Medicare Compliance Challenges in the Age of Healthcare Accountability

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The Perfect Storm

- CMS has moved towards using medical necessity to recoup dollars with the introduction of Condition Code 44
- We saw the QIO’s evaluate 1 day stays and focus on the PEPPER DRG’s
- The RAC demonstration project was a huge success in CMS’s eyes
- QIO’s pushed aside – the real PRO’s come in
- ZPIC, PSC, CERT, and MAC denials begin
Agenda

• Who is looking at you?
• What is Medicare admission review?
  – Best practices with supporting regulations
• What really is the difference between IP and OBS?
  – What is the “gray area?”
• Erroneous processes
• How to approach audits?

Governmental Audit and Fraud Fighting Entities and Initiatives

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Fraud Fighting Initiatives

- **DOJ**
  - Civil and criminal fraud investigations: False Claims Act/Health Care Fraud
- **OIG**
  - Audits: ZPIC and CERT referrals
  - Fraud investigations
  - Medicaid investigations
- **Recovery Auditors**
  - New review programs
  - Chart limits increased…..again
- **MAC**
  - Short stay audits
  - DRG-specific prepayment denials
  - Introducing new interpretations of the regulations
- **CERT**
  - Specifying “error rate”
  - DRG-specific denials
Current DOJ Activities

- Defibrillators
- Chest pain
- Kyphoplasty
- Referrals from other government contractors
- Qui Tam cases
2012 OIG Work Plan Targets New Risk Areas for Hospitals

16 risk areas that OIG focuses on during OIG Medicare compliance reviews, although not necessarily all at once:

- Outpatient claims paid greater than charges
- Inpatient payments greater than $150,000
- Outpatient payments greater than $25,000
- Payments for hemophilia services
- One-day stays at acute care
- Major complication/comorbidity and complication/comorbidity
- Payments for septicemia services
- Payments for inpatient same-day discharges and readmissions
- Payments for outpatient surgeries billed with units greater than one. (usually a clerical error)
- Outpatient claims billed during DRG payment window
- Inpatient manufacturer credits for replacement of medical devices
- Outpatient manufacturer credits for replacement of medical devices
- Post-acute transfers to SNF/HHA/another acute care/non-acute inpatient facility
- SNF/HHA consolidated billing — outpatient services
- Outpatient claims billed with modifier 59 ( unbundling)
- Inpatient claims paid greater than charges

OIG to Ramp Up Compliance Reviews for 2012

Sixty more Medicare compliance reviews are already planned or underway, underscoring the HHS Office of Inspector General’s commitment to this new multi-faceted strategy for auditing hospitals, OIG officials say.

“This is an evolving initiative,” Brian Ritchie, the HHS Assistant Inspector General for CMS Audits, said ..... “It’s a big investment in the hospital area.”

From a pool of 3,600 short-term acute care hospitals, Ritchie says the OIG picks partly based on:

- Their past performance on single-issue audits;
- Where they stand compared to other hospitals' billing volumes according to CMS’s Program for Evaluating Payment Patterns Electronic Report (PEPPER); and
- Whether there is continued “poor performance” (e.g., Medicare administrative contractors and quality improvement organizations have been to hospitals and “tried to educate them,” for example, with little success).
Recovery Auditors

Recent Changes

Current Recovery Audit Activities

CMS announces Recovery Audit Demonstrations

- Recovery audit prepayment review – begins August 27, 2012
- Prior authorization for certain devices – end of summer
- Part A to Part B rebilling - began January 1, 2012
• The Demonstration will take place between August 27, 2012 through August 26, 2015.
• The 11 states included in this Demonstration are CA, FL, IL, LA, MI, MO, NC, NY, PA, OH, and TX.
• Focus on claims with high improper payment rates
  – Begin with short inpatient stays (< 2 days)
  – Inpatient Hospital stays only

• The Recovery Auditors (RACs) will target the originally published MS-DRGs, however, they will be phased in throughout the first few months of the Demonstration:
  – August 27: MS-DRG 312 SYNCOPE & COLLAPSE
  – TBD: MS-DRG 069 TRANSIENT ISCHEMIA
  – TBD: MS-DRG 377 G.I. HEMORRHAGE W MCC
  – TBD: MS-DRG 378 G.I. HEMORRHAGE W CC
  – TBD: MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
  – TBD: MS-DRG 637 DIABETES W MCC
  – TBD: MS-DRG 638 DIABETES W CC
  – TBD: MS-DRG 639 DIABETES W/O CC/MCC

• Percent of claims to be reviewed is unknown at this time.
RAC Pre-Payment Project

• Will NOT replace MAC pre payment review
  – “Contractors will coordinate review areas to not duplicate efforts”
• Selected claims will be off-limits from future post-payment reviews by a CMS contractor
• A hospital has 30 days to send documentation for review (if not case will be denied)
• Will review for DRG validation and coding issues
• For now, limits on pre-payment and post-payment reviews won’t typically exceed current post-payment ADR limits

RAC Pre-Payment Project: Q and A from Education Form

• Normal CMS appeals process
• Time is in calendar days not business days
• Date is based on claim submission date (not date of service)
• RAC receives same contingency fee payment
• No physicians or Part B claims to be reviewed
• CAHs and PIPs CAN be included in program
Part A to Part B Rebilling Demonstration

• If your hospital is participating, what impact does it have on your program?
  – Your front end stays the same
  – You should use the discussion period
  – You should be tracking denial rates; contractors will become aware of who is participating
  – You can opt out at any time

Chart Pull Limits Increase

The additional documentation requests limits will follow the guidelines below:

• Each limit is based on the provider’s prior calendar year Medicare claims volume.
• The limit is based on claims volume only. The type of claims do not factor into the limit.
• The maximum number of requests per 45 days is 400.
  – Providers with over $100,000,000 in MS-DRG payments who were notified by CMS of an increased cap of 500 requests will now have a cap of 600.

Chart Pull Limits Increase

- Recovery Auditors may request up to 35 records per 45 days from providers whose calculated limit is 34 additional documentation requests or less.
- The limit is equal to 2% of all claims submitted for the previous calendar year divided by 8. The Recovery Auditors may go more than 45 days between record requests but may not make requests more frequently than every 45 days. A provider’s limit will be applied across all claim types, including professional services.
- CMS may give the Recovery Auditors permission to exceed the limit. Permission to exceed the limit may occur by CMS’s own initiative or from the Recovery Auditor requesting permission. CMS or the Recovery Auditor will notify affected providers in writing.


ALJ Rulings for Observation Billing

There have been a number of Administrative Law Judge (ALJ) decisions in recent months that uphold a claims administration contractor’s denial of inpatient services as not reasonable and necessary, but require the contractor to pay for the services on an outpatient basis and/or at an “observation level of care.” One representative example of these decisions indicates that:

“Medicare payment is not appropriate for inpatient hospital care services that were provided to the Beneficiary from November 19 through 20, 2009. Appellant is entitled to downgraded payment at the rate of observation level of care for its services.”
ALJ Rulings for Observation Billing

Medicare pays for observation services under the outpatient prospective payment system (OPPS). However, observation services are generally bundled and not paid separately. Therefore, the Centers for Medicare & Medicaid Services (CMS) has reasoned that the ALJ's decision requires the claims administration contractor to pay for all services that would be separately payable under the OPPS had the hospital initially billed Medicare for outpatient services on a 13x or 85x type of claim. In this circumstance, the ALJ's order is in conflict with Chapter 6, sections 10 and 20.6 of the Medicare Benefit Policy Manual (Publication 100-02) and Chapter 1, section 50.3 of the Medicare Claims Processing Manual (Publication 100-04).

Chapter 6, sections 10 and 20.6 of the Medicare Benefit Policy Manual (Publication 100-02) specifies a limited list of medical and other health services that may be paid under Medicare Part B when an inpatient admission is “disapproved as not reasonable and necessary (and waiver of liability payment was not paid).” Chapter 1, section 50.3 of the Medicare Claims Processing Manual (Publication 100-04) indicates that an "outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. By this definition, an inpatient stay that has been disapproved is still a stay for an admitted patient that is not transformed into an outpatient stay. Payment may only be made under the OPPS for patients that are outpatients – that is, a patient that has not been submitted as an inpatient.

ALJ Rulings for Observation Billing

The claims administration contractors shall follow the instructions below to effectuate ALJ decisions that uphold determinations that inpatient claims were not medically necessary, but instruct CMS to make payment as if those claims were for outpatient services, including observation care.

1. Within 30 calendar days of receipt of the effectuation notice from the Administrative QIC (AdQIC), contractors shall contact the provider to secure a new replacement claim with the appropriate outpatient HCPCS codes and line item charges representing rendered services, including observation, where appropriate. A line item charge for observation may only be included if there was an order for observation. In the absence of an order for observation, the observation charges should not be included if the ALJ only specified payment for outpatient care or services. However, if the ALJ specified "observation level of care" or "including observation care," line item charges for observation may be added if otherwise appropriate, as the ALJ is specifically substituting the order to admit for the order for observation.

Note: If a contractor does not receive a replacement claim from the provider within 180 days from the date the contractor contacts the provider, it shall close the case and consider the effectuation complete. These cases and cases that do not meet timely effectuation requirements because the provider did not submit the replacement claim timely shall be reported in the monthly status report (MSR), not the CROWD Report.
Medicare Administrative Contractors (MACs)

Audit Areas

MAC Activity

- Responsible for more than processing claims
- Increased reviews
  - Mobile audits
  - Prepayment reviews
- Increased denial activity, especially during contract renewal periods
- MACs have few limits
- MACs are focusing reviews on medical necessity

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.
MAC Challenge

- Not all MACs have Part A experience
- Most are new to non-coding medical necessity admission status issues
- Numerous examples of guidance provided that appears to not be consistent with statutes, regulations and manual guidance
- Examples:
  - Time as sole basis for admission status
  - Corrective Action Plan requested prior to appeals

MAC Activity Example

- DRG 313 – “Our opinion is that if a patient with chest pain has negative enzymes and a normal EKG, they are an outpatient”
  - In this group 68/69 were successfully appealed
- Trailblazer audited elective PCI and denied 98% of 250 claims
  - In this group 143/145 successfully appealed
  - Lost contract
Today’s Audit Environment

• The regulations haven’t changed
• The procedures haven’t changed
• How can providers be wrong 90% of the time?
• It is about how the contractors interpret the regulations
• If providers don’t challenge them, the new interpretations become the new rules

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Zone Program Integrity Contractors (ZPICs)

Audit Areas

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• The primary goal of Zone Program Integrity Contractors (ZPICs), formerly the Program Safeguard Contractors (PSCs), is to investigate instances of suspected fraud, waste, and abuse.
  - ZPICs perform the following functions:
    • Investigate potential fraud;
    • Conduct investigations;
    • Perform medical reviews;
    • Perform data analysis;
    • Identify need for administrative actions; and
    • Refer cases to law enforcement.
    • Use extrapolation as a means to determine overpayment amounts to be recouped.
You Don’t Need to Run Faster Than the Cheetah, But You Need to Run Faster Than The Slowest Antelope

How Will Providers Be Held Accountable?

It is not just about getting the answer correct; it is all about your “PROCESS”

OIG doesn’t just determine whether the end result — the Medicare claim — was correct. It wants to know what kind of reviews hospitals perform to ensure the “ultimate submission of claims” is correct.
“Gray” or Uncertain Medical Necessity: Why it Matters

CMS’ decision to increase the scope of cases that are being targeted for compliance audits pushes hospitals into the “Age of Audit Accountability.” “Getting it Right” for compliance reasons has never been of greater importance.

Medicare / Medicaid 2010 Care at Hospitals

Cases that are clearly appropriate for Inpatient setting or clinical need:
- Acute MI
- Coronary Artery Bypass Graft
- Open Appendectomy
- Acute Intracranial Bleed
- Heart Valve Transplant
- Respiratory Failure

Cases that are clearly appropriate for Outpatient setting:
- Scheduled Transfusion
- Injection / Chemotherapy
- Skin Biopsy
- Tympanostomy Tube Placement
- Dilation & Curettage

“Gray” Area – Cases that require individual assessment due to unclear Medical Necessity:
- 16.6M cases
- $79B in Reimbursement at Risk

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What Is “Medical Necessity?”

The Medicare definition of medical necessity under the Social Security Act states “no Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” The terminology “reasonable and necessary” sounds fairly straightforward, but...
What is Medical Necessity?

• Is the therapy/treatment/device/procedure
  - Necessary and appropriate for the patient in question

• Is the setting in which the therapy/treatment/device/procedure
  • Necessary and appropriate for the patient in question

How Do Hospitals Manage “Gray” Medical Necessity?

**Gray Cases**

**Decisions based on:**

- **Physician Order**
  - Inconsistent and random based on individual opinion/style
  - ALJ decisions do not rest solely on the physician order

- **Screening Criteria**
  - Misuse of IP screening criteria tool
  - Huge bias towards OP

- **Screening Criteria with RN Case Manager Judgment**
  - Violates Conditions of Participation (described as “revenue optimization” by DOJ)
  - RNs not trained nor legally permitted to make this decision, so variation is wide

- **Screening Criteria with Attending**
  - Similar result as solely relying on Order
  - Inconsistent and random based on individual opinion/style
  - Attending also often passively agree with criteria screen result

**Common Erroneous Processes**

- Over-status:
  - IP: 25-42%
  - OBS/OP: 12-27%

**CommonErroneous Results**

- Over-status:
  - IP: 6-14%
  - OBS/OP: 27-43%

- Over-status:
  - IP: 12-53%
  - OBS/OP: 17-36%

- Over-status:
  - IP: 25-42%
  - OBS/OP: 12-27%
What Are Best Practices?

Supporting Regulations

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...
- 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
• **Best Practices for Admission & Continued Stay Review (HPMP Compliance Workbook pg 38)**
  
  “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.”

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• **Section 1879(a) of the Social Security Act (Limitation on Liability) provides where:**

(1) a determination is made that… payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services …, and

(2) both such individual and such provider of services…did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B, then to the extent permitted by this title, payment shall…be made…as though the coverage denial…had not occurred.”
What Are The Standards and Regulations Regarding Medical Necessity?

• 42 CFR §411.406(e) provides
  • “that a provider that furnishes services that are not reasonable and necessary is considered to have known that the services were not covered if it is clear that the provider could have been expected to have known that the services were excluded from coverage on the basis of notification of PRO screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue or its knowledge of what are considered acceptable standards of practice by the local medical community.”

• The best way for a provider could not be expected to know that payment for services would be denied was if it conducted an Admission Review process to certify medical necessity for ALL beneficiaries.

What Are The Standards and Regulations Regarding Physician Decisions of Medical Necessity??

• HCFA Ruling 95-1
  • “Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature” refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine” and the "Journal of the American Medical Association.” By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine.”
“if the medical evidence is inconsistent with the physician's certification, the medical review entity considers the attending physician's certification only on a par with the other pertinent medical evidence. The review entity also considers factors such as the condition of the patient upon admission, the nature of the primary diagnosis, the existence of co-morbid conditions”

It is HCFA's Ruling that no presumptive weight should be assigned to the treating physician's medical opinion in determining the medical necessity of inpatient hospital or SNF services under section 1862(a)(1) of the Act. A physician's opinion will be evaluated in the context of the evidence in the complete administrative record. Even though a physician's certification is required for payment, coverage decisions are not made based solely on this certification; they are made based on objective medical information about the patient's condition and the services received.
What Are The Standards and Regulations Regarding Physician Decisions of Medical Necessity??

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Why All the Confusion?

• Most Case Managers use criteria such as Interqual & Milliman (as they must) to judge medical necessity

• Criteria used are evidence-based

• Admission criteria though are screening tools with a false negative rate
  - Rates have varied throughout the years but generally are around the 15% + range

• For those cases that fail 1st level review, secondary physician review is REQUIRED
What Does Medicare Say About Criteria?

Inpatient (CMS Medicare Benefit Policy Manual, Chapter 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... 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;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

It's all about the physician!!!!!

Admissions of particular patients are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.”
Solution:
Recommended Admission Review Process

Recognize that this is about daily tactics:

- Case Management applies strict admission criteria to 100% of medical cases placed in a hospital bed and documents this review in an auditable format.
- 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).
- 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.
- Attending physician changes order as appropriate.
- Must run 7 days a week/365 days a year.

How to Approach Audits

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How Should You Approach All Audits?

- Communicate to all relevant parties quickly and engage them
  - Finance, Compliance, Legal, Medical Records, Clinical Leadership, EHR

- Ask key questions internally
  - Who does this audit involve?
  - Do we want to review the charts?
  - Do we pursue attorney/client privilege?
  - What is the role of legal counsel?

- Communicate with the auditor to gather information about the audit
  - Why are we being targeted with this audit?
  - What will the scheduling be?
  - Will it be onsite or off-site?
  - What is the time period?
  - Can we review audit results? Will there be an opportunity to discuss prior to appeals process?

What Not to Do

- DO NOT wait until a few days before the auditors arrive to take action
- DO NOT refrain from asking for more information about the audit and audit selection process
- DO NOT simply accept the audit findings as accurate
- DO NOT cease filing appeals
- DO NOT begin self-denying or overusing observation in an attempt to avoid future audit
Common Vulnerability: Electronic Health Record

- All data is recorded but in different areas of the chart
- Find ways to connect the dots for auditors
  - Demonstrate a consistently followed Utilization Review process in record
  - Find a way to include CM notes in record
  - Ensure physicians are demonstrating thought process and assessment of risk factors in documentation somewhere in record

Common Vulnerabilities: Types of Audits

OIG
- These audits are about “answer” and “process”
- Technical issues (e.g. the order was written as “admit for observation”)
- A “pattern of fraud”, or a “lack of controls” may be noted if you haven’t consistently followed a process

DOJ
- Specific topics (ICDs, Kyphoplasty) or referrals

MACs
- Prepayment reviews common
- Audits focus on medical necessity
- MACs apply “clinical judgment” during reviews
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
Remember…

• If you are treating patients and submitting claims, you will be audited
• It is about how the contractors interpret the regulations:
  – Applying 2012 Interqual® to deny 2008 cases
  – Reviewing the physician decision based on the discharge, instead of the information at admission
  – Lack of deference to physician decision-making
  – Timing is only one factor to be considered in CMS regulations- there is no “24-hour rule”

Think About This…

When does the beginning of the defense in an appeal process begin?

When the patient walks in the door!
Medical Necessity

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

ALJ Level of Appeal

- Key Observations
  - ALJ hearings are as varied as the ALJs themselves
- The axiom: when you have seen one ALJ hearing, you have seen one ALJ hearing
  - Different ALJs have different styles, and as a result, often place different demands on the appellant
  - Preparation and experience are of paramount importance
ALJ Variability Examples

- Syncope and the ear exam
- Dictator approach
- Personal experiences
- Expert witness (cardiologist)
- Personal criteria
- Hearing procedures (brief, noted page numbers, etc)

Best Practice Approach

- Demonstrate a consistently followed Utilization Review process for every patient
- Educate medical staff on documentation practices to avoid future technical issues
- Prove that the error rate within your hospital is not accurate by focusing on successfully appealing denials
- Hospitals need to be prepared to defend their decisions and advocate for their rights
Takeaways

• Medical Necessity is a complicated issue – but it is possible to achieve success
• Admission decisions must be based on clinical and regulatory evidence and best practices
• Consistent process must be paired with diligent oversight and data review
• Identify procedural failures
• Recognize that your hospital will receive inappropriate denials and be prepared to appeal
• Be prepared to advocate for your hospital and to advocate for all hospitals with other groups

Questions?

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