



The RACs' Latest Focus: Short Stay, High Cost Procedures. *Are you in the RACs' Cross Hairs?*

Be "On" Target, Not "A" Target. Prevent RAC Medical Necessity Denials

October 8, 2008

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Today's Presenters

- **Don May**, Vice President, Policy – American Hospital Association
- **Robert R. Corrato**, MD, MBA, President & CEO – Executive Health Resources
- **Joseph Zebrowitz**, MD, Executive Vice President – Executive Health Resources
- **Lynn M. Leoce**, MSN, RN, CPUR, IQCI, ACM, Corporate Director of Case Management – Adventist Health System

Don May, Vice President, Policy – American Hospital Association

RAC: Overview

- National Rollout Plan
- Results / Impact to date
- AHA Strategy & Resources



RAC Demo Findings

RAC Impact: March 2006 to March 2008

Overpayments Collected: **\$992.7 m**

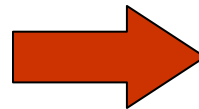
Less Underpayments Repaid: - (\$37.8 m)

Less \$ Overturned on Appeal: - (\$46.0 m)

Less PRG IRF Re-review: - (\$14.0 m)

Less Costs to Run Demo: - (\$201.3 m)

BACK TO TRUST FUNDS

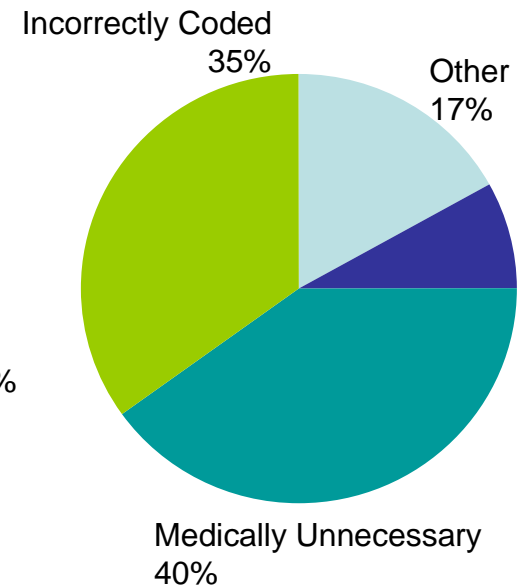
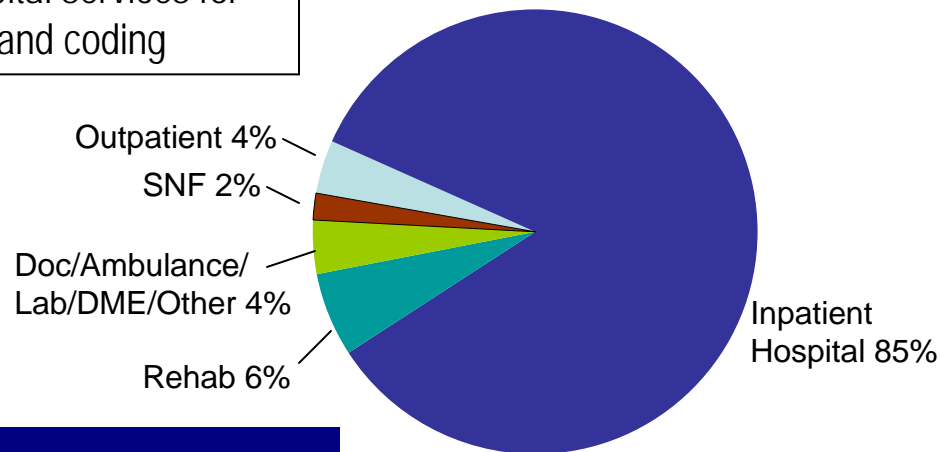


\$693.6 m*



Where Did RACs Find Overpayments?

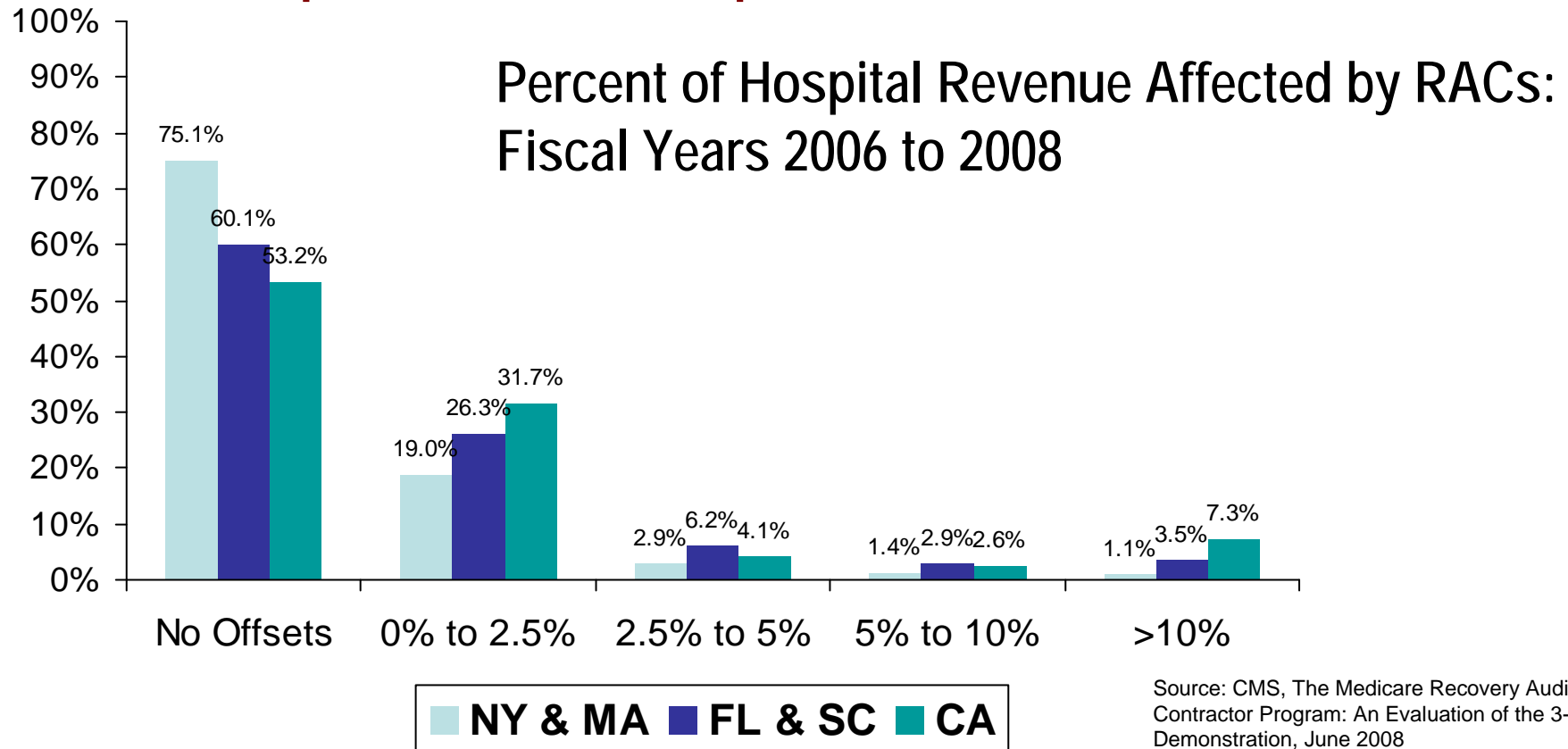
Most overpayments were collected from inpatient hospital services for medical necessity and coding



95% from Hospitals

Source: CMS, The Medicare Recovery Audit Contractor Program: An Evaluation of the 3-Year Demonstration, June 2008

RAC Impact On Hospitals

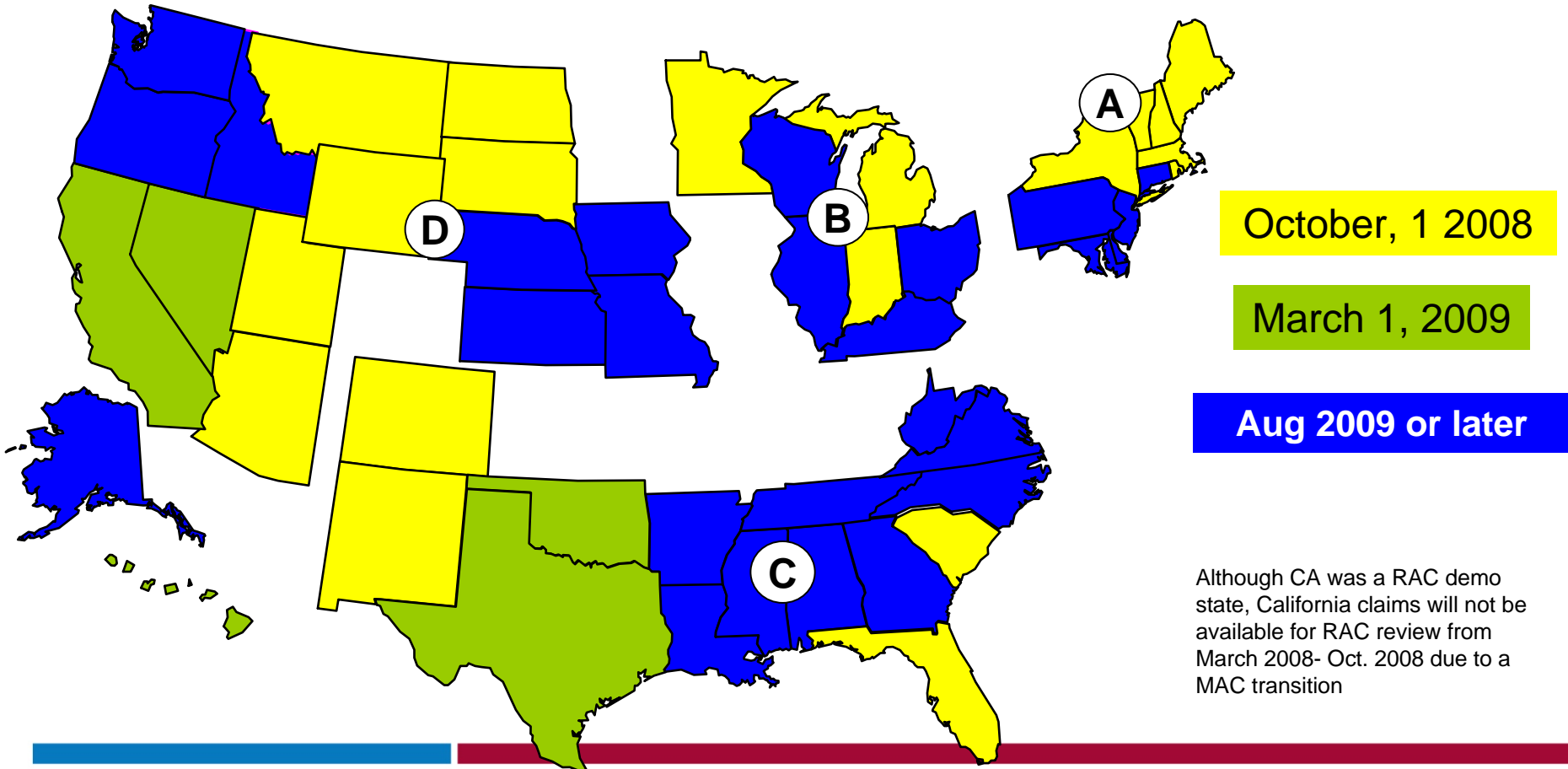


RAC: Rollout Schedule

- RAC Demo ended March 27
- Demo evaluation report released July 11
- 4 new RACs announced October 1
- CMS/RACs to conduct outreach to hospitals in first round of RAC rollout
 - 4-6 weeks if existing RAC
 - 8-12 weeks if new RAC
- RAC audits begin 4-6 weeks after CMS/RAC education with state hospital association

CMS' National Rollout Plan

September 2008



CMS Announcement

4 New RACs Announced Oct. 6

- Region A – Diversified Collection Services
- Region B – CGI Technologies and Solutions
- Region C – Connolly Consulting Region D – HealthDataInsights

AHA Strategy

- Push CMS for administrative changes
 - Letters and continual discussions with CMS
 - RAC improvements for permanent program
- Push Congress for legislative relief
 - Advocacy – STOP and Fix-it
 - Capps-Nunes legislation (HR 4105)
- Member Education
 - Collaboration and education with state, metro and regional hospital associations
 - Member advisories and education
 - *RAC*Trac: Collect data and examples of egregious behavior

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 - *RACTrac*: Collect data and examples of egregious behavior

RAC Legislation

H.R. 4105

The Medicare Recovery Audit Contractor Program Moratorium Act of 2007

- Rep. Lois Capps (D-CA) Rep. Devin Nunes (R-CA)
- 100 Co-sponsors
 - (23Rs and 77Ds)
- 1-year Moratorium
- CMS Report
- GAO Study

• Senate Bill??



RAC Legislation

Senate Draft RAC Legislation

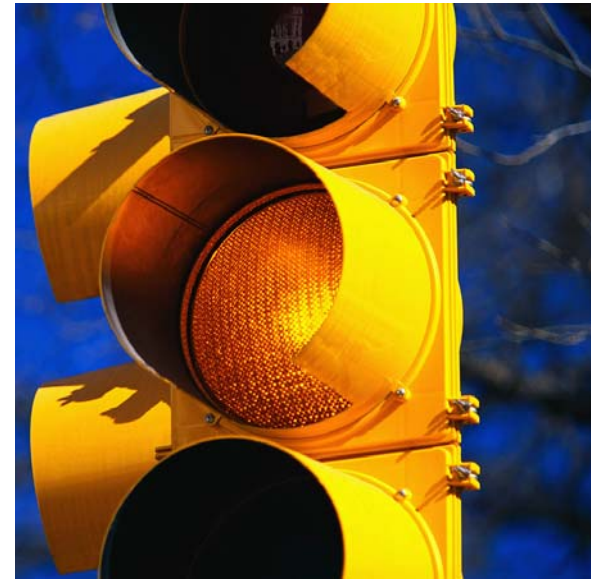
- Sen. Bill Nelson (D-FL) potential sponsor
- September introduction?
- R Cosponsor?
- Potential Provisions Include:
 - Medical Necessity Review Study
 - Contingency Fee Method of Payment
 - Penalty for High Overturn Rate
 - 1-year Look-Back Period
 - Provider Education



Message to CMS and Congress

STOP and Fix-it

- Slow down
- Reduce or remove contingency method of payment
- Exclude medical necessity from RAC review (or more physician involvement)
- Reduce look-back to 12 months
- Centralized electronic tracking platform of RAC denials and appeals
- Exemption from “timely billing” rules
- Improved CMS management and transparency of RAC program
 - RAC and Provider education
- Bigger focus on UNDERpayments



AHA Strategy

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 - *RACTrac*: Collect data and examples of egregious behavior

AHA Resources on RACs

SAMPLE LETTER

February 20, 2008

The Honorable XXXX
U.S. House of Representatives
XXXX House Office Building
Washington, DC 20515

Dear Congressman XXXX:

I am writing to express my strong support for the *Medicare Recovery Audit Contractor Program Moratorium Act of 2007* (H.R. 4105) and to ask that you co-sponsor this important legislation.

Authorized by the *Medicare Modernization Act of 2003*, the Medicare Recovery Audit Contractor (RAC) program was established as a demonstration project in selected states (NY, CA, FL) to identify improper Medicare payments, both underpayments and overpayments. The *Tax Relief and Health Care Act of 2006* made the RAC program permanent and authorized the Centers for Medicare & Medicaid Services (CMS) to expand the program to all 50 states by 2010. CMS already has expanded the program to South Carolina and Massachusetts, and in March, 15 additional states are scheduled to begin the program. By January 2009, CMS plans to expand the RAC program to all 50 states.

Throughout the three-state demonstration, RACs have aggressively targeted provider payments with little administrative oversight from CMS. For instance, an independent review of a sample of California RAC denials found that 40 percent were unwarranted. In addition, a contingency payment of as much as 30 cents of every Medicare dollar recouped by the contractor has resulted in countless abusive behaviors by RACs toward Medicare providers.

Despite these problems, CMS intends to continue to expand the program nationwide. (Insert state here) is scheduled to come under RAC review in (March/October 2008/January 2009). H.R. 4105, introduced by Reps. Lois Capps (D-CA) and Devin Nunes (R-CA), would place a moratorium on all RAC activities for a year, allowing CMS time to address ongoing problems with the overall RAC program while giving the Government Accountability Office the opportunity to evaluate the effectiveness of the program as a whole. CMS needs to slow down the implementation of the RAC program, and a moratorium would give the agency the opportunity to assess and evaluate how the demonstration has worked as well as provide time to make improvements in program operations. It is critical that the problems encountered during the demonstration program be resolved before the proposed nationwide rollout moves forward, including a much-needed, expansive program of provider education.

I thank you again for your attention to this important issue. I look forward to working with you on issues of importance to America's community hospitals.

Sincerely,

VISIT AHA WEBSITE www.aha.org/rac

EMAIL US
RACinfo@aha.org

Member Advisory

January 25, 2008

**MEDICARE RECOVERY AUDIT CONTRACTORS (RACs):
WHAT THEY ARE AND HOW THEY WORK**

At A Glance

Member Advisory

March 3, 2008

**RECOVERY AUDIT CONTRACTORS (RACs):
PREPARING FOR RAC AUDITS**

At A Glance

The Issue:
The Medicare Recovery Audit Contractor (RAC) program is authorized by Congress to identify improper Medicare payments – both overpayments and underpayments. The RAC program began operation in three states (California, Florida and New York) under a demonstration program and has since been expanded to two additional states (Massachusetts and South Carolina). The Centers for Medicare & Medicaid Services (CMS) plans to roll out a permanent, nationwide RAC program by 2010. As part of its rollout strategy, CMS intends to award contracts to four regional RACs by this April and begin review activity in all states by January 2009. The *Medicare Recovery Audit Contractor Program Moratorium Act of 2007* (H.R. 4105), which would establish a one-year moratorium on the RAC program, was introduced last year in the House, but no action has yet been taken.

CMS recently reported that RACs collected \$357 million in overpayments from Medicare providers in the three early demonstration states during fiscal year 2007, with 92 to 94 percent of these funds collected from hospitals. To avoid RAC denials under the fully implemented program, hospitals should pay special attention to ensure appropriate admissions, coding and documentation practices, which are likely to be scrutinized by RACs.

This advisory highlights the types of inpatient claims that were targeted during the RAC demonstration and some strategies and tools your organization can implement to minimize the impact of future RAC audits. *This information is provided only as a guideline. Consult with legal counsel and your financial experts before finalizing any policy or practice.*

What You Can Do:
Although we are urging Congress and CMS to make changes to the RAC program, the AHA is advising hospitals to begin preparing for RAC reviews. Hospitals should start by assembling an internal RAC team to plan and implement process improvements to reduce RAC vulnerabilities, including a self-audit to identify RAC risks. Please share this advisory with other hospital leaders and your RAC team to learn about likely targets under the national RAC program and to determine which tools and strategies in this advisory would be most effective in helping your hospital ensure Medicare claims accuracy.

Further Questions:
Please contact AHA Member Relations at 1 (800) 424-4301 or email RACinfo@aha.org.

AHA's Member Advisories are produced whenever there are significant developments that affect the job you do in your community. A 13-page, in-depth examination of this issue follows.

AHA Strategy

- Upcoming Member Advisories Medicare Appeals Process and how RAC program works
- AHA RAC Call Series
 - Appealing RAC Denials
 - RAC Coding Strategies
 - Maximize RAC Compliance/Minimize RAC Risk



AHA CENTRAL OFFICE™

An American Hospital Association Service

Robert R. Corrato, MD, MBA, President & CEO –
Executive Health Resources

Joseph Zebrowitz, MD, Executive Vice President –
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Medicare 1965



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Medicare 2008

Value-based purchasing (VBP), which links payment to performance, is a key policy mechanism that CMS proposes to transform Medicare from a passive payer of claims to an active purchaser of care.

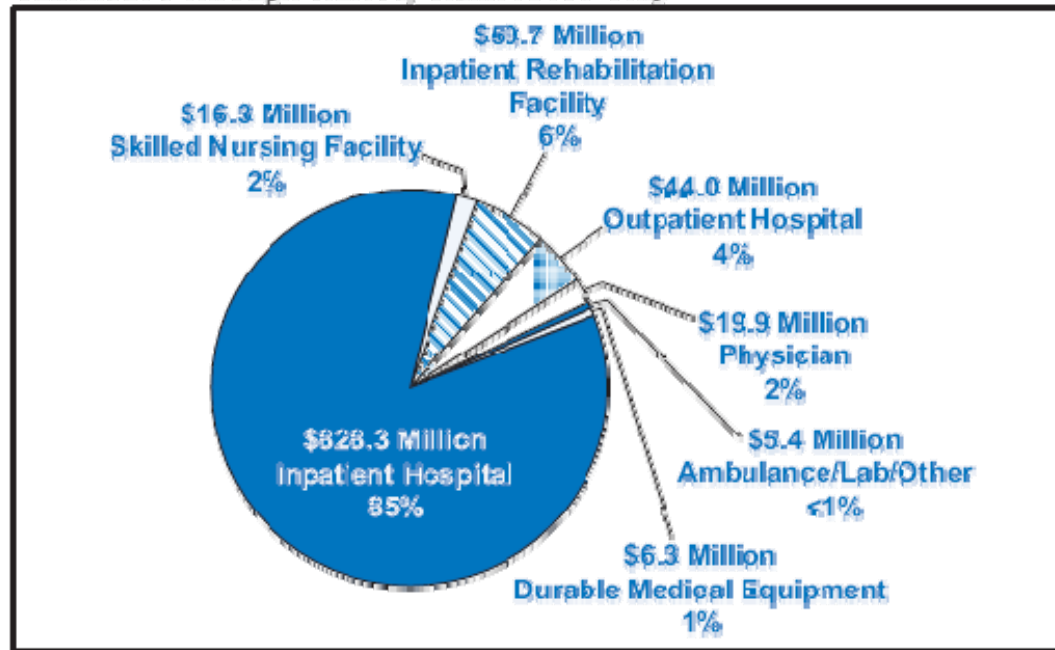


--CMS HHS Hospital VBS Plan Issues Paper

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\$828M in RAC Denials to Inpatient Hospitals

Figure 5. Overpayments Collected by Provider Type:
Cumulative Through 3/27/08, Claim RACs Only



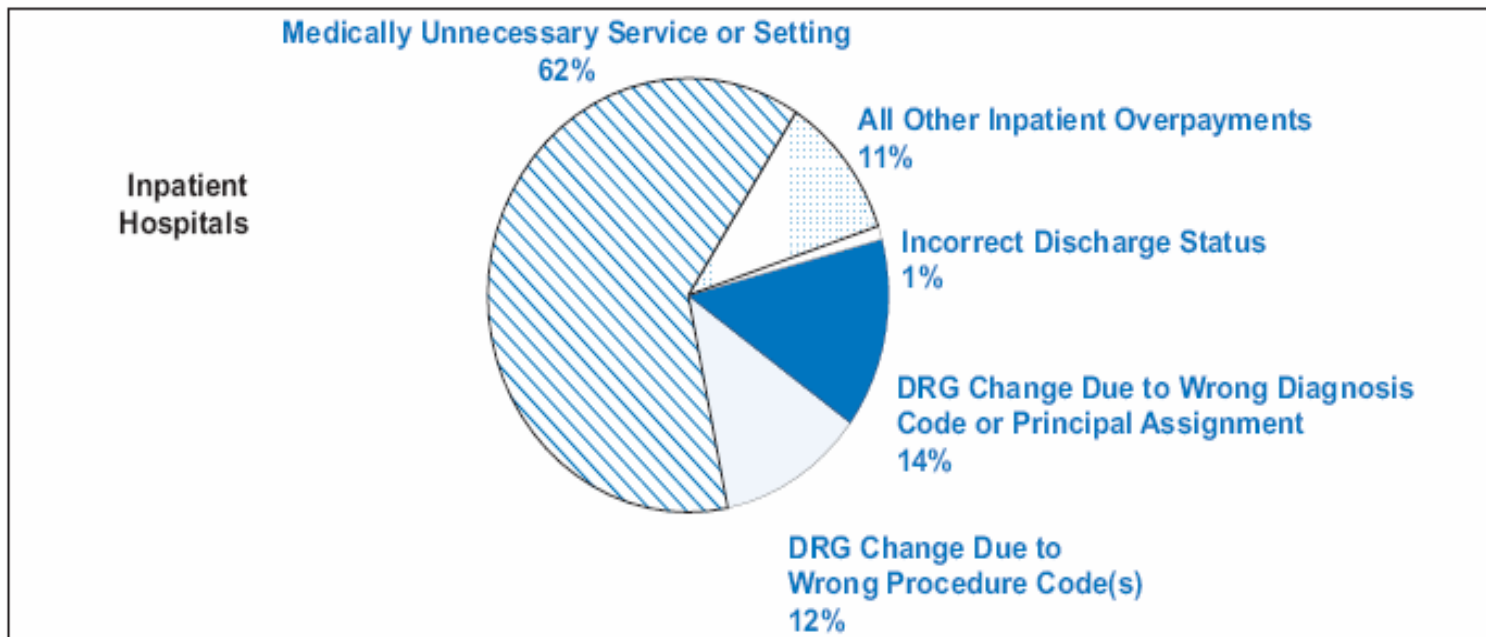
Note: These data are net net of appeals.

Source: RAC invoice files and RAC Data Warehouse (ratios needed to calculate Physician percentages from Ambulance/Lab/Other data were self-reported by the Claim RACs).

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Medical Necessity is 62% of Audit Error

Figure F1. Audit Areas and Top Errors by Provider Type, Net of Appeals:
Cumulative Through 3/27/08, Claim RACs Only (Percent of Overpayment Amount)



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Surgical Procedures

Over \$152M of the \$391M in Inpatient Hospital Medical Necessity Denials Related to Surgical Procedures

Table G1. Top Services With RAC-Initiated Overpayment Collections (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only

Type of Provider	Description of Item or Service	Amount Collected Less Cases Overturned on Appeal (Million Dollars)	Number of Claims With Overpayments Less Cases Overturned on Appeal	Location of Problem
Inpatient Hospital	Surgical procedures in wrong setting (medically unnecessary)	88.0 ✓	5,421	NY
	Excisional debridement (incorrectly coded)	66.8	6,092	NY, FL, CA
	Cardiac defibrillator implant in wrong setting (medically unnecessary)	64.7 ✓	2,216	FL
	Treatment for heart failure and shock in wrong setting (medically unnecessary)	33.1	6,144	NY, FL, CA
	Respiratory system diagnoses with ventilator support (incorrectly coded)	31.6	2,102	NY, FL, CA

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Medical Necessity

Social Security Act §1862(a)(1)(A).

- In most instances, CMS ... determines whether the item or service is “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

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Medical Necessity

- This really encompasses two separate questions
 - Is the therapy/treatment/device/procedure
 - Necessary and appropriate for the patient in question?
 - Is the setting in which it is deployed
 - Necessary and appropriate for the patient in question?

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Medical Necessity

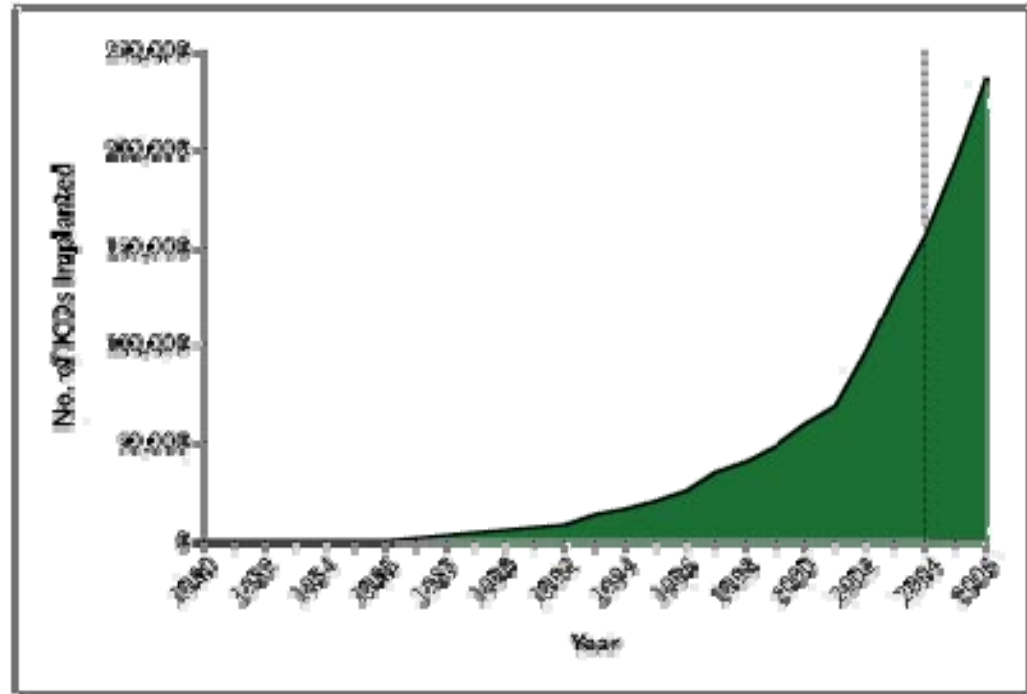
Is the therapy/treatment/device/procedure necessary and appropriate for the patient in question?

- What are the indications for the procedure?
- What are the exclusions?
 - FDA determines safety and effectiveness
 - CMS (or its contractors) determines whether, or under what circumstances the services will be reimbursed
- Example: Implantable Cardioverter Defibrillators (ICDs)
 - Unquestionably life saving devices

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Change In Medically Necessary Use of ICDs

Change in Medically Necessary Use of ICDs in the U.S. Over Time.



The NEW ENGLAND
JOURNAL of MEDICINE

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Medical Necessity

Is the setting in which the therapy/treatment/device/procedure is deployed necessary and appropriate for the patient in question?

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Medical Necessity

- What is the appropriate setting?
 - ICD's
 - Historically, all of these were treated as inpatients
 - Smaller devices, less invasive techniques
 - Currently may be scheduled from outpatient setting
 - Most receive care “in the hospital” after the procedure
 - This care may be as an “inpatient admission” or...
 - as an “outpatient” : Post-procedural monitoring, observation, outpatient

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How do most hospitals manage Medicare Procedure Admission Status Certification?

- Decision to do procedure in non-urgent/emergent fashion is commonly made by surgeon well before date of procedure
- Surgeon evaluates patient in advance of procedure to determine risks and often obtains consultative input for “clearance” for surgery
- Surgeon’s office staff usually calls hospital and requests time on OR or short procedure unit schedule for procedure

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How do most hospitals manage Medicare Procedure Admission Status Certification?

- Surgeon will often write order for inpatient vs observation status based on the location in which the procedure will be done
- Surgeon understands risks related to patient and procedure factors, but usually doesn't apply this information when making the admission status determination
 - Rather, the assessment of risk is used by the surgeon to increase his/her level of vigilance for any potential peri procedure issues/problems and deal with them as they might occur
- Informed Consent

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How do most hospitals manage Medicare Procedure Admission Status Certification?

- UR staff usually do not review procedural cases given the assumption that they are appropriate for the setting requested by the surgeon's staff
- Most surgeons are not specially trained in how to correctly apply clinical evidence and regulatory guidance to determine medical necessity for the purposes of assigning initial admission status

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How do most hospitals manage Medicare Procedure Admission Status Certification?

- In the event of an unexpected outcome (not necessarily a complication) peri or post procedure, there is often no review by UR staff to assess a potential change in admission status
- Usually little/no documentation regarding the process for determining admission status in the chart

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Regulatory Definition of “Inpatient”

MEDICARE BENEFIT POLICY MANUAL

“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;...”

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Regulatory Definition of "Observation"

MEDICARE BENEFIT POLICY MANUAL

"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")."

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Your UR Plan

The Standards By Which Your UR Committee Process 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.”

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What Physician Input is Required?

- 42CFR482.30(d) *Standard: Determination regarding admissions or continued stays.*
 - “(1) The determination that an admission or continued stay is not medically necessary—
 - (i) May be made by **one member of the UR committee** if the practitioner or practitioners responsible for the care of the patient...concur with the determination or fail to present their views when afforded the opportunity; and
 - (ii) Must be **made by at least two members of the UR committee in all other cases.**
 - (2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient... and afford the practitioner or practitioners the opportunity to present their views.
 - (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient...”

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HPMP Guidance for how to operationally carry out the daily admission review

- 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.*”

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Process for Procedure Admission Status Certification

- Pre-Procedure Admission Status Certification Process
 - Preadmission testing and evaluation occur
 - Request for “OR” time comes to hospital from physician office
 - Case evaluated for presence on Medicare Inpatient Only List
 - If on List, case is IP
 - If not on List, full admission status review must occur
 - IP screening criteria are applied to case by UR staff using all available preadmission data

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Process for Procedure Admission Status Certification

- If IP criteria met, approve and perform procedure at inpatient status and level of care
- If IP criteria not met, refer case for Physician Advisor review
- Physician Advisor reviews case, applies evidence based clinical and regulatory guidance, and discusses case with treating physician as appropriate
- Admission status determined, concordant physician admission order obtained, and care delivered at the correct level of care
- Auditable document that outlines basis for admission status determination placed on the patient chart

❖ Operationally very difficult to implement

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Process for Procedure Admission Status Certification

- Peri/Post-Procedure Admission Status Certification Process
 - Patient who remains unexpectedly in hospital overnight post procedure receives UR screening criteria review
 - If IP criteria met, approve and perform continued care at inpatient status and level of care
 - If IP criteria not met, refer case for Physician Advisor review
 - Physician Advisor reviews case, applies evidence based clinical and regulatory guidance, and discusses case with treating physician as appropriate

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Process for Procedure Admission Status Certification

- Admission status determined, concordant physician admission order obtained, and care delivered at the correct level of care
- Auditable document that outlines basis for admission status determination placed on the patient chart
- Possible Outcomes:
 - OP procedure converts to IP status
 - IP admission is certified following OP procedure
 - Care is considered part of normal post OP procedure recovery and is included in the previously certified admission status for the procedure

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UR Staff Screen 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

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UR Staff Screen Criteria Review Keys To Success

- 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

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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 the judgment of "one" physician
 - Need to provide library of evidence based outcomes research across major diagnostic areas for decision making to be consistent and defensible
 - Must include regulatory guidance
 - Must be updated as these knowledge bases change

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Physician Review Keys To Success

- 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

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EHR Case Study: Interventional Cardiac Procedures (ICPs)

- The paradigm that has existed - that the billing status of a procedure is established by the procedure itself - is no longer valid. Many procedures can be done as Inpatient (IP) or Outpatient (OP).
- The standards that the Hospital is given by the Code of Federal Regulation, CMS ruling 95-1, Medicare benefits Policy Manual and HPMP workbook require a two level review:
 - Criteria (like Interqual) based review - PCI are no longer on the IP list for IQ or on the CMS IP only list
 - Second level review by Physician (suggested a physician advisor in HPMP workbook) The opinion of the physician is not that important- status is based on an evidence based/literature based standard of care that is focused on risk stratification

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EHR Case Study: Interventional Cardiac Procedures (ICPs)

- Therefore, in looking at ICPs, you have to take two factors into account:
 - Procedure based risk factors
 - Patient specific risk factors
 - The interaction between the two sets of risk
- These procedures are targets of the RAC and QIO auditors.
 - The “3 Cs”
 - Common, Costly and Confusing

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EHR Case Study: Interventional Cardiac Procedures (ICPs)

- A common practice by hospitals is to try to simplify this into a one page list of what makes patients IP or OP.
 - Does not well evaluate the interaction of individual patient risk factors
 - Does not well evaluate the interaction of procedure and patient risk factors
 - Usually not updated often enough in response to changing clinical and regulatory guidance
 - Often, not robust enough to be supported at the Medicare Appeals , OIG or DOJ levels.

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Inpatient or Outpatient?

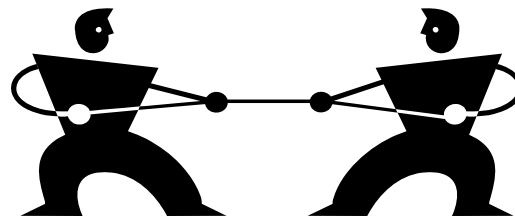
- Physician schedules procedure 7 days in advance as an elective procedure
- Planned 2 hour procedure to implant a single chamber Right Ventricular ICD
- 65 year old male
- Dilated Cardiomyopathy with a Left Ventricular EF = 20%
- s/p CABG X 2
- Mitral Regurgitation
- Currently receiving ASA/Plavix
- Heart Transplant Listed
- Does not meet IQ – what should you do?

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Surviving the ICP “Tug of War”

The Adventist Health System Challenge

- **Lynn M. Leoce**, MSN, RN, CPUR, IQCI, ACM, Corporate Director of Case Management – Adventist Health System



FMQAI Press Release

- CMS Data Reports ICPs Are Top DRGs Billed For One-Day Stays in Florida
- Effective July 1, 2006 FMQAI No Longer Uniformly Allows Inpatient Billing for These Services
- Medical Record Documentation Must Reflect Need for Inpatient Level of Care to Prevent Denial



FMQAI Press Release

- Cases Will Be Reviewed Individually to Determine Appropriate Billing Status
- Medical Record Must Reflect Need for Inpatient Level of Care
- Routine Cases or Expected Discharges Within 24 Hours Not Validated by SI/IS Criteria Will Be Denied



Status Determination Dilemma

Inpatient Versus Outpatient

- Is the Procedure Elective or Urgent?

Inpatient Exceptions:

- Thoracotomy
- Urgent or Emergent
- BV ICD's
- Utilization Management Screening Not Typically Performed for These Procedures.
- Is Severity of Illness (SI) and Intensity of Service (IS) Met for Status Assigned?

Status Determination Dilemma

- How Does CMS Define Inpatient Status Determinations?
- Shift In Medicare “Inpatient Only List”
 - Due to Variations in Practice, May Be Performed in the Outpatient Setting
- *Threat* of Denials and Concerns over Impact of Lost Revenue.
- What Criteria are Considered “Urgent?”
- Should We Err on the Side of Caution: Outpatient Status?

Hospitals Challenge

- Review Denied Cases and Implement Appeals Process
 -Appeal....Appeal....Appeal!
- Conduct Internal Audit to Determine Hospital Risk for Targeted Procedures
- Develop Standardized Process for Chart Review to Ensure Compliance
- Initiate Proactive Measures to Reduce Denials and Protect Reimbursement

Pro-Active Action Plan

- Research Medical Journals and Published Medical Literature for Guidance on ICP Procedures
 - National Coverage Decisions (NCDs)
 - Local Coverage Decisions (LCDs)
 - Clinical Evidence Summaries
 - Regulatory Guidance
- Provide Physician Education
 - Utilize Industry Experts on Regulatory Guidelines and Documentation Strategies to Ensure Appropriate Status
 - Overview of Medical Necessity Criteria



Pro-Active Action Plan

- Early Screening of ICP Procedures
 - Scheduled and Non-scheduled
- Apply Medical Necessity Screening Criteria (1st Level Review)
 - Screen Admissions at ALL Points of Entry
 - Obtain Documentation Real-Time
- Utilize Physician Advisors for Secondary Review and Status Determinations
- Track All Referral Activity to Determine Intervention and Outcomes
- Stay Consistent with Your Action Plan-Every Day!

Key Points To Remember . . .

- Status is No Longer Determined by Procedure
- Coordination of Efforts
 - Hospital Administration
 - Physicians/Physician Advisors
 - Case Management/Nursing
- Don't Give Away the Farm, i.e. **Over-Conservatism**
- Be Confident In Accuracy of Claim Submission and Its Future Impact on Patient Safety, Quality of Care and Reimbursement

Key Points To Remember . . .

- Keep Informed of Changes in Procedural Guidelines and Standards of Practice
 - Evidence Based Medicine
- Stay With Your Action Plan
 - Don't Abandon Compliance Screening
- Schedule Routine Meetings With Physician Partners to Analyze Processes and Develop Process Improvement Initiatives

Robert R. Corrato, MD, MBA, President & CEO –
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Kyphoplasty Procedures

DOJ and OIG Investigation



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Kyphon Case

- Government Claims Against Kyphon
 - Fraudulent Marketing for Inpatient Admissions to Hospitals
 - Physicians Induced to Submit “Up coded” Procedure Codes
 - Sell Need for “Bone Biopsy” Procedures to Physicians and Hospitals
 - Provided Free Kyphon Equipment to Hospitals
- Government States Kyphoplasty Procedures Can Be Safely Performed as Outpatient

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Case Outcome

- Kyphon Paid Back \$75M to Federal Government
- DOJ and OIG Launch Investigation on Hospitals and Physicians that Performed Kyphoplasty Procedures
- Subpoenas Served to Hospitals and Physicians that Performed Procedure Beginning 1999

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Medical Necessity Guidelines

- Not on CMS Inpatient Only List
- InterQual Guidelines-Inpatient Surgery/Procedure List for 2005-2007
- Procedure Considered Controversial Prior to 2005
- Removed from InterQual Inpatient List in 2008
- McKesson Recommends Procedure Requires Secondary Review

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Investigation: Information Requested

- Kyphoplasty Procedures by Year (All Payors)
- Names of Physicians Performing Procedures
- Hospital Billing Procedures for Kyphoplasty

- Physician Operation Cards (equipment needs)
- Hospital Process for Approving Performance of a New Procedure
- Physician Standing Orders

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Medical Record Review

- Kyphoplasty's Performed as Inpatient With Zero or One Day LOS
 - Procedural Information
 - Admitting Diagnosis
 - Sedation Used
 - Medications Dispensed Post Recovery Room
 - Discharge Disposition
 - Treatment of Co-Morbid Conditions

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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?

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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?

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Useful Compliance Publications

- CMS Recovery Audit Contractor Evaluation Report June 2008
- CMS 2007 RAC Status FY 2007
- Appendix 3 – RAC Expansion Schedule 11-7-07
- Revised Statement of Work RAC Program 11-7-07
- GAO report on QIO accuracy
- RAC report on First Year
- Legislation Expanding RACs
- Medlearn Matters on Condition Code 44
- Medicaid Integrity Program legislation
- Expansion of Admit to Case Management Protocol Article
- Surgical Setting Report Template
- Transfer DRG White Paper

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

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Questions?

Thank you for participating in this educational event.
Do you have any questions for our panel?

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Featured Speaker

Don May is Vice President for Policy at the American Hospital Association. Don directs the AHA's policy development activities for Medicare and Medicaid funding of hospitals and health systems. Prior to joining the AHA, he was a Senior Manager with The Lewin Group where he managed projects with the AHA and other state and national associations on topics such as the impact of the BBA, trends in hospital financial performance, Medicaid payment adequacy, and community health. Prior to joining The Lewin Group, Don served as Assistant Hospital Program Administrator for the Ohio Medicaid Program. Don has his Master's in Public Administration from the Ohio State University and a Bachelor's in Political Science from Ohio University.

www.aha-solutions.org

Featured Speaker

Dr. Corrato founded EHR in 1997 and has since served as EHR's President and Chief Executive Officer. At present, more than 500 hospital and healthcare organizations in 44 states are using EHR's solutions. Since the start of the Recovery Audit Contractor (RAC) demonstration project, Dr. Corrato has amassed extensive experience with all stages of the RAC review and appeal process. He has engaged in thousands of RAC appeals and hundreds of Administrative Law Judge hearings and has achieved unmatched success in obtaining the reversal of admissions inappropriately denied by RACs.

Prior to founding EHR, Dr. Corrato held the post of deputy director of the Office of Health Policy and Clinical Outcomes at Thomas Jefferson University in Philadelphia. An internist with extensive outpatient, inpatient, academic and community-based clinical practice experience, he is one of only six physicians in the U.S. to have completed medical fellowship training in managed care/administrative medicine. Dr. Corrato earned his master of business administration degree from the Wharton School of Business at the University of Pennsylvania and received his medical degree from the Medical College of Pennsylvania.

Featured Speaker

Dr. Zebrowitz currently serves as Executive Vice President for Executive Health Resources (EHR). At present, more than 500 hospital and healthcare organizations in 44 states are using EHR's solutions. Dr. Zebrowitz was instrumental in the development of EHR's suite of clinical revenue cycle management solutions, and is highly involved in EHR's strategic planning. Dr. Zebrowitz regularly conducts educational sessions at EHR's client hospitals and has completed hundreds of regulatory assessment audits for EHR's hospital clients. Dr. Zebrowitz also oversees EHR's education and regulatory assessment teams.

Prior to joining EHR, Dr. Zebrowitz was a Founder and Vice President of Strategic Alliances at eHealthContracts, now Concuity Inc. Before Concuity, Dr. Zebrowitz was a practicing obstetrician/gynecologist at Abington Memorial Hospital in Pennsylvania. Dr. Zebrowitz received his medical degree from Temple University School of Medicine and a bachelor's degree from the University of Pennsylvania. He also attended the Wharton School of Business at the University of Pennsylvania, where he is a frequent lecturer.

Featured Speaker

Ms. Leoce has served as Corporate Director of Case Management for the Adventist Health System since March of 2004. Her case management experience includes manager of case management, complex case management and total health care management for Florida Hospital Orlando. In addition, Lynn served as a member of the Optimum Stay Committee, Ethics Committee, and Palliative Care Committee.

Prior to case management, Lynn served as an assistant nurse manager for family practice, women's health, renal transplant unit, and perinatal high risk unit at Florida Hospital Orlando.

Lynn received both a Bachelor of Science and a Master of Science in Nursing from the University of Phoenix. She is a Certified InterQual Instructor, Certified Professional Utilization Reviewer by the McKesson Corporation and is an Accredited Case Manager by the American Case Management Association (ACMA). Lynn is a member of the Sigma Theta Tau International Nursing Honor Society as well as Phi Beta Kappa Honor Society. Lynn is a member of the Florida Hospital Association and the Healthcare Finance Management Association (HFMA).

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.



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