The National Medicare RAC Summit

“Organizing the Internal Retrospective Claim Review Team and Process for Success”

September 15, 2009
Presenter: Kathy Skrzypczak
Assistant Vice President, Corporate Services
Martin Memorial Health System
Presentation Outline

- Health System Background
- Demonstration Project Experience
- Managing Risk - The Team
- Considerations for Best Practices
Martin Memorial Health System

- Integrated Health System, located on the Central East Coast, Florida
- Operations in 2 counties
- 3,300 Associates
- Two Inpatient Facilities, 344 licensed beds
- 325 Medical Staff Members
- Employ 80 physicians
- 5 Outpatient Diagnostic Testing Centers
Martin Memorial Health System

- Health System Net Revenues = $342M
- Medical Center Net Revenues = $302M
- 17,500 Inpatient Admissions
- 2,000 Observation Admissions
- Medicare Payer Mix = 68%
- 50% Net Rev. Outpatient Business Lines
Demonstration Project Experience

- 2,570 Cases Reviewed, (2,447 Complex Reviews)
- 4.5% Automated Reviews
- Service Dates from F/Y 2002 - 2007
  - Reviewed 17% of F/Y 2003 Discharges
  - Reviewed 9% of F/Y 2004 Discharges
- Health Data Insights (HDI) Determinations
  - 1,555 No Findings (60.5%)
  - 1,011 Denials/DRG Changes (39.4%)
  - 4 Underpayments (0.1%)
RAC Denials/Changes

- Denials/Changes (1,011 claims)
- $3.4 Million Take backs
  - 752 Medical Necessity for Inpatient Services (74.4%)
  - 101 DRG Changes (10.0%)
  - 66 Incorrect Discharge Status (6.5%)
  - 57 Outpatient per Unit Billing (5.6%)
  - 35 Other (3.5%)
Overall Appeal Experience

- Appealed 62% of the denials
- 495 Overturned (80%)
- Recouped $2.1 Million To Date
- 31 cases still in Appeals Process
- The Appeals process will continue until late 2009
The RAC TEAM – Multi-disciplinary

- Asst. VP, Corporate Services
- RAC, Coordinator
- Director, Case Management/Utilization Review
- Utilization Review Project Specialist
- Supervisor, Hospital Coding
- Director, Corp. Business Services (Registration, Billing)
- Director, Health Information Management
- Chief Compliance Officer
- Clinical Documentation Improvement Specialist
Considerations for Best Practices
Considerations for Best Practices

1. Centralized Communications
2. Staffing Considerations - Support
3. Medical Records Management
4. Electronic Document Management
5. Claims Tracking Software Solution
6. Utilization Review Process at Admission
7. Access to Utilization Review Documentation
8. Physician Advisors
Centralized Communications

- External Communications
  - Incoming Mail
  - Incoming Requests for Medical Record Copies
  - Tracking Response documentation

- Internal Contact Point
  - Appeal Status
  - Business Office Claims follow-up
  - Missing Documentation follow-up

“Claims Denial Coordinator”
Staffing Considerations  - Support

Administrative Support - “Claims Denial Coordinator” – (mid-level clerical position)

- Monitor timeliness of responses to record requests and appeals
- Monitor appeal outcomes
- Identify trends in claims requests and denials
- Coordinate Denial Management Team meeting
- Assist with drafting appeal communications
- Follow up with outside organizations for claim resolutions

Potential Increased Resources –
- Record Requests – Release of Information
- Reviewing RAC Responses and Drafting Appeals
Medical Records Management

Additional Information:

- Coding Department – Retrospective Queries are part of the permanent medical record
- Utilization Review Documentation
- Physician Advisor Worksheets are filed in the Medical Record and copied as part of the Contractor Record Request

- Consider a pre-mailing “chart review” process
- Think about the future
  - Retain electronic images of documents sent in response to a record request
  - Avoid accessing paper documentation multiple times
Electronic Document Management

- Ability for multiple individuals to electronically access copies of:
  - Mail tracking slips
  - Contractor responses
  - Appeal letters
  - Appeal responses

- Possible options:
  - Links from billing system
  - Stored within claims denial management system
Software Tracking Considerations

- Step 1 - Identify Users and Needs:
  - **Medical Records** – Track release of information – documents, data, and dates
  - **Finance** – Data Analysis – Fiscal Exposure
  - **Accounting** – Financial Statement Entries
  - **Case Management/Utilization Review** – Workflow for Claim Determinations and Appeals
  - **Coding** - Workflow for Claim Determinations and Appeals
  - **Compliance Dept** – Compliance Program Monitoring Plan to identify Risk Areas for Investigation
Software Tracking Considerations

- Centralized database to be used
  - for numerous payers
  - by multiple concurrent users
- Specific Data Fields such as;
  - Patient identifiers
  - Audit number
  - Dates of service
  - Dates responses due by
  - Tracking numbers, references
- Ability to hold electronic files and scanned documents;
  - copies of contractor communications,
  - hybrid medical record,
  - copies of postal service tracking, etc.
Software Tracking Considerations (cont.)

- Designed to support workflow; “target dates for actions” and assigned party
- Ability to store coding and utilization review notes/backup
- Internet based; potential to support management of appeals by an external third party
- Retain claim determination outcomes at all levels of appeal; including reason for denial
- Progressive product development – working toward communicating with audit contractors electronically
- Ability to generate AHA RACTrak data
Utilization Review Process at Admission

- Protocol to facilitate the assignment of the admission status
- Policy approved by the Medical Staff
- Does not affect or reflect the quality of care delivered
- Physician use a standardized admission sheet - “Admit Per Case Management Standard” which supports physician designation for admission w/delegation of the assignment of the “billing status” to Case Management
- Hospital approved criteria – InterQual®
- Review of a patient’s presenting severity of illness and intensity of services provided to treat that illness
- Physician notifies Case Management if they disagree with admission status and are required to document in the medical reason for disagreement
Utilization Review Process at Admission

- Martin Memorial – “Admission Per Case Management Protocol” Logistics
  - All new admissions are placed in a “hold status” for admission type
  - Chart reviews may not always occur on the day of admission, however, the review is based on patient’s clinical information at the time of admission
  - Communicate to the physician via a sticker within the progress notes if the admission status is determined to be “Observation”
  - Case Managers conduct “continued stay” reviews every three days
Access to Utilization Review Documentation

- Retain notes for future use on the Utilization Review Criteria Used to Qualify patients for inpatient admission
- Document Category Cases was reviewed under
  - Infectious Disease, Cardiac, etc.
- Document clinical support of:
  - Severity of Illness (clinical indicators, blood pressure, temperature, etc.)
  - Intensity of Service (rate of IV medications, diagnostic testing, etc.)
- Abnormal test results
Access to U/R Documentation

- Meditech Screen 6
Physician Advisors

- General Rule: UR Staff is restricted to assigning the admission status based on Interqual Guidelines.
- Exceptions to the general rule are agreed upon by the Physician Advisor and the UR staff and drafted in a policy that further defines clinical indications for establishing admission status.
- Remaining cases are sent for PA Review.
- PA Worksheet summarizes Case Facts.
- PA worksheet is filed in medical record and made available for outside record requests.
- Consider Interqual® Training.
- Physician Advisors Process - Backups.
Questions
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