The New Age of Healthcare Accountability:
Understanding the Medicaid Recovery Audit Programs

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So What is the Key Word Today?

It is no longer 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 and revenue integrity reasons has never been greater.

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 is expanding

Inpatient Care
- 18.3m cases
- $160.3B Reimbursed

Outpatient Care
- 87.3m cases
- $43.2B Reimbursed

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

Medical
- Chest Pain
- Syncope (fainting)
- Dehydration
- Back Pain

Surgical
- Cardiac Procedures
- Mastectomy
- Prostatectomy
- Laparoscopic Appendectomy

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CMS and Auditor Focus on “Gray” or Uncertain Areas of Medical Necessity

- CMS believes that the annual error rate is $34B, equating to 2/3rds in the area of Medical Necessity
- US Office of Management and Budget projects that the actual annual error is $42B
- Either way, the only way to remove error is to review all of the “gray” at-risk cases

“Gray” area growth nationally from 2007 to 2010: 36.7% increase
- Interventional & Diagnostic Cardiac Procedures (catheters, stents, ICD, pacemakers – 1.6m cases/year)
- Spinal Procedures – 107k cases/year
- Readmission target expanded from 7 to 30 days – 2.2m cases/year
- Changes in CMS “Inpatient Only” list – 510k cases/year

Why does the “gray” area grow?
- Advances in medical technology and treatment methods make an outpatient setting appropriate for some patients
- These advancements are reflected in changes in screening criteria and CMS’ “Inpatient Only” list
- CMS and auditors identify target areas based on where they think abuses occur or where hospitals are likely to make mistakes (costly, common, confusing)

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How Do Hospitals Manage “Gray” Medical Necessity without EHR?

Based on audits of >250 hospitals

**Gray Cases:** 16.6M, representing $79B

**Common Erroneous Processes:**
- Decisions based solely on Physician Order
  - Inconsistent and random based on individual opinion/style
  - ALJ decisions do not rest solely on the physician order*
- Decision based solely on 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 or onsite PA Opinion
  - Similar result as solely relying on Order
  - Inconsistent and random based on individual opinion/style
  - Attendings also often passively agree with criteria screen result

**Common Erroneous Results:**
- Over-status IP: 25-42%
- Over-status OBS/OP: 12-27%
- Over-status IP: 6-14%
- Over-status OBS/OP: 27-43%
- Over-status IP: 12-53%
- Over-status OBS/OP: 17-36%
- Over-status IP: 25-42%
- Over-status OBS/OP: 12-27%

*Based upon >2,000 ALJ hearings conducted by EHR
Why is Getting Patient Status Correct Such An Important Issue?

- Incorrect overuse of Inpatient
  - Recovery Audit Contractors
  - Potential False Claims issue if no compliant process is in place
  - Eventual loss of revenue on audit and loss of opportunity for appropriate OBS APC and ancillary charge payment

- Incorrect overuse of Observation
  - Revenue integrity issue for hospitals and physicians (affects bond rating)
  - Length of stay artificially elevated
  - Mortality data artificially elevated
  - Market share data artificially lowered
  - Cost of inpatient care data artificially elevated
  - Transfer DRG payment impact
  - Qualified stay impact on patient skilled care benefit
  - Unexpected patient financial responsibility

It’s about getting it right!

Note: Medical Necessity Compliance Should Not Be Confused with Revenue Cycle Optimization or Physician Advisor Staffing
Medicare Audits 2011: A Target Rich Environment

Traditional Targets
(PEPPER 1 day stay, DRG validation)

ZPIC
Zero Day stay, extrapolation, ‘specialized fraud fighters’

MAC Probe Audits
(1+ day targets, esp. chest pain & high cost procedures)

OIG & DOJ
Fraud, False Claims
Kyphoplasty, chest pain, ICD

RAC Targets
Initial 18 announced, many more to follow

CLAIMS REVIEWS

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*$34.3 billion in improper payments

“The primary causes of improper payments, as identified in the FY 2010 Medicare FFS Improper Payments report, were insufficient documentation errors, medically unnecessary services, and to a lesser extent, coding errors.”

*From the February 2011 Improper Medicare Fee-For-Service Payments Report
Accountability Increases

- RAC Update
- MAC roles
- False Claims Act Enforcements
- Quality based Payment Liabilities
- Individual Liabilities – Permissive Exclusion
- Medicaid RAC’s Entering the Picture
- HIPAA Violations
- Provider Risk Stratification
- Duplicate Audit Issues
- Bundled Payments Initiative
## RACs Are But the Tip of the Audit Iceberg…

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Medicaid Recovery Audit Contractors: CMS Final Rule

- Establishment of the Medicaid Recovery Audit Contractor was required by §6411 of the Patient Protection and Affordable Care Act

- Each state must contract with at least one Medicaid RAC to review payments made under the Medicaid program

- Estimated to save over $2 billion over the next 5 years

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455

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Medicaid Recovery Audit Contractors: CMS Final Rule

- Will begin on January 1, 2012
- There is no global phase-in strategy
- The lookback period will be 3 years, unless the RAC receives approval from the state (§455.508(f))
- Process and procedural issues will be left up to the individual states

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455
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Implementation by the States

- States must adequately incentivize the detection of underpayments
- The states will determine chart pull limits
- The states will establish the appeals process

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455
Medicaid RAC Incentives

- States will determine contingency fees based on a percentage of recovered overpayments (§455.510(b))

- They can earn a separate fee for identifying underpayments (§455.510(c)(2))

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455
Medicaid RAC Appeals

- States must provide appeals rights under state law or administrative procedures to Medicaid providers (§455.512)
- No mention of a discussion period
- If a RAC determination is reversed on appeal, the contingency fee must be returned in a reasonable timeframe (§455.510(b)(3))

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455

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Medicaid RAC Medical Record Limits Determined by States

• Limits on the number and frequency of medical records to be reviewed by the Medicaid RACs will be set by the states (§455.506(e))

• Acceptance of electronic medical records from providers is mandatory (§455.508(e)(3))

• RACs should not audit claims that have already been audited or are currently being audited by another entity (§455.508(g))

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455

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Other Items of Interest: Minimal Medical Personnel

- The entity must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with §455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval($455.508(b)).

- A requirement that RACs hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims ($455.508(c)).

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455
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Other Items of Interest: Education & Outreach

- The RAC must work with the State to develop an education and outreach program component, including notification of audit policies and audit protocols (§455.508(d)).

- Mandatory RAC customer service measures, including: providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact (§455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers’ request (§455.508(e)(3)); and notifying providers of overpayment findings within 60 calendar days (§455.508(e)(4)).

Source: Medicaid Program; Recovery Audit Contractors Final Rule, 42 CFR 455

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Pennsylvania Medicaid RACs

- CGI Group, Inc. (CGI) was awarded a 4-year, $44.9 million contract renewal with PA to continue assisting in the prevention, detection and correction of improper payments in the Medicaid program.

- HMS will provide financial overpayment reviews and recovery services under a subcontract.


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Why Have a UR Committee?

Code of Federal Regulations
Title 42 Volume 3
Chapter IV
Section 482.30

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.

Typically also a contractual obligation for agreements with managed care organizations.
(b) Standard: Composition of utilization review committee. A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in 482.12(c)(1).
Recommended Composition of UR Committee

• Medical Staff Leadership
  – CMO/VPMA/Department Chairs
  – Physician Advisor intimately involved and knowledgeable regarding day to day UR issues specific to your hospital

• Administrative Leadership
  – CFO a must to tie in resource and finance component with UR functions/issues

• Case Management: Director and key personnel
• HIM (coding knowledge)
• Business Office Leadership (registration expertise)
• Patient Financial Services (billing expertise)
• Others as need by invitation based on focused reviews
Who is on Your UR Committee?

Voting Members (physicians) considerations:
- Be aware of conflicts of interest
  - Hospitalists
  - Specialists
  - Political Affiliations/Aspirations
- Fear of Conflict
- Physician Advisor as Ad-Hoc or Voting Member

482.30 (3) The committee's or group's reviews **may not** be conducted by any individual who—
- Has a direct financial interest (for example, an ownership interest) in that hospital; or
- Was professionally involved in the care of the patient whose case is being reviewed.
42 CFR 482.30(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.”

Establishes baseline types of review by the UR committee

However, timing & frequency of such review is nebulous per the guidance given that:
   - “Review of admissions may be performed before, at, or after hospital admission.” 42 CFR 482.30(c)(2).
• 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.
• Best Practices for Admission & Continued Stay Review (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.”

• Establishes the foundation for a 2 level Admission Review process for ALL Medicare beneficiaries
• CMS contractors are not required to automatically deny a claim that does not meet the admission guidelines of a screening tool.

• CMS considers the use of screening criteria as only one tool that should be utilized by contractors to assist them in making an inpatient hospital claim determination.

• For each case, the review staff will utilize the following when making a medical necessity determination
  – Admission criteria;
  – Invasive procedure criteria;
  – CMS coverage guidelines;
  – Published CMS criteria; and
  – Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community).
Are Observation Rates Increasing?

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

• Criteria use Severity of Illness (SI) and Intensity of Service (IS) to establish medical necessity.

• Admission Criteria are screening tools with a failure rate (15-20%).
  – May now be up to 23-25%, IQ 2011 may be higher

• Secondary Physician Review is REQUIRED.
Recommended Admission Review Process

Recognize that this is about daily tactics:

1. Case Management applies current, strict admission criteria to 100% of medical cases placed in a hospital bed and documents this review in an auditable format.

2. 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).

3. 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.

4. Attending physician changes order as appropriate.

5. Must run 7 days a week/365 days a year.
UR Staff Screening Criteria Review
Keys to Success

- Use of Screening Criteria that are recognized by your Medicaid intermediaries
- Apply Screening Criteria to 100% of Medicaid cases
- Ensure UR Staff strictly apply Screening Criteria
- 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 this PA to “use their medical judgment”.
  – Need to provide library of evidence based outcomes research across major diagnostic areas for decision making to be consistent and defensible
  – If you do not have this, cases will be hard to defend.

• 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
UR Committee Data Considerations

- Data focus needs to be historical/experiential
  - LOS
  - Cost per day (per physician)
  - Outlier reviews
  - 1 day stays
  - Denial rates
  - Readmissions

- Set realistic targets
- Keep a running 6-8 quarters of data for internal tracking and benchmarks
- Establish UR dashboard to report to MEC, leadership, etc
- Use comparative data to benchmark your facility
  - Core Measures, data from Medicare quality initiatives, PEPPER reports for 1 day stays, etc.
Finally….

• It is no longer a matter “IF” you are going to get audited, but instead “WHEN”

• We can win; but you have to pay attention on the front end and continually improve our processes.
Useful Compliance Publications

Access the EHR Compliance Library, log onto [www.ehrdocs.com](http://www.ehrdocs.com) select Resource Center, Compliance Library

- EHR Client Bulletins and archived audio conferences
- Latest CMS Recovery Audit Contractor (RAC) Demonstration Evaluation Reports
- Recent Report on Medicare Compliance articles
- RAC Program Legislation
- Revised Statements of Work for RAC Program
Questions?

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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.

EHR has been recognized as one of the “Best Places to Work” in the Philadelphia region by Philadelphia Business Journal three years in a row.