight presumption could warrant medical review at any time. *See* CR 8508, Transmittal 1315, 11/15/2013.

Emerging areas of auditor focus Admissions On or After October 1, 2013

- Generally speaking, IP stays spanning 0-1 midnight following formal IP admission will be the focus of review for patient status. In particular, the MACs will review the following:
  - The admission order requirements,
  - The certification requirements, and
  - The 2 midnight benchmark.

Emerging areas of auditor focus
Admissions On or After October 1, 2013

- Cases where IP stays lasting less than 2 midnights are generally appropriate for Part A payment:
  - IP only procedures
  - Mechanical Ventilation
  - If an unforeseen circumstance results in a shorter stay than the physician's reasonable expectation of at least 2 midnights. *Examples*:
    - Death
    - Election of hospice care
    - Transfer to another hospital
    - Departure AMA
    - Clinical improvement
      - **Importance of documentation and hearing testimony:** ***Per FAQ, "Review contractors' expectations for sufficient documentation will be rooted in good medical practice."***

Emerging areas of auditor focus Admissions On or After October 1, 2013

- **Probe and Educate Review Findings**
- Missing or flawed order for inpatient admission
  - *"CMS reminds providers that while Medicare does not require specific language to be used on the inpatient order, it is in the interest of the hospital for the admitting practitioner to use language that clearly expresses intent to admit the patient as inpatient."*

Emerging areas of auditor focus Admissions On or After October 1, 2013

- **Probe and Educate Review Findings**
- Short stay procedures
  - *"A beneficiary presented for a procedure in which treatment and discharge typically occur in less than 2 midnights. The procedure is not on the inpatient-only list. The physician wrote an order to admit to inpatient upon arrival at the hospital for pre-operative care. The medical record did not support the expectation of a 2-midnight stay for hospital care. The beneficiary underwent the procedure without any complications…"*
    - The cited example involved just a 10 hour hospital stay

Emerging areas of auditor focus Admissions On or After October 1, 2013

- **Probe and Educate Review Findings**
- Short stays for medical conditions
  - *"The beneficiary presented to the ED with recent onset of dizziness and denied additional complaints. The beneficiary reported a recent adjustment to his blood pressure medication. The physician's notes stated that the beneficiary was stable and that his blood pressure medication was to be held and dosage adjusted. The notes also indicated that the physician intended to observe the beneficiary overnight…"*

Emerging areas of auditor focus Admissions On or After October 1, 2013

- **Probe and Educate Review Findings**
- Physician attestation statements without supporting medical record documentation

QUESTIONS?

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