Medicare Compliance Updates and Best Practices for Providers

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Agenda

- **Medicare Compliance**
  - **DOJ**
  - **OIG**
  - **Contractors**
- **2016 OPPS**
- **Best Practices**
- **Physician buy-in**
- **Summary**

Governmental Audit and Fraud Fighting Entities

Who	What
OIG	Office of the Inspector General
DOJ	Department of Justice
MCR RA	Medicare Recovery Auditors
SMRC	Supplemental Medical Review Contractor
MAC	Medicare Administrative Contractors
HEAT	Health Care Fraud Prevention and Enforcement Action Team
CERT	Comprehensive Error Rate Testing
MIP	Medicaid Integrity Plan
MIG	Medicaid Integrity Group
MICs	Medicaid Integrity Contractors
MIG	Medicaid Inspector General
MCD RAC	Medicaid Recovery Audit Contractors
PERM	Payment Error Rate Measurement
QIC	Qualified Independent Contractor (MAXIMUS)
QIO	Quality Improvement Organization (KePRO, Livanta)
UPICs	Unified Program Integrity Contractors
ZPICs	Zone Program Integrity Contractors

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Today's Audit Environment

- If you are treating patients and submitting claims, you will likely be audited.
- It is about how the contractors interpret the regulations.
- Appeal cases that are inappropriately denied, or the contractors' interpretations become the new standard:
  - 2-MN as sole determining factor
  - Reasonableness of 2-MN expectation
  - < 2-MN inpatients
- The solution is **NOT** to make all reviewed cases OP/OBS!

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Transmittal 585 (Effective May 4, 2015)

- CMS added language to Ch. 3 of the *Medicare Program Integrity Manual* whereby MACs, RAs, CERT, SMRC, and ZPICs may **up code** or **down code** a claim *in certain situations*.
- Excludes items or services NOT "reasonable and necessary" or "medically necessary."
- When the medical record supports a different procedure or diagnosis code, the contractor will not deny the entire claim but will change the code and adjust the payment.

Source: http://www.hcpro.com/CCP-315296-5091/Note-from-the-Instructor-Medicare-Contractors-Allowed-to-Up-Code-or-Down-Code.html

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Department of Justice (DOJ) Update

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DOJ Activities

- Referrals from other government contractors
- *Qui tam* cases
- **Health Care Fraud Prevention and Enforcement Action Team (HEAT)**

HEAT

- Since March 2007, operations in nine locations have charged almost 2300 defendants (convicted 1800) who collectively have falsely billed the Medicare program for almost $7B.
- Between 2008 and 2011, HEAT increased by 75% individuals charged with criminal health care fraud.
- Since 2011, CMS has suspended enrollments of high-risk providers and removed over 17,000 providers from the Medicare program involving $530M in fraudulent billing.
- In 2011, HEAT coordinated the largest-ever federal health care fraud takedown involving $530 million in fraudulent billing.
- Most recently charged 89 individuals in 8 cities (27 docs, nurses and other medical professionals) for Medicare fraud involving ~$223M in false billings.

Source: http://www.stopmedicarefraud.gov/aboutfraud/heattaskforce/index.htm

HEAT

- **Miami, FL:** 25 charged for their alleged participation in various fraud schemes involving approximately $44M in false billings for HH care and mental health services, and pharmacy fraud.
- **New Orleans:** 11 charged (2 two doctors) for a $51M HH fraud scheme.
- **Houston, TX:** 2 charged, a nurse and a social worker, with fraud schemes involving at total of $8.1 million in false billings for home health care.
- **Los Angeles, CA:** 13 charged for schemes to defraud Medicare of ~ $23M.
- **Detroit, MI:** 18 charged for fraud schemes involving $49M in false claims for medically unnecessary services (HH services, psycho- and infusion therapy).
- **Tampa, FL:** 7 charged for a variety of schemes of fraudulent billings to millions of dollars in services and tests that never occurred.
- **Chicago, IL:** 7 charged, including two doctors, with a variety of fraud schemes.
- **Brooklyn, NY:**
  - 4 (2 doctors) charged in fraud schemes involving $9.1M in false claims.
  - 9 allegedly involved in $15M scheme where massages by unlicensed therapists were billed to Medicare as physical therapy.

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Source: http://www.hhs.gov/news/press/2013pres/05/20130514a.html

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Office of Inspector General (OIG) Update

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Current OIG Audit Activity

- Coding/complications
- Short-stay procedures
- Canceled surgery
- Readmissions
- High-cost cases
- Technical issues

2015 OIG Work Plan Targets

Medicare

- Inpatient claims for mechanical ventilation
- Selected inpatient and outpatient billing requirements
- Medicare benefit integrity contractors' activities
- ZPICs and PSCs – Identification and collection status of Medicare overpayments

Medicaid

- Recovering Medicaid overpayments – Credit balances in Medicaid patient accounts
- Duplicate payments for beneficiaries with multiple Medicaid identification numbers

2016 OIG Work Plan Targets

Expected Issue Date – FY2016

Medicare

- New inpatient admission criteria

Medicaid

- States and territories without Medicaid fraud control units
- Medicaid managed care beneficiary grievances and appeals process

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CY 2016 OPPS Proposed Rule: Short Inpatient Hospital Stay and Medical Review Modifications and Policy Changes

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XV. Short Inpatient Hospital Stays (80 FR 39348-39353)

- 2016 OPPS proposed rule released on July 1, 2015 and officially published in the July 8, 2015 Federal Register.
- Section XV is divided into two subsections:
  A. Background for the 2-Midnight Rule
  B. Proposed Policy Clarification for Medical Review of Inpatient Hospital Admissions under Medicare Part A

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2016 OPPS Proposed Rule – Short IP Hospital Stays

Current Guidance:	Proposed Guidance:
"When a beneficiary enters a hospital for a surgical procedure not specified as inpatient only under § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for only a limited period of time that does not cross 2 midnights, the services would be generally inappropriate for payment under Medicare Part A" (80 FR 39349).	"Under the proposed policy change, for stays for which the physician expects the patient to need less than 2 midnights of hospital care and the procedure is not on the inpatient only list or on the national exception list, an inpatient admission would be ***payable on a case-by-case basis*** under Medicare Part A in those circumstances under which the ***physician determines that an inpatient stay is warranted*** and the ***documentation in the medical record supports that an inpatient admission is necessary***" (80 FR 39351).

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Short Inpatient Hospital Stays

Proposed Change:

"Modify our existing 'rare and unusual' exceptions policy to allow for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician's determination that *the patient requires inpatient hospital care* despite an expected length of stay that is less than 2 midnights." (80 FR 39350).

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Inpatient Admission Expectation < 2 Midnights

For payment purposes, the following factors, among others, would be relevant to determining whether an inpatient admission where the patient stay is expected to be less than 2 midnights is nonetheless appropriate for Part A payment:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient; and,
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).

Source: 80 FR 39350-39351

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Key Points

- Renewed emphasis on provider judgment and medical necessity
  - "Inpatient Hospital Care" rather than "Hospital Level of Care"
  - RAs may resume performing patient status reviews for claims with admission dates of Oct. 1, 2015 or later.
- Renewed enforcement by Quality Improvement Organization (QIO)
  - Extensive referral possibilities
    - MACs for "payment adjustments"
    - Recovery Auditors for additional payment audits
    - DOJ/OIG/ZPIC
  - QIO auditing ("Probe and Educate") begins on October 1, 2015.

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Case-by-Case Review Determinations: Who will be making them?

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Quality Improvement Organizations (QIOs)

What are QIOs?

A QIO is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs work under the direction of the Centers for Medicare & Medicaid Services to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.

Source: CMS.gov

QIO Review of Short Inpatient Hospital Stays

"Regardless of whether we finalize the policy proposals outlined above, we are announcing that, no later than October 1, 2015, we are changing the medical review strategy and plan to have Quality Improvement Organization (QIO) contractors conduct these reviews of short inpatient stays rather than the MACs." (80 FR 39352).

QIO Review of Short Inpatient Hospital Stays

- QIOs will review a sample of *post-payment* claims and make a determination of the medical appropriateness of the admission as an inpatient. (80 FR 39353).
- QIOs will refer claim denials to the MACs for payment adjustments.
- The process for providers to appeal denied claims by the QIO will remain unchanged.

Source: 80 FR 39353

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QIO Review of Short Inpatient Hospital Stays

- The MACs will no longer be responsible for conducting these types of reviews (as they had been under Probe & Educate).
- QIOs will educate hospitals about claims denied under the 2-midnight policy and collaborate with hospitals to develop a quality improvement framework to improve organizational processes and/or systems.

Source: 80 FR 39353

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QIO Referral to Recovery Auditors

Under the QIO short-stay inpatient review process, hospitals that are found to exhibit the following pattern of practices will be referred to the Recovery Auditor:

- **High denial rates** (*not defined)*
- **Consistently failing to adhere to the 2-MN Rule**
  - Includes frequent inpatient hospital admissions for stays that do not span one midnight (i.e. 0-day stays).
  - *Other than 0-day stays, the proposed rule did not define "consistently failing to adhere to the 2-MN rule."*
- **Failing to improve their performance after QIO educational intervention**
  - *Did not define the measure of improvement necessary to avoid Recovery Auditor referral.*

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Recovery Auditor Patient Status Reviews – 10/1/15

"Under current law, recovery auditors may resume [performing patient status reviews] for dates of admission of October 1, 2015 and later. After that date, the recovery auditors will conduct patient status reviews focused on those providers that are referred from the QIOs and have high denial rates. **The number of claims that a recovery auditor will be allowed to review for patient status will be based on the claim volume of the hospital and the denial rate identified by the QIO."** (80 FR 39352)

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Recommended Next Steps and Review Process

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Recommended Utilization Review Plan & Components

PLAN

- 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

REVIEW

- The committee ***must review professional services provided*** *in order* to determine medical necessity and to promote the most efficient use of available health facilities and services

INTERPRET

- The UR Plan is the documented process by which the organization will adhere to the standards identified in the Conditions of Participation as well as the defined operational standard for the Utilization Review Committee

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How Did You Respond to 1599?

- **Common approaches:**
  - No change – original (2012) UM process
  - "All I need is a stopwatch." – time is all that matters
  - Incorporated time requirement into medical necessity decision making.

- **Then there were variations of who did the reviews:**
  - First level review nurses, second level physicians
  - First level review by nurses, no second level review
  - Non-clinical personnel doing first level, nurses doing second level
  - No utilization reviews, follow physician order

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Now…..Back to the Future…..

Questions hospitals should consider:

- Will the documentation be sufficient to support the admitting physician's determination that the patient requires inpatient hospital care despite an ELOS < 2 MN?
- If you don't document medical necessity to demonstrate a "complex medical decision" to support IP, what will you document?
- What medical necessity cases will RAs target in October?
  - ≥2-midnight IP cases
  - Target of Custodial, Delay and Convenience?
  - 1-midnight IP cases
- Will OIG and DOJ increase activity?
- QIO audits: pre- or post-bill review of 1-midnight IP cases?
  - Will they provide real and accurate education/feedback?
  - Will auditors focus on surgical and cardiac procedures?

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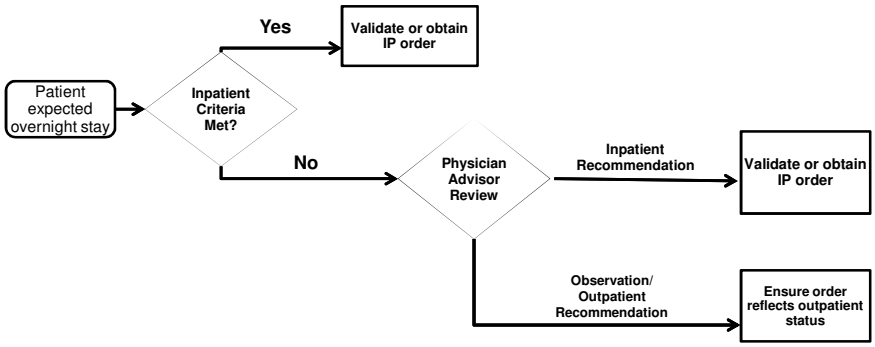
Recommended UM Workflow*



* For all admissions except between dates of Oct 1, 2013 and Jan 1, 2016

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How to E.N.G.A.G.E. Physician Cooperation

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E.N.G.A.G.E.

- **E**xecutive Support
- **N**egate physician concepts
- **G**ain Cooperation
- **A**dvisors
- **G**et better documentation
- **E**ducate

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Executive Support

“We don’t want to upset the docs.”

“That doctor does a lot of volume here.”

“They will take their patients to another hospital.”

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Executive Support

Bending over backwards to make life "easier" for the physician enables poor behavior.

30 days to complete Discharge Summaries yet still many (and other documentation) are overdue.

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Negate physician concepts

"This is so hospitals can get paid more"

- Medicare allows for better coding for:
  - Reimbursement
  - Accuracy and specificity

Physician Benefits of better documentation

- Quality Measures
  - SOI – Severity of Illness – graded 1-4
  - ROM – Risk of Mortality – graded 1-4

Compares Physicians to their Peers

- "Urosepsis" – Patient dies day 1 or 2
- Non-codable – SOI/ROM = 1/1
  - Consequences

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Gain Cooperation

- **Cooperation through Motivation**
- **WIIFM:** What's In It For Me?
- **Helping them understand**
  - Quality Measures
  - Value Based Modifier (VBM)
  - Bundled Payments
  - HCC
  - Physician Compare, HealthGrades.com, more
  - Potential Employment Metrics/Payer Preferences
  - Medicare Spending per Beneficiary
  - Present on admission (POA)
- **Transmittal 541**
- **Industry Approaches**

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Advisors

- Help to make sure that documentation can be supported as RAC, MAC, Commercial Payer DRG Denials are increasing with the reason being "not clinically supported." *(The fact that the doctor writes a diagnosis does not mean that it is supported in the chart.)*
- Elevates documentation practices that avoid vague, incomplete and conflicting information from CDIS to physicians to coders.
- Help queries to be more effectively and expeditiously answered as peer-to-peer engagements bridge the gap in documentation interpretation
- Serves as a clinical advisor to CDS and coders.
- Aid in ongoing physician education.

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Advisors

If trained extensively in CDI principles:

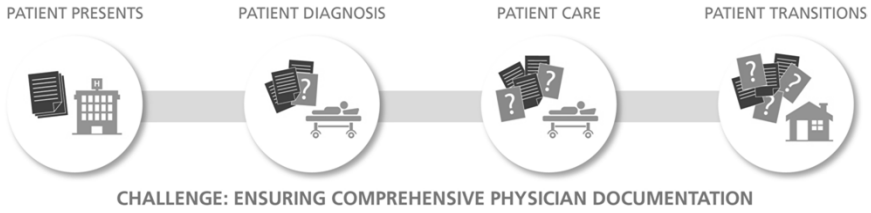
- Physicians respond to physicians in a different way — discuss the case as peers in a non-leading way.
- Physician-to-Physician conversations — serve to re-inforce solid documentation principles because physicians learn well through reinforcement.
- Supports the CDI program.

Advisors

The 4 main attributes a physician advisor must have are:

1. Broad clinical knowledge base across all specialties.
2. Respect from the medical staff.
3. Ability to effectively communicate with physicians and non-physicians.
4. Availability

Get Better Documentation



CHALLENGE: ENSURING COMPREHENSIVE PHYSICIAN DOCUMENTATION

- Gaps created with hand-offs
- Details not captured or transferred
- ED tests not logged by treating physician
- Other clinicians' perspective siloed

- Physicians don't "think in ink"
- Diagnosis and plan of care not detailed
- Key info omitted in physician summary
- Clarification sought through queries

- CDI struggles with gaps in patient story
- Plan of care and variables vague
- Key info omitted in physician summary
- Unresolved queries

- Coding doesn't have needed detail
- Inaccurate DRG = missed reimbursement
- Weakened defensibility
- CMI and quality impacts

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Educate

- **Educate physicians about the right way not the way they've always done it.**
  - AHA SURVEY: Real-time, patient-specific conversations are the most effective education strategy to make physicians aware of how to improve documentation (84.3% of survey participants agreed). Some of the most common approaches hospitals use to educate physicians were deemed ineffective.
- **Acknowledge the limited time that physician resources can allocate to CDI.**
  - AHA SURVEY: Conflicting priorities and limited bandwidth leave hospitals seeking outside physician expertise to augment CDI program effectiveness. 83% of physician advisors/champions spend 0–10 hours a week supporting CDI.
- **Make sure physicians know there's room for improvement across the board.**
  - AHA SURVEY: Despite the expertise of your medical staff or where you're at on the CDI program stage continuum, improvement opportunities are a universal theme with 98.5% of programs having physicians who could improve documentation practices.

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Summary

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2016 OPPS

- This is a **proposed** rule at this point in time.
- OPPS proposal becomes final Oct-Nov; goes into effect Jan. 1, 2016
- Consider your concurrent process, and if any changes need to be made.
- Audits may increase on Oct. 1, 2015

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.

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The Bottom Line

- 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, physicians, and patients!

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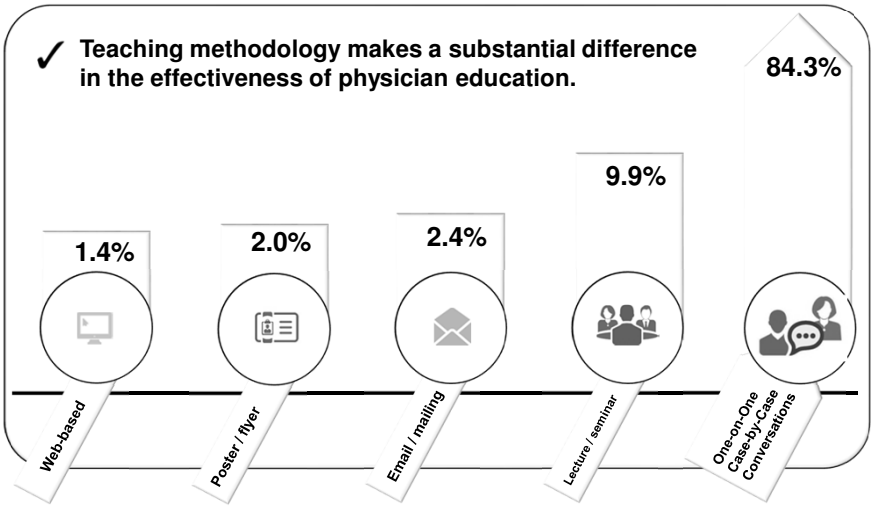
Physician Education is the Answer (55.1% Agree)

✓ **Teaching methodology makes a substantial difference in the effectiveness of physician education.**



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THANK YOU.

Questions?

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