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INVESTIGATE THE WORLD OF COMPLIANCE

Strategies for Preventing & Appealing RAC Medical Necessity Denials

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RACs:
A Wake Up Call for Hospitals

- Requires that we defend and/or correct past behavior and outcomes
- Also creates a reason to implement processes to avoid future problems

Where & How Do We Start?

Why is Getting Patient Status Correct Such An Important Issue?

- Incorrect overuse of Inpatient
  - Inpatient short stays that are deemed not appropriate create a compliance and potential False Claims issue if no compliant process is in place
  - Eventual loss of revenue on audit and loss of opportunity for appropriate OBS APC and ancillary charge payment
- Incorrect overuse of Observation
  - Compliance issue
    - Due to incorrect determination
  - Revenue integrity issue
    - Loss of avg. $4-5K/medical case
  - Length of stay artificially elevated
  - Transfer DRG payment impact
  - Qualified stay impact on patient skilled care benefit
  - Unexpected patient financial responsibility
    - E.g.- self administered medication charges

“Revenue Integrity”

- Ensuring that the Medicare and Medicaid revenue received is CORRECT, so that, on subsequent internal or external audit, the revenue received will not need to be returned and the opportunity to subsequently bill the claim correctly will not be lost.

Regulatory Definition of "Inpatient"

Medicare Benefit Policy Manual Chp 1 § 10

"An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."

"However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

The severity of the signs and symptoms exhibited by the patient;
The **medical predictability** of something adverse happening to the patient;…"

Regulatory Definition of "Observation"

Medicare Benefit Policy Manual, Chp 6, § 70.4

"Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and at least periodic monitoring by a hospital's nursing or other staff which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff by-laws to admit patients to the hospital or to order outpatient tests."

"When a physician orders that a patient be placed under observation, the patient's status is that of an outpatient. The **purpose of observation is to determine the need for further treatment or for inpatient admission**. Thus, a patient in observation may improve and be released, or be admitted as an inpatient (See Pub. 100-02, Medicare Benefit Policy Manual, chapter 1, §10 "Covered Inpatient Hospital Services Covered Under Part A")."

Your UR Plan is the Standard by Which You Will Be Judged

- Your UR Plan is the standard by which you will be judged to be in (or out of) compliance with the UR CoPs with Medicare Part A
- "The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs."
- 42CFR482.30(c)(1) *Standard: Scope and frequency of review.*
- "The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of—
  - ✓ **(i) Admissions to the institution**;
  - ✓ (ii) The duration of stays; and
  - ✓ (iii) Professional services furnished, including drugs and biologicals."

Regulatory Guidance for How the UR Committee Can Best Carry Out Its Mandate

- **Best Practices for Admission & Continued Stay Review (HPMP Compliance Workbook pg 33)**
  - "Because it is not reasonable to expect that physicians can screen all admissions, continued stays, etc. for appropriateness, **screening criteria must be adopted by physicians that can be used by the UM staff to screen admissions**, length of stay, etc. The criteria used should screen both the severity of illness (condition) and the intensity of service (treatment). There are numerous commercial screening criteria available. In addition, some QIOs have developed their own criteria for screening medical necessity of admissions and procedures. CMS does not endorse any one type of screening criteria."
  - "**Cases that fail the criteria should be referred to physicians for review**. **For your UM program to screen medical necessity appropriately, the decision to admit, retain, or discharge a patient should be made by a physician**, either through the use of physician approved or developed criteria, or through a physician advisor."
  - Note that "Physician Developed Criteria means an *evidence based, literature backed protocol – not just an opinion.*

How Do Most Hospitals Manage Medicare Admission Review?

- Decision to admit is commonly made in the ED
- Admitting (or ED) Physician checks off a box – "Admit to Inpatient' or "Place in Observation" or writes an order
- Case/Utilization Management Professional reviews case
  - UR inpatient screening criteria are applied
- If case does not meet inpatient criteria, call sometimes made to treating physician to ask for more information
  - **Physician response is "variable" at best…**
  - **"The Curmudgeon", "The Runner" and "The Pleaser"**
- Final admission claim certification made based solely on meeting or not meeting UR screening criteria without true secondary review by a trained UR physician
- Little/no documentation regarding review process in the chart

Why All the Confusion?

- Most Case Managers use standardized admission criteria such as Interqual & Milliman (as they must) to judge medical necessity
- Criteria are screening tools with high false negative error rate (Approx 20%)
- While Secondary Physician Review is REQUIRED, it RARELY happens correctly…why?
  - Most treating physicians do NOT understand how to apply the regulatory and clinical definitions of Inpatient and Observation to correctly determine admission claim status
  - Very frequently, the treating physician does not even conduct a secondary physician review

Compare Admission Status Certification Outcomes: 1st Level Criteria Screen Alone vs. Secondary Physician Advisor Review

Example of a "Wrong Setting" Complex Review Audit

CLAIM FACTS

- *The beneficiary presents to the emergency room with shortness of breath. EKG is normal. Chest x-ray rules out pneumonia.*
- *The hospital admits the beneficiary for a one-day hospital stay.*
- *Medical record reviews indicates no reason why the services could not have been performed on an outpatient basis.*
- *The entire inpatient claim is denied.*
- *Error Type: Medically Unnecessary*

CORRECTIVE ACTIONS

- *Hospitals can be more careful when submitting claims for one-day stays to ensure that the services rendered were medically necessary in that setting.*
- *Medicare claims processing contractors can remind hospitals to be careful when admitting patients for one-day stays to make sure that the setting is medically necessary.*

What if the patient was 75, female, has 4 cardiac risk factors including diabetes, a history of CAD status post stent placement a few months ago, is on an antiplatelet drug, and states the shortness of breath was similar to that when she had her heart attack that didn't show up on the EKG that required coronary artery stenting?

In this case, might "inpatient" be the correct setting????

Solution:
Recommended Admission Review Process

Recognize that this is about daily tactics:

1. Case Management applies strict admission criteria to 100% of medical cases placed in a hospital bed and documents this review in an auditable format
2. ALL cases that do not pass criteria (regardless of admission order status) are referred to a Physician Advisor who is an expert in CMS rules and regulations and clinical standards of care (Easily adopts variations of ACMP)
3. Physician Advisor reviews case, speaks with admitting physician when needed, renders final decision based upon UR Standards and documents decision in auditable format on chart or in UR documentation
4. Treating physician changes order as appropriate
5. Must run 7 days a week/365 days a year

Ensuring ALL are Aware of Admission Status

- Treating Physician
  - Physician order and intent
- Hospital
  - Claim submitted is consistent with admission status determination
- Beneficiary
  - Delivery of message detailing admission status, impact on beneficiary financial responsibility, and options regarding where and when beneficiary may receive services
  - BEFORE DISCHARGE from hospital bed

UR Staff Screening Criteria Review
Keys to Success

- Use of Screening Criteria that are recognized by your Medicare intermediaries
  - Check with your MAC, FI or QIO
- Apply Screening Criteria to 100% of Medicare cases
- Ensure UR Staff strictly apply Screening Criteria
  - UR Staff going outside of Criteria to make admission status determinations is not within the standards of the CoPs
- Inter-rater reliability testing to ensure appropriate use of Criteria and valid decisions
  - Standardized case
  - Audit by case type
- Regular recurring education in the use of Screening Criteria
  - Especially in the case of UR Staff turnover
- Ensure all cases that require secondary physician review are referred to Physician Advisor for secondary physician review
  - Timeliness is key

Physician Review Keys to Success

- Team
  - Almost impossible for one person to do consistently
  - Need different skill sets and knowledge basis
- Content
  - You can not depend on this PA to “use their medical judgment”. CMS does not care
  - Need to provide library of evidence based outcomes research across major diagnostic areas for decision making to be consistent and defensible
  - If you do not have this, you are really rolling the dice
- Training
  - Physician needs training in medical management, CMS rules and regulations, and the evidence based medicine above
- Quality Assurance
  - Best practice is a real time Q/A process to ensure highest quality of reviews
- Technology/Reporting
  - Need a methodology to track cases on a facility and system level. Should trends Physician, pay or (if doing denials), and process patterns for improvements

Getting Your Medical Staff to Work with Your Admission review Process

- Claim Concordance Will Impact Physician Compliance & Revenue Integrity
- Updated RAC SOW FAQs (11/07) state that E&M Codes WILL be audited in the future
- Hospital-Physician Claim Concordance will be an upcoming OIG investigative target
- MAC edits have been created to identify lack of claim concordance

Once We Establish A Compliant Admission Review Process, Now We Can Apply The Process To Evaluate Past Performance & Determine Appropriate Corrective Action

1 Day IP Stays N = 195	Incomplete Documentation	Low Acuity
Percent	21%	5%
Number	42	10

Observation Stays N = 254	Clear Evidence for Inpatient	Clear + Borderline
Percent	60%	28%
Number	152	72

Review, Determine and Remediate Causes for Past Admission Review Process Failures

- **Common Past Problems Identified:**
  - Treating physician alone makes uninformed admission status determination
  - CMs “making the call” outside criteria
  - Treating physician not brought into the admission status review process
  - “Doc of the day” process that results in inappropriate admission status determination variation
  - Part time Physician Advisor results in less than 100% compliance
  - Process relying on ED/hospitalist trained in IQ results in incomplete and incorrect physician review
  - Same process for medicine and surgery results in missed review of procedural cases

One Common Sequela of Failed Physician Secondary Review – IPs Placed in OBS Status

- Progressive neurologic deficit
- Syncope of uncertain etiology
- Failed outpatient therapy (asthma, N/V)
- New onset chest pain with urgent cath
- Acute CHF
- Abdominal Pain with x-ray confirmed Ileus
- New Onset Seizure
- Acute Pancreatitis, NPO
- Lumbar Disc Space Infection treated with Antibiotics and Drainage

Common Thread:

Errors of UR Screening Criteria are missed

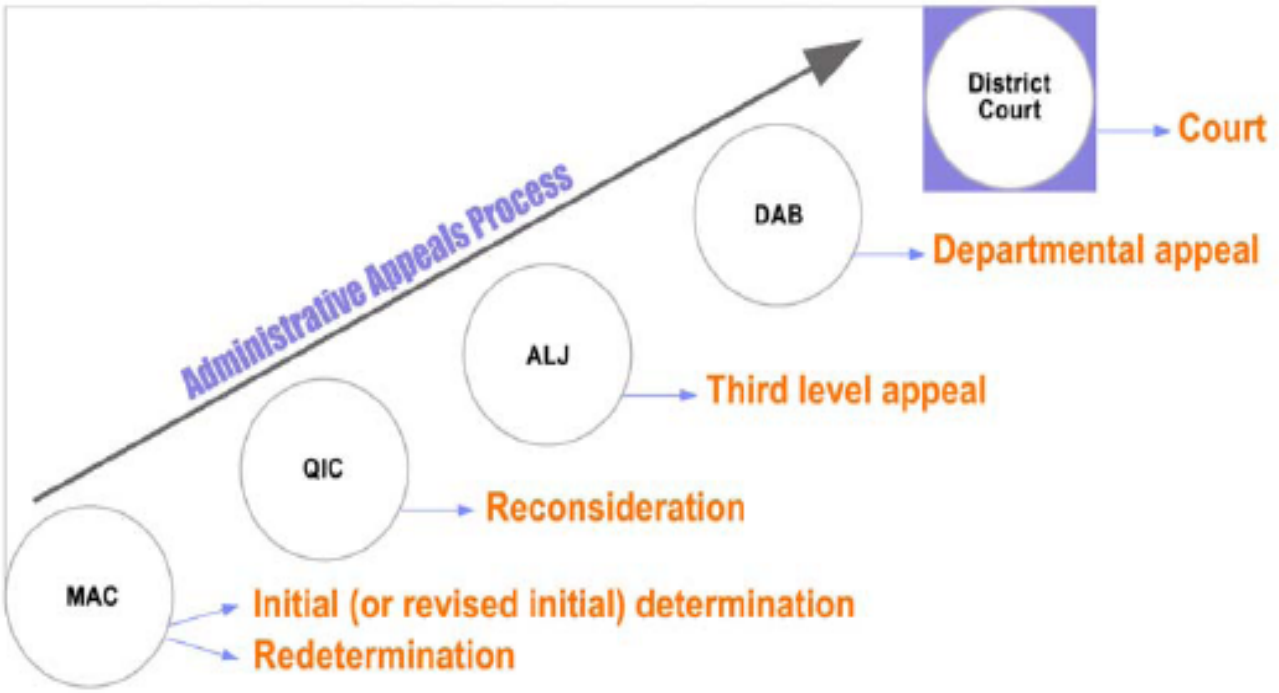
SSA Limitation on Liability

- Provides for waiver of liability of the provider if the provider could not have reasonably known that the services provided would not be covered by Medicare
- A consistent, comprehensive and complaint process of concurrent review must be present to ensure that the provider may benefit from the Limitation on Liability provided by the SSA
- Thus, a compliant admission review process should philosophically ***result in a claim which can never be later denied…..***

…or so one would think….

Understand Your Rights of Appeal

Figure 3-4. Claims Appeals



EHR RAC Appeals Results

- RAC Demonstration Project to date:
- 8087 Records Reviewed
- 7835 Denials Appealed
- Total Fully Adjudicated and Closed: 5965
- 5283 overturns so far
- Total Cases Appealed to the ALJ Level to date: 1365
- Total Adjudicated ALJ Cases 527
- Adjudicated ALJ Cases Won 512
- Total cases in process at Redetermination level 408
- Total cases in process at Reconsideration level 624
- Total cases in process at ALJ level 838
- Total cases in process at DAB level 10

The EHR Experience

- It is best not to rely on a single procedural argument to win an appeal when the underlying medical necessity denial is unsound
- Challenge the validity of an unsound medical necessity denial with Physician analysis while at the same time pursuing procedural remedies when applicable

Medicare Appeals Process: Important Points

- You must progress in stepwise fashion through the levels of appeal—if a deadline is missed, all future appeals may be barred unless good cause for late filing can be demonstrated
- Evidence not submitted at the 2nd level of appeal (Reconsideration) may be barred from introduction later in the appeals process

Three Tiered Tactical Approach to RAC Appeals

- All appeals should be designed to prepare for the ALJ
- Your argument must address three key components to have a high likelihood of success:
  - **Clinical:** Strong medical necessity argument using evidence based literature
  - **Compliance:** Need to demonstrate a compliant process for certifying medical necessity was followed
  - **Legal:** Want to demonstrate, when applicable, that the RAC has not opined consistent with the SSA

Medical Necessity

- Explicitly detail why the care provided was medically necessary
- The critical factor: the judgment of the admitting physician with reference to the guidance of the Medicare Benefit Policy Manual and other CMS Manuals
- Utilization management criteria, local and national standards of medical care, published clinical guidelines, and local and national coverage determinations may be considered

Reopening Limitations

- CMS contractors require good cause to reopen a case subsequent to 12 months after the payment of a claim
- The California experience with PRG-Schultz, reopening limitations, and ALJs
- Published Decisions of the DAB
- CMS plans to send all applicable cases which were reversed by the ALJ on the basis of Reopening Limitations to the DAB for review

Recoupment and Interest

- When a RAC denies an admission—the FI or MAC may recoup the overpayment
- Interest may be owned by the provider, or CMS may owe interest to the provider once the appeal has been adjudicated
- The interest rate is updated quarterly: most recently 11.125%

Reconsideration Appeals: Know What to Ask For

- Issues not raised in your letter of appeal may not be addressed
- The QIC will consider technical and regulatory arguments if specifically requested--such as waivers of overpayment, statistical analysis of extrapolation, and other issues not directly related to medical necessity

ALJ Appeal Options

- Legal representation with expert medical witness testimony--$$$
- Representation by one of the hospital's nurse case managers--? of experience, effectiveness.
- EHR physician advisor representation—experience, cost effectiveness, established record of results.

Preparation of the Memorandum

- A detailed memorandum is prepared for each case and submitted to the ALJ prior to the hearing
- This memorandum is comprised of a thorough case review, detailed arguments regarding the medical necessity of care, and procedural arguments

Extrapolation

- CMS has empowered RACs to use extrapolation
- Sustained or high degree of error
- Failure of documented education
- Can produce estimates of massive overpayments with minimal investment of contractor resources
- The determination of a sustained or high degree of payment error is not appealable

RAC Appeal Process – Do's

- Have a single point of contact for RAC denials – The RAC "CZAR"
- Establish what the nature of the denial is first
- Have different Depts. in Charge of Managing Different Denials (i.e., HIM for coding, UR for Med Necessity) but reporting through the CZAR.
- Do an honest assessment of your internal resources and flexibility
- Make sure your concurrent Medicare admission review certification process results in documentation of the compliant manner in which the certification was reached

RAC Appeal Process – Don’ts

- Do not have a committee with 20 people on it meeting weekly
- Do not expect your physicians will ever get this straight
- Do not expect that things not under scrutiny not will not be under scrutiny later
- Do not expect this will run itself without Q/A

Summary

- The RACS are just getting started
- They are not going anywhere
- The end of the program saw large shift to medical necessity
- You need to seriously evaluate your program today to ensure low risk down the line
- Culture is king

15 Questions To Ask Of An Admission Review Program

1. Does the UR Plan reflect a compliant process to meet the UR Standards of the CoPs?
2. Is there valid and documented physician medical necessity decision making occurring?
3. Is “guidance,” as put forth by CMS contractors, being followed?
4. Is UR staff appropriately meeting it’s daily operational admission screening criteria accountabilities?
   - Is UR staff incorrectly applying or going outside of the strict application of screening criteria?
5. Is there ongoing education of UR staff in the use of screening criteria?
6. Is there inter-rater reliability testing & QA of screening criteria review by UR staff ?
7. Are UR screening criteria being applied to ALL Medicare beneficiaries in the hospital?
8. Are admission review results documented in an auditable fashion and placed within the patient chart?

15 Questions To Ask Of An Admission Review Program

9. Are secondary physician review determinations based upon the evaluation of regulatory guidance?
10. Is there communication between the physician making the secondary physician review determination and the treating physician?
11. Is there continuing education of physicians making secondary physician review determinations to ensure application of up to date clinical evidence and regulatory guidance?
12. Is there inter-rater reliability and QA testing of the secondary physician review?
13. Does the chart documentation reflect the secondary physician review determination and the process?
14. Is there a process to ensure that the physician order is concordant with the admission status determination?
15. Is there a process to ensure that the treating physician, hospital and beneficiary are aware of final claim status before patient discharge?

Useful Compliance Publications

Access the Compliance Library, log onto www.ehrdocs.com, select Resource Center, Compliance Library

- EHR Client Bulletins and archived audio conferences
- Latest CMS Recovery Audit Contractor (RAC) Demonstration Evaluation Reports
- Recent Report on Medicare Compliance articles
- RAC Program Legislation
- RAC Expansion Schedule
- Revised Statements of Work for RAC Program

QUESTIONS?

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About
Executive Health Resources

EHR® received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of Medicare and Medicaid Compliance Services, including Medical Necessity Certification, Continued Stay Review and Denial Review and Appeal.

The American Hospital Association has exclusively endorsed Executive Health Resources' Medicare Compliance Management, Length of Stay Management, Retrospective Clinical Denials and Concurrent Clinical Denials Programs.

EHR has been recognized as one of the "Best Places to Work" in the Philadelphia region by Philadelphia Business Journal.

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