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Medical necessity review: Compliance in a new era of accountability

By Robert R. Corrato, MD, MBA, David Hoffman, Esq., and Michael Taylor, MD

Editor's note: Robert R. Corrato is President and Chief Executive Officer with Executive Health Resources in Newtown Square, Pennsylvania. He may be contacted by e-mail at rcorrato@ehrdocs.com.

David Hoffman is President of David Hoffman & Associates, PC, in Philadelphia, Pennsylvania. He may be contacted by e-mail at dhoffman@DHoffmanAssoc.com.

Michael Taylor is Vice President of Clinical Operations with Executive Health Resources in Newtown Square, Pennsylvania. He may be contacted by e-mail at mtaylor@ehrdocs.com.

The federal government estimates that, in recent years, tens of billions of dollars have been improperly paid through Medicare programs.[1] As a result, hospitals now face a new era of health care audit accountability as the government seeks to reduce or eliminate inappropriate overpayments to providers and suppliers.

The Centers for Medicare and Medicaid Services (CMS) reports that the majority of Medicare overpayments made erroneously to hospitals are due to errant determinations of medical necessity.[2] Over the past two years, procedures such as kyphoplasty (a treatment for back pain) and cardiac defibrillator implantations have received particular scrutiny by the Department of Justice (DOJ), because of the potential for fraudulent claims submission arising from inappropriate utilization of the inpatient hospital setting or lack of medical necessity for the procedure itself.

Recent allegations relating to over-utilization of Medicare inpatient services demonstrate that awareness of the importance of Medicare inpatient utilization patterns has reached the mainstream business community and financial sector. Add to this, Capitol Hill's ongoing battle to reduce Medicare costs, and hospitals are finding that, more than ever, medical necessity compliance is a top priority within their organizations.

In today's environment of increased health care scrutiny and accountability, it is more important than ever for hospitals to maintain a strong, concurrent compliance review program to ensure appropriate utilization of inpatient services.

Expanded power to fight overpayments, fraud, and abuse

In addition to subjecting providers and suppliers to increased scrutiny through programs, such as Recovery Audit Contractor (RAC) and Zone Program Integrity Contractor (ZPIC) review, the government has simultaneously strengthened its ability to deal with suspected fraud through rulemaking.

On January 24, 2011, the Department of Health and Human Services (DHHS) announced new rules, authorized by the Affordable Care Act, that apply to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Under the new rules, payments to providers can be suspended in the event of a credible allegation of fraud or abuse. When considered in light of a recent expansion of the False Claims Act to make clear that hospitals have a duty to refund overpayments within 60 days of identification, government investigators now have more powerful tools in their fight against Medicare overpayments, fraud, and abuse.

A look at the government's expanded toolbox reveals that providers must consider, not just institutional risk, but personal risk as well. On October 20, 2010, the Office of Inspector General (OIG) of DHHS issued guidance for implementing its permissive exclusion authority under Section 1128(b)(15) of the Social Security Act. (Exclusion refers to the ability of the OIG to exclude individuals or entities from participating in the federal health care programs.) Section 1128(b)(15) specifically authorizes the OIG to exclude an owner, officer, or managing employee of a sanctioned entity (i.e., health care provider, supplier, or manufacturer) from participation in federal health care programs.

Furthermore, recent testimony before Congress makes clear that a key plank in the government's strategy is to target not just institutions that engage in fraud and abuse, but the executives who manage those institutions.

RACs are only the tip of the iceberg

While the contingency fee-based RACs have been the subject of much media attention in recent years, CMS has greatly expanded the role of other auditors, as well. Medicare Administrative Contractors (MACs) have essentially combined the roles previously performed by Part A Fiscal Intermediaries and Part B Carriers. MACs have the authority to institute and monitor Progressive Corrective Action (PCA) Plans, which may entail actions such as putting hospitals on pre-payment review.

Other important Medicare audit programs include Comprehensive Error Rate Testing (CERT), which works to measure payment error rates, and ZPICs, which are specialized contractors tasked with ferreting out fraud and abuse in the Medicare program.

The two aspects of medical necessity

Hospitals should be aware that CMS contractors and other investigators may examine two different aspects of medical necessity: (1) the medical necessity for the procedure or medical service itself, and (2) the medical necessity for the setting of care. Both of these aspects of medical necessity have been extensively examined in recent years by CMS contractors and have been the subject of government enforcement activities. Medical necessity for a procedure or service itself is often determined by National Coverage Determinations, Local Coverage Determinations, evidence-based clinical care guidelines, and local and national standards of medical practice.

Because Medicare providers are tasked with providing care in the most appropriate setting, medical necessity of the setting in which the patient is treated is also a target of auditor attention. Such auditors frequently review short-stay hospital admissions to determine if the patient could have been treated just as safely and effectively in the outpatient setting.

Medical necessity of the inpatient setting was a major target of RAC denials in the demonstration project, and remains a focus of RAC and MAC audit scrutiny today. To ensure optimal compliance, a hospital's utilization review program should evaluate both of these aspects of medical necessity.

Achieving medical necessity compliance

As a first step toward creating a medical necessity compliance process, a hospital may consider reviewing its past performance as an organization with the goal of understanding and recognizing whether there is potential exposure or liability due to pre-existing poor utilization review practices.

The following nine suggestions are offered in order to create a compliant process for Medicare medical necessity admission review.

1. Build a strong UR plan and UR Committee

The process of medical necessity compliance starts with the

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utilization review (UR) standards of the Medicare Conditions of Participation (CoP). In accordance with Title 42 of the Code of Federal Regulations under 482.30 and its subparts, hospitals are required to maintain an active UR Committee as part of a comprehensive UR plan. At a minimum, the UR Committee is charged with reviewing hospital's admissions, continued stays, and outlier cases.

It is the responsibility of the UR Committee to review the UR plan annually, to continually identify areas of improvement, and to include physicians and other hospital medical staff stakeholders in the process of ensuring Medicare admission review compliance.

2. First-level concurrent medical necessity review

It is important for hospital case and utilization managers to use credible, up-to-date inpatient admission screening criteria when conducting first-level reviews and making evaluations for patient status. Such widely accepted utilization screening criteria as InterQual, Milliman, or MCAP™ frequently fulfill this role at hospitals.

It is important to note, however, that CMS does not endorse any particular set of commercial screening criteria, and the satisfaction of any particular set of commercial screening criteria is not a guarantee of Medicare coverage. Hospitals should monitor the accuracy of their first-level screening reviews by asking questions such as:

- Are we applying the criteria correctly?
- Are we measuring and achieving appropriate levels of inter-rater reliability in the application of criteria?

First-level criteria screening reviews are generally conducted by non-physicians, and the professionals who perform these reviews should take care to operate within their appropriate professional scope of practice. The role of the case and utilization manager is to strictly apply the screening criteria, not to substitute for or overrule physician judgments of medical necessity.

It is important to note that first-level screening criteria are not meant to be a substitute for case-by-case expert physician review of medical necessity. In fact, many of these criteria have anywhere from a 20% to 25% error rate. In some instances, some patients who don't satisfy commercial admission criteria at the first-level review may nevertheless require inpatient admission, based on physician assessment.

3. Second-level concurrent medical necessity physician review

When a case does not satisfy the hospital's first-level utilization review screening criteria, that case should be referred for second-level physician review. As detailed by the Hospital Payment Monitoring Program (HPMP) Compliance Workbook, hospitals should ensure a two-level admission medical certification process that includes strict application of inpatient screening criteria by case or utilization management professionals, followed by expert physician advisor review for those cases that do not meet the screening criteria.[3] As directed by the Medicare State Operations Manual, only a physician can make the final determination of the medical necessity of an admission.

4. Establish a strong Physician Advisor program.

As hospitals do not close their doors and turn off the lights during nights and weekends, a compliant utilization review program must operate 365 days a year, seven days a week. Physician advisors operating in such a program must be knowledgeable regarding Medicare rules and regulations, and up to date on the latest medical evidence.

Physician advisors need to be skilled and experienced in making proven, consistent, and valid medical necessity recommendations (i.e., recommendations that

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are not subject to unexplained variation and that will stand up to scrutiny, as necessary, through the audit and appeals process).

5. Educate and monitor key staff members

Hospitals should ensure ongoing training, education, and inter-rater reliability testing of their utilization management and physician advisor teams. A sound, ongoing education program is a necessity to support and maintain hospital regulatory compliance, and to ensure continued optimal performance of both first- and second-level utilization review processes.

6. Educate treating physicians

The treating physician is a key part of the process and must be an active and central participant in the utilization review process. With this in mind, hospitals should consider providing ongoing treating physician education on:

- the importance of complete documentation,
- the need to work closely with UR/case management and physician advisors, and
- the role of the treating physician in ensuring both hospital and physician practice regulatory compliance.

7. Create an enduring and auditable document

An evidence-based utilization review process that adheres to regulatory requirements and CMS policy guidance may result in significant protection to the hospital pursuant to Section 1879 of the Social Security Act. In essence, Section 1879 of the Act provides that when a provider does not know, and cannot reasonably have known, that a service will not be covered by Medicare as medically unnecessary, the provider is entitled to payment by Medicare for that service. This is known as the Limitation on Liability.

If a hospital fails to thoroughly document evidence of its compliant, concurrent, medical necessity utilization review process, then that hospital may lose the benefit of the protection conferred to it under the Social Security Act's Limitation on Liability. For this reason, an enduring and auditable document should be created for each Medicare admission to provide permanent evidence of the hospital's compliant Medicare admission claim status certification process that will be available for review in the event of an audit by a RAC contractor or other investigator.

This document should include not only documentation of the first-level screening and secondary physician advisor reviews, but any subsequent conversation between the physician advisor and the treating physician that resulted in additional chart documentation.

8. Conduct regular PEPPER analysis

On a quarterly basis, hospitals should review their Program for Evaluating Payment Patterns Electronic Report, more commonly known as PEPPER. This report takes a critical look at targeted diagnoses that are often associated with short stays to identify areas that may require improvement or attention. The data can help serve as a guide to help hospitals identify potential areas of vulnerability.

9. Engage key stakeholders

The final step in the process ensures that UR/case management, physician advisors, HIM/Coding, finance, and compliance professionals are all involved in the process of ensuring a compliant, daily, Medicare medical necessity utilization review program. At the same time, the team that manages this process must be sufficiently streamlined to execute it on a daily basis.

Closing thoughts

In today's environment of increased health care accountability, it's no longer a matter of "if," but "when" a given hospital will be audited. Compliance requires a concurrent medical necessity review process that is legally defensible to avoid auditor denials and to retrospectively manage and appeal inappropriate auditor denials.

The costs of non-compliance far outweigh the costs of compliance.

The best practice approach to a comprehensive medical necessity compliance program is a proactive approach that infuses clinical and regulatory guidelines in the decision-making process, ongoing communications among team members, and proper training to ensure all cases are properly screened, documented, and validated. ■

1. Kathleen M. King and Kay L. Daly: "Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments." Government Accountability Office, March 2011. Available at http://www.gao.gov/new.items/d11409t.pdf
2. "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration." June 2008. Available at http://www.cms.gov/RAC/Downloads/RACEvaluationReport.pdf
3. HPMP Compliance Workbook. (Prepared by TMF Health Quality Institute, the Quality Improvement Organization Support Center for the Hospital Payment Monitoring Program, under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. 8SOW-TX-HPMPQ-08-06), page 38. January 2006, (rev. March 2008). The workbook is available for download at http://www.metastar.com/Web/Portals/0/Documents/HPMP/HPMP-Compliance-Workbook.pdf

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