

A Consequence of the RAC: Closer MAC Focus

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Why a MAC Issue?

- RAC reporting at MAC level
- Re-compete of MAC contracts

Pay it right, the first time ...

Executive Order 13520

- Reducing improper payments by –
 - Refining error rate measurement processes
 - Improving system edits
 - Updating coverage policies and manuals
 - Conducting provider education efforts
- 50 percent error rate reduction
 - To 6.2 percent by 2012

Inpatient Claim Reviews

- Transition from QIO to FIs/MACs
 - QIOs to focus on quality improvement
 - Will no longer do payment accuracy measurement on inpatient claims
 - FIs/MACs will review for inpatient medical necessity and coding

Inpatient Claim Reviews

- Reviews can be post-pay back to 1/1/08
- Not random reviews
 - Targeted based on analysis
- Pre- or post-payment basis
- To use “clinical judgment”
 - No specific screening tool to be required
 - Will involve physicians as needed

Inpatient Claim Reviews

- No payment for copying costs
- Appeal rights as with other denials
 - However, filed at initial level with contractor that reviewed the claim and issued denial

Contractor Probe Reviews

- Top 20 DRGs ranked by projected improper payments
 - Hospital Payment Monitoring Program error rates
 - Percent of medically unnecessary services
 - Contractor claim data (top 50 DRGs by total paid and claim volume)
 - Recovery Audit Contractor findings

Contractor Probe Reviews

- Perform comprehensive review of each claim selected
 - Medical necessity/appropriateness for admission
 - Determine whether covered care was provided at any time during the stay
 - DRG validation (diagnoses, procedures)
 - Review procedures affecting DRG

2010 Preliminary Error Rates

DRG	Description	2009 Error Rate	2010 Error Rate
313	Chest pain	55.16%	76.71%
552	Medical back problem w/o MCC	70.92%	71.25%
392	Gastroent. and misc. digestive w/o MCC	49.08%	41.93%
641	Nutritional misc metabolic disorder w/o MCC	49.27%	48.43%
227	Cardiac defib w/o cardiac cath w/o MCC	20.65%	45.43%

Preliminary Findings

- InterQual criteria not met and record did not otherwise support need for inpatient level of care
- Cases continue to show lack of severity of illness and/or intensity of service
- MD orders observation services and case manager writes inpatient status was appropriate and admission is converted
- Admit for 3-day qualifying stay

During 2011

- Pre-payment review of selected DRGs
 - MS-DRG 313 (Chest Pain)
 - MS-DRG 552 (Medical Back)
 - MS-DRG 470 (Major Joint Replacements)
 - MS-DRG 460 (Spinal Fusions)
- Evaluate DRGs 641 and 392 for potential action

And for 2012...

- Focus on high dollar claims
- Review of specific DRGs
 - Determined by contractor review results, CERT and RAC findings and FATHOM analysis
 - Evaluating 12 DRGs for initial pre-payment review activity
 - 2012 preliminary results show cardiac services at issue

And for 2012 . . .

- Focus on elective surgical procedures
- Length of stay not an element in record selection
- Pre-payment review (30-100%)
- Post-payment review for associated Part B services

Development of LCDs

- Lumbar spinal fusion for instability and degenerative disc conditions
- Major joint replacement (hip and knees)
- Vascular stenting of lower extremity arteries

LCD Documentation Requirements

- Relevant medical history
- Previous non-invasive diagnostic evaluations to substantiate medical necessity
- No improvement in pain and function following conservative treatments have been implemented
- Failed conservative non-surgical management therapies

LCD Documentation Requirements

The physician's documentation for the case should clearly support both the diagnostic criteria for the indication . . . and the medical need. . . .

The medical record must contain documentation that fully supports the medical necessity and justification of the procedure performed.

Questions?

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