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Utilizing PEPPER and Data Analysis to Enhance Your Compliance Efforts

Stephen Leb, MD, F.A.C.S.
Senior Medical Director
Executive Health Resources

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Agenda

- Summary of IPPS
  - 1455 and 1599
- Understanding the PEPPERs
  - Short Term Acute Care Facility
  - Critical Access Hospital
  - Inpatient Rehab Facility
  - Skilled Nursing Facility
  - PHP
  - IPF
- After the PEPPER: Data Analysis- UR Committee

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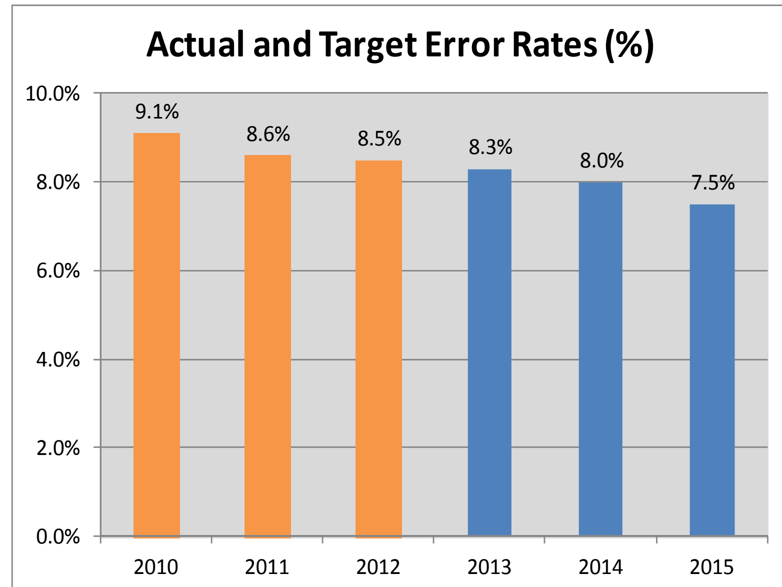
Improper Payment Report

* Estimated $31.2 billion in improper payments in 2013

"The primary causes of improper payments, as identified in the Medicare FFS Improper Payments reports, are insufficient documentation errors, medically unnecessary services, and to a lesser extent, incorrect coding."



*From the FY 2012 HHS Agency Financial Report (AFR)

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Physicians are Not Exempt

WHO	WHAT
CERT	Comprehensive Error Rate Testing
DOJ	Department of Justice
HEAT	Health Care Fraud Prevention and Enforcement Action Team
MAC	Medicare Administrative Contractors
MCD RAC	Medicaid Recovery Audit Contractors
MCR RA	Medicare Recovery Auditors
MIC	Medicaid Integrity Contractors
MIG	CMS Medicaid Integrity Group
MIGs	Medicaid Inspectors General
MIP	Medicaid Integrity Plan
OIG	Office of the Inspector General
PERM	Payment Error Rate Measurement
PSC	Program Safeguard Contractors
ZPIC	Zone Program Integrity Contractors

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Only A Doctor Can Legally Admit Patients To A Hospital

- **42 CFR 482.12(c)(2)**
  - "Patients are admitted to the hospital *only on a recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.*"
- **Medicare State Operations Manual**
  - "In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate."

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2014 IPPS Key Requirements

- **Time**: CMS introduces 2 midnights for clarification for inpatient
- **Physician order**: must have an order for inpatient status with "admit" and "inpatient"
- **Physician documentation/certification**: the physician should document the necessity of inpatient admission with hospital care crossing at least 2 midnights. This rationale must be reasonable and consistent with evidence based standard of care.

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Benchmark vs. Presumption

- **"Benchmark of 2 midnights"**
  - "the decision to admit the beneficiary should be based on the **cumulative time spent at the hospital beginning with the initial outpatient service.** In other words, if the physician makes the decision to admit after the beneficiary arrived at the hospital and began receiving services, **he or she should consider the time already spent receiving those services in estimating the beneficiary's total expected length of stay**."

Page 50946, IPPS

- **"Presumption of 2 midnights"**
  - "Under the 2-midnight presumption, **inpatient hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment** and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care…"

Page 50949, IPPS

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Physician Order

- For payment of hospital inpatient services under Medicare Part A, the order must specify the admitting practitioner's recommendation to admit "to inpatient," "as an inpatient," "for inpatient services," or similar language specifying his or her recommendation for inpatient care

Page 50942, IPPS

- "Admit to Tower 7" or "Admit to Dr. Smith" are no longer acceptable

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Certification Includes:

- **Order for inpatient admission** (supported by admission and progress notes)
- **Reason for hospitalization:** Primary diagnosis, secondary diagnosis, procedure
- **Estimated Time:** expectation of time patient will need to remain in the hospital
- **Plan for post hospital care**
- **Signature and documentation in medical record prior to discharge**

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PEPPER Overview

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PEPPER 2014 Overview

- The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is intended to support the hospital's own auditing and monitoring activities
- Created in 2003, the current edition of PEPPER includes an expanded list of areas at risk for improper Medicare payment
- These targets reflect the latest denial data from RAC, CERT, and MAC/FI audits
- Changes in both quantity and format of PEPPER data need to be fully understood in order to maximize their value

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Who Should Use PEPPER?

- Utilization Review Committee
- Case management
- Medical coding and billing
- Compliance officers/committees
- Finance and Leadership

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Hospitals are Obligated to Interpret Outliers

- Standard of proof for FCA is reckless disregard or deliberate ignorance
- If a hospital reviews its PEPPER and finds that their billing is out of line, they are expected to:
  - Audit medical records
  - Discern if it's a compliance problem or another explanation

Source: Report on Medicare Compliance, "Some Compliance Programs May Fail to Reduce the Risks of False Claims." September 19, 2011.

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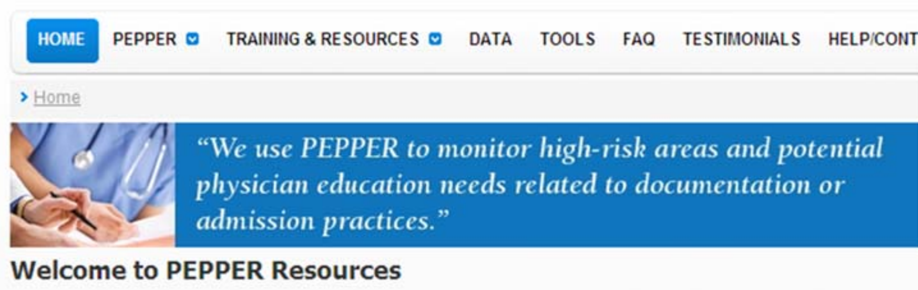
PEPPER Data and Info

Obtain PEPPER data files from qualitynet.org:

Training and other info: pepperresources.org



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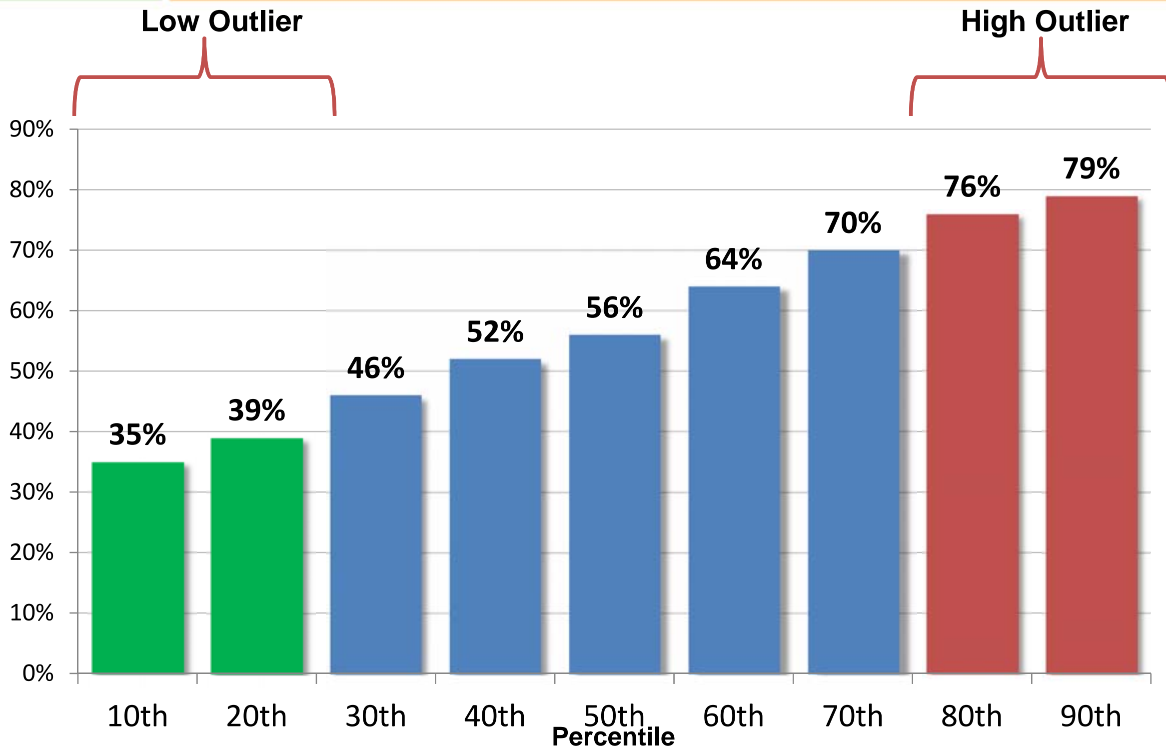
Understanding Outliers



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PEPPER Release Dates

Provider Type	Distribution Date	Distribution Method
Skilled nursing facilities	Annually, on or about August 26	Free-standing SNFs: Direct mail to facility CEO.SNF Distinct Part Units of short-term acute care hospitals: Electronically via QualityNet secure file exchange
Inpatient psychiatric facilities	Annually, between March 20 and April 12	Free-standing IPFs: Direct mail to facility CEO. IPF Distinct Part Units of short-term acute care hospitals: Electronically via QualityNet secure file exchange
Inpatient rehabilitation facilities	Annually, between March 20 and April 12	Free-standing IRFs: Direct mail to facility CEO. IRF Distinct Part Units of short-term acute care hospitals: Electronically via QualityNet secure file exchange
Hospices	Annually, between March 25 and April 12	Direct mail via FedEx to CEO
Partial Hospitalization Programs	Annually, between March 25 and April 12	PHPs administered through Community Mental Health Centers, and free-standing IPFs, IRFs, long-term acute care hospitals and children's hospitals: Direct mail to CEO. PHPs administered through st-acute care hospitals and IPF distinct part units of st-acute care hospitals: electronically via QualityNet secure file exchange

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PEPPER Release Dates (con' t)

Provider Type	Distribution Date	Distribution Method
Short-term acute care hospitals	Quarterly, on or about February 25, May 24, August 26 and November 26	QualityNet secure file exchange
Long-term acute care hospitals	Annually, between March 25 and April 12	Direct mail via FedEx to facility CEO
Critical access hospitals	Annually, on or about March 25	QualityNet secure file exchange

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Short Term Acute Care Hospital PEPPER

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PEPPER Overview

- *PEPPER originated in 2003*
- Compares your Hospital to national (first priority), MAC/FI jurisdictional, and state statistics
- PEPPER statistic = # of targeted cases / # of related cases (must have 11 targeted cases per quarter to appear in PEPPER)
- Rolling 3 years of experience updated quarterly (CMS FY starts Oct 1)
- Payment error targets in the PEPPER: (1) MS-DRG Validation and (2) Medical Necessity
- Significantly expanded starting Q4-2010

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What the PEPPER is Not

- Does not monitor outpatient services, such as observation care or outpatient procedures
  - Except for 1 target that includes both inpatient and outpatient cardiac stents
- Does not include Medicare Advantage (HMO) claims or other payers
- Does not compare hospitals by size, demographics, or type of services

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PEPPER 2013 Updates

- **Your Hospital's National High Outlier Ranking is**

  2792 out of a total of 3465 (19th %ile)
- Quarterly data allows analysis of trends
- Data is available within 4-6 months of claim filing
- $29.6 billion in improper payments in 2012
- HHS expanding use of Recovery Audit Contractors to allow review of high risk claims before they are paid.

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PEPPER 2013 Updates (con' t)

Greater Use of Clinical Validation Puts DRGs at Risk

"Clinical validation is the process of determining whether evidence in the medical record — such as signs and symptoms, diagnostic test results and treatments — supports the diagnosis code. Coders used to rely on the fact the doctor documented a diagnosis, but auditors are digging deeper. There has to be documentation that the diagnosis is supported clinically and meets the definition of an additional diagnosis for the purpose of coding complications and comorbidities and major CCs. A diagnosis of "acute respiratory failure" won't cut it in the absence of clinical evidence, such as a symptomatic patient who required oxygen and had abnormal arterial blood gases. The same goes for bacterial pneumonia if the chart has no record of a chest X-ray, positive sputum culture and order for antibiotics. It's an opportunity for the RAC to delete the diagnosis code and impact final DRG assignment. The HHS Office of Inspector General also uses clinical validation to identify errors in Medicare compliance reviews."

**From AISHealth's Report on Medicare Compliance - Volume 22, Number 19 • May 27, 2013*

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Changes Starting Q1 2014

Summary of Revised PEPPER Categories

New PEPPER Categories

2-day stays for medical DRGs
2-day stays for surgical DRGs
1-day stays for medical DRGs
1-day stays for surgical DRGs
Same-day stays for medical DRGs
Same-day stays for surgical DRGs

Removed Categories

All 0-2 day stay clinical categories (Vasc, Ht Failure, Card Arrythmia, Esoph/Gastro, Nut/Met, Renal Failure)
1-day chest pain
1-day stays (total)

Differences between new 1-day medical and old 1-day medical – new category is exactly 1-day stays; old one was 0-1 day stays.

A few minor denominator differences for discharges after 1/1/13.

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MS-DRG Validation and Coding

Concept:
Are the targeted MS-DRG cases a higher or lower percent of related cases when compared with other hospitals?

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DRG Validation Ratios

MS-DRG coding is tested in the PEPPER by looking at ratios of higher severity MSDRGs to the universe of related MSDRGs

(Example: Simple Pneumonia)

Count of Discharges for MSDRGs 193, 194
(simple pneumonia with CC or MCC)

Higher Severity DRGs

Count of Discharges for MSDRGs 190, 191, 192
(COPD with or without CC/MCC) plus
Count of Discharges for MSDRGs 193, 194, 195
(simple pneumonia with or without CC/MCC)

All Related DRGs

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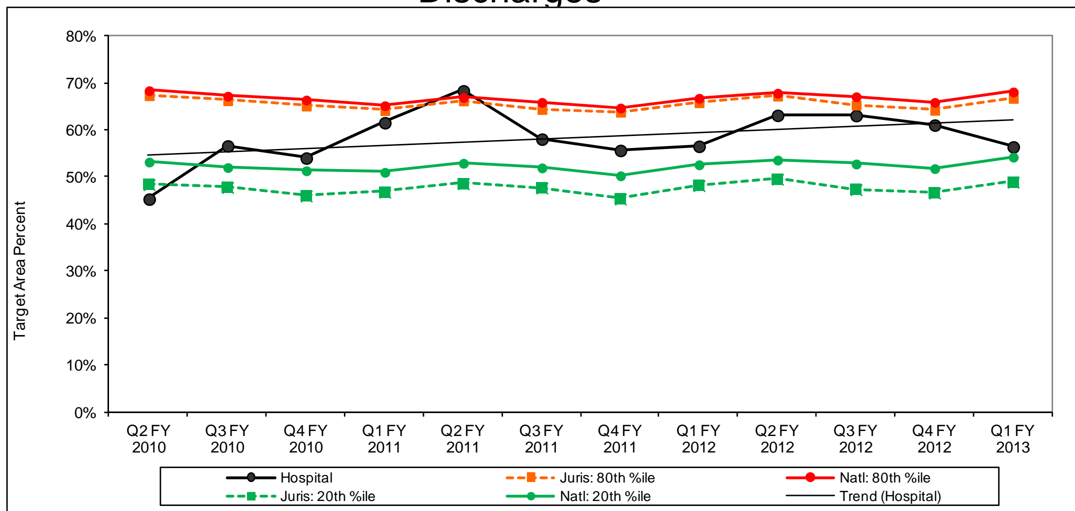
Medical CC/MCC

Medical Discharges with CC or MCC / Total Medical Discharges



2 high/low outlier quarters

Q1-2013 is in the <u>26th</u> national percentile

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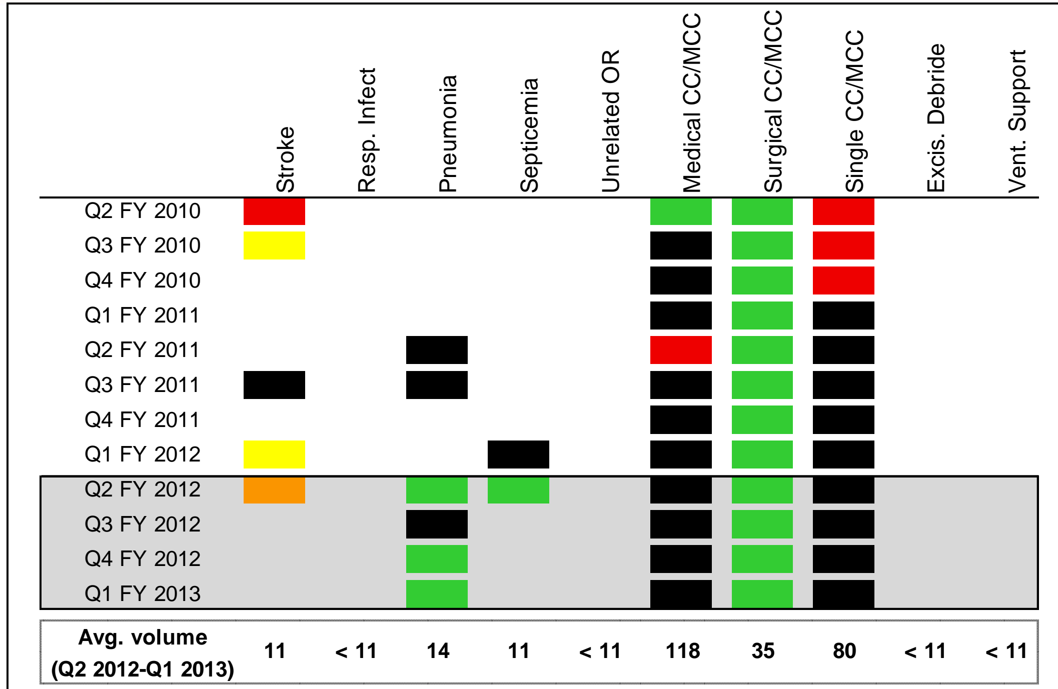
DRG Validation and Coding By Quarter



> National 80%tile
> Juris. 80%tile
> State 80%tile
< Min. 20%tile
In normal range
No data

[2]Note: low threshold includes state outlier statistics

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Medical Necessity

Concepts:
Are the targeted MS-DRG cases a higher or lower percent of related cases when compared with other hospitals?

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Medical Necessity Ratios 2-Day Stays Medical

Medical Necessity is tested in the PEPPER by looking at ratios of cases with a higher probability of medical necessity concerns to the universe of related cases

(Example: 2 Day Medical DRGs)

Count of Discharges with LOS 2 and med DRGs (“through” date – “admission” date = 2)
excluding transfers, deaths, left AMA

Higher Concern Cases

Count of all Discharges for Medical DRGs

All Related Cases

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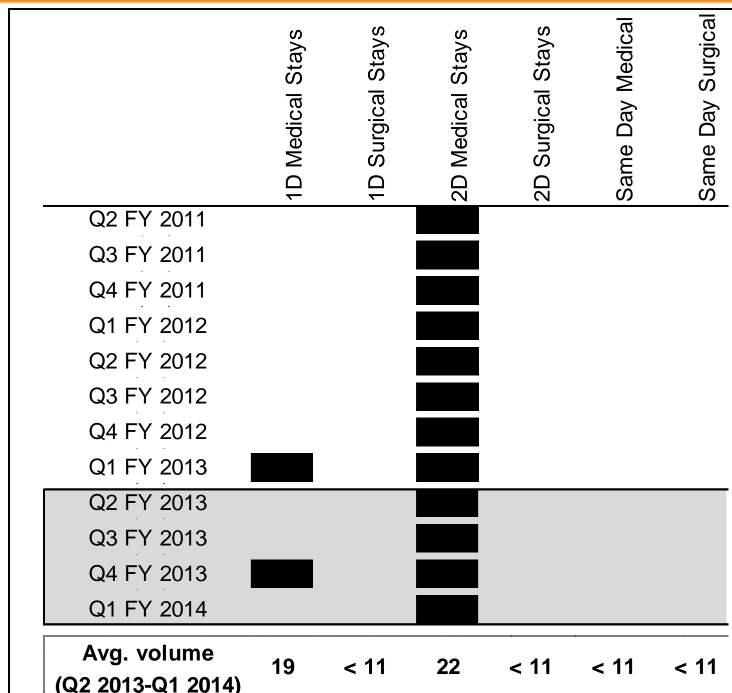
Medical Necessity Short Stay Categories By Quarter



	1D Medical Stays	1D Surgical Stays	2D Medical Stays	2D Surgical Stays	Same Day Medical	Same Day Surgical
Q2 FY 2011			■			
Q3 FY 2011			■			
Q4 FY 2011			■			
Q1 FY 2012			■			
Q2 FY 2012			■			
Q3 FY 2012			■			
Q4 FY 2012			■			
Q1 FY 2013	■		■			
Q2 FY 2013			■			
Q3 FY 2013			■			
Q4 FY 2013	■		■			
Q1 FY 2014			■			
Avg. volume (Q2 2013-Q1 2014)	19	< 11	22	< 11	< 11	< 11

> National 80%tile
> Juris. 80%tile
> State 80%tile
< 40% of National 80%tile
In normal range
No data

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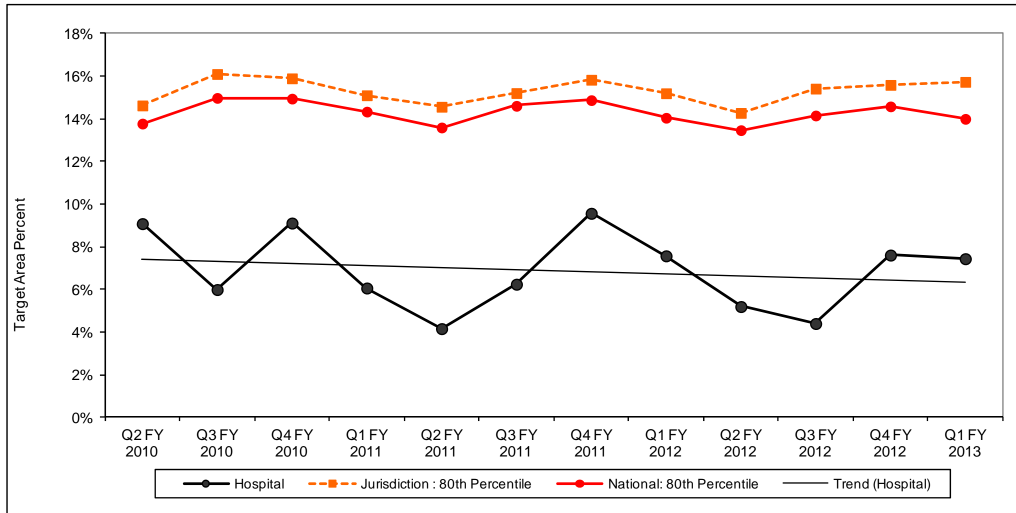
1-Day Stays: All

Discharges with LOS <= 1, exc. discharge status of 02, 07, or 20, exc. prior observation > 24 hrs / Discharges exc. discharge status 02



No Outlier Quarters

Q1-2013 is in the 22nd national percentile

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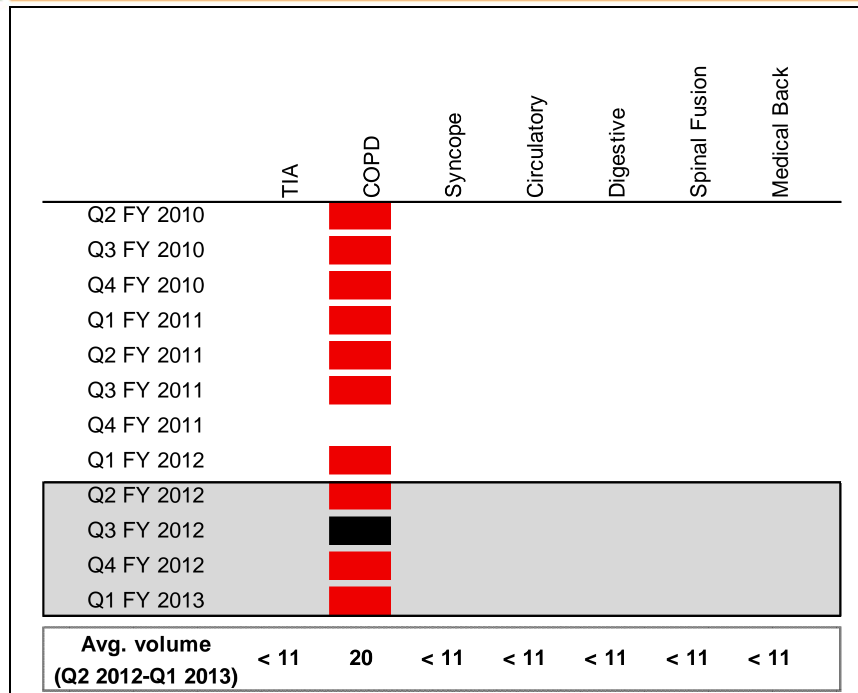
Medical Necessity Admission Rate Categories By Quarter



> National 80%tile
> Juris. 80%tile
> State 80%tile
< 40% of National 80%tile
In normal range
No data

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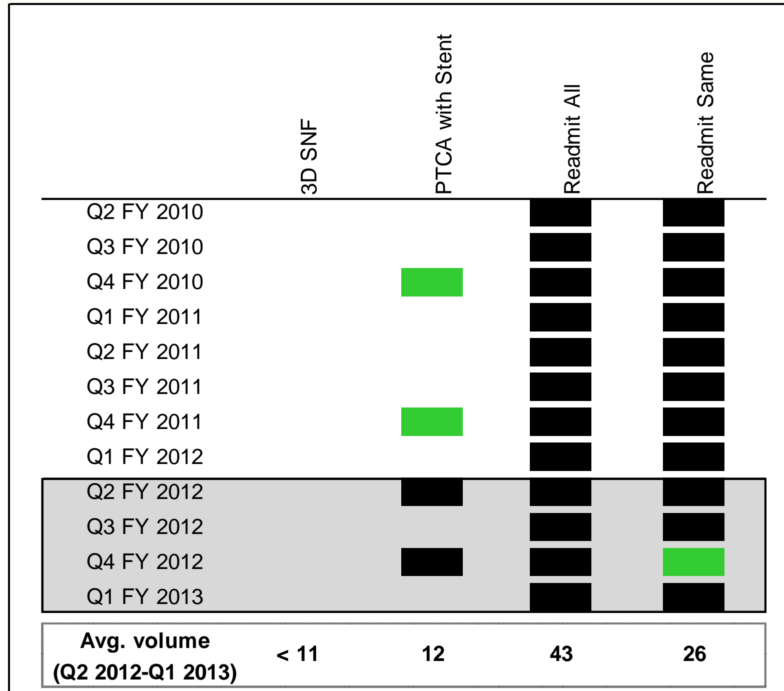
Medical Necessity Miscellaneous Categories By Quarter



	3D SNF	PTCA with Stent	Readmit All	Readmit Same
Q2 FY 2010			black	black
Q3 FY 2010			black	black
Q4 FY 2010		green	black	black
Q1 FY 2011			black	black
Q2 FY 2011			black	black
Q3 FY 2011			black	black
Q4 FY 2011		green	black	black
Q1 FY 2012			black	black
Q2 FY 2012		black	black	black
Q3 FY 2012			black	black
Q4 FY 2012		black	black	green
Q1 FY 2013			black	black
Avg. volume (Q2 2012-Q1 2013)	**< 11**	**12**	**43**	**26**

- Red: > National 80%tile
- Orange: > Juris. 80%tile
- Yellow: > State 80%tile
- Green: < 40% of National 80%tile
- Black: In normal range
- White: No data

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After the PEPPER: Using Data to Enhance Your Compliance Program

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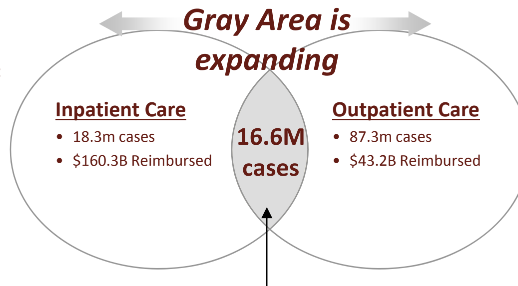
"Gray" or Uncertain Medical Necessity: Why it Matters?

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 – 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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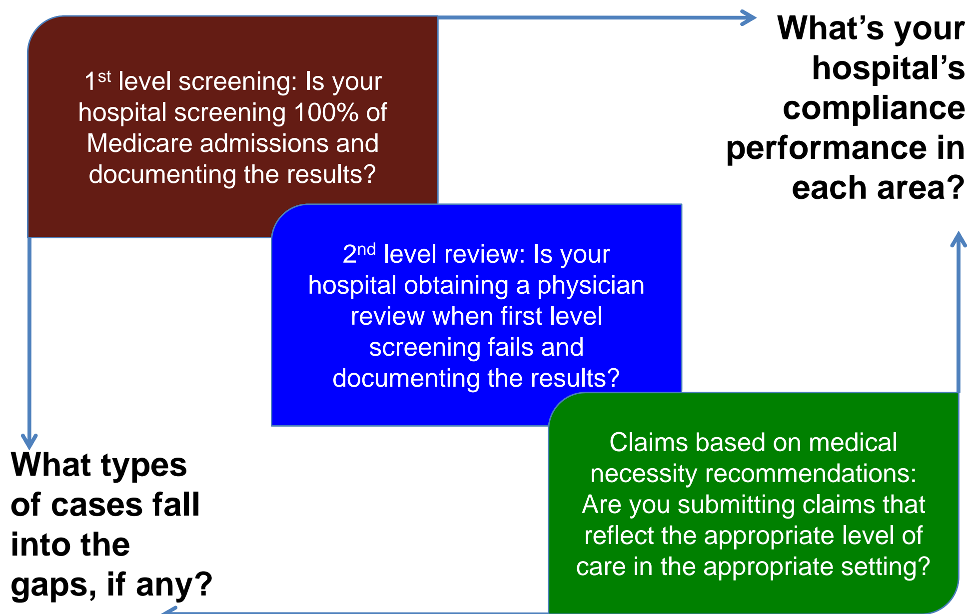
A Compliant Process



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0-1 Day Stay Rate for Medical Clinical Categories

Highlighted red if more than 140% of the benchmark average.
Highlighted green if less than 60% of the benchmark average.

Clinical Category	IP Med 0-1 Day	IP Med Total	IP Med 0-1 Day %	EHR 0-1 Day Benchmark	2nd Level Review %
CARDIOLOGY	200	1,349	14.8%	19.2%	28.0%
PULMONOLOGY	57	1,090	5.2%	7.2%	24.6%
GASTRO-INTESTINAL	75	747	10.0%	11.7%	36.0%
INFECTIOUS DISEASES	27	622	4.3%	6.3%	22.2%
NEUROLOGY	61	555	11.0%	14.2%	16.4%
GU/RENAL	24	548	4.4%	9.3%	20.8%
ENDOCRINE/METABOLIC	42	296	14.2%	14.4%	40.5%
HEMATOLOGY/ONCOLOGY	29	235	12.3%	11.7%	13.8%
MUSCULOSKELETAL	15	140	10.7%	11.2%	33.3%
MEDICAL (MISC)	31	131	23.7%	21.5%	35.5%
VASCULAR	11	103	10.7%	12.6%	18.2%
BACK	8	90	8.9%	12.3%	37.5%
TRAUMA	6	50	12.0%	15.5%	0.0%

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Observation Rate by Clinical Category

Highlighted red if more than 140% of the benchmark average.
Highlighted green if less than 60% of the benchmark average.

Clinical Category	Obs Med Cases	Total Med Cases	Obs Med %	EHR Obs Benchmark	2nd Level Review %
CARDIOLOGY	200	1,549	12.9%	18.4%	68.0%
PULMONOLOGY	21	1,111	1.9%	3.3%	42.9%
GASTRO-INTESTINAL	16	763	2.1%	8.9%	81.3%
INFECTIOUS DISEASES	6	628	1.0%	1.4%	66.7%
NEUROLOGY	29	584	5.0%	8.4%	62.1%
GU/RENAL	17	565	3.0%	4.9%	41.2%
ENDOCRINE/METABOLIC	32	328	9.8%	11.1%	81.3%
HEMATOLOGY/ONCOLOGY	9	244	3.7%	8.1%	55.6%
MEDICAL (MISC)	30	161	18.6%	17.7%	56.7%
MUSCULOSKELETAL	15	155	9.7%	16.0%	66.7%
BACK	24	114	21.1%	16.9%	66.7%
VASCULAR	0	103	0.0%	8.0%	0.0%
TRAUMA	10	60	16.7%	15.3%	60.0%

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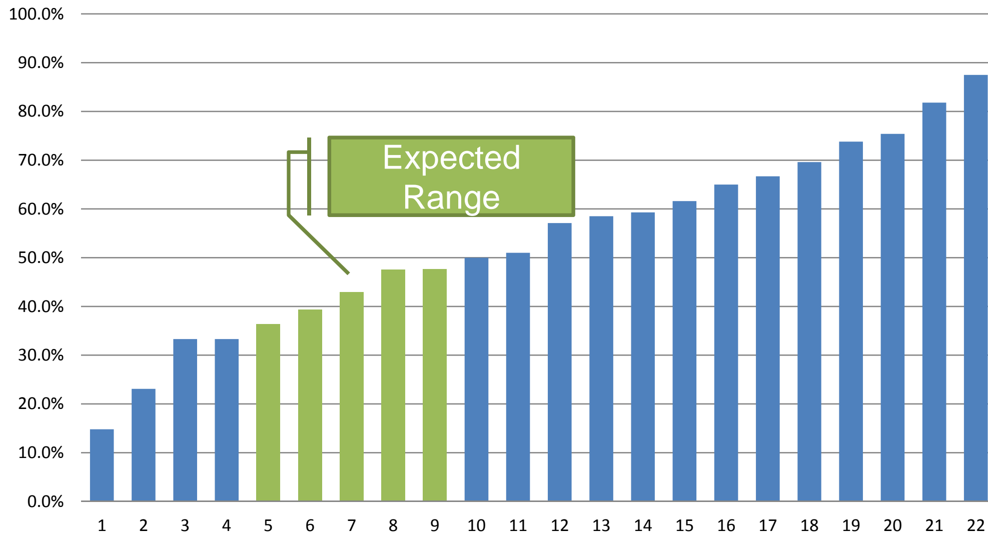
Cardiac Medical Cases Distribution of IQ Failure Rates

IQ Failure Rates by Person (minimum of 10 cases per person)



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Observation Rate by Payor

Q: We review ALL Medicare cases and our observation is increasing?

Observation Rates

Payor Category	IP Medical	OP Observation	Obs Rate
COMMERCIAL	12,005	6,410	34.81%
MEDICAID	3,331	2,087	38.52%
MEDICARE	**13,062**	**1,783**	**12.01%**
OTHER	3,156	1,652	34.36%

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Expected Cases for Review

- 84 High Risk Cases (OBS and Inpt) per Month
  - = (485 + 614) / 12

- high risk MED DRGs* (From CGI approved Medical Necessity list)
- 0,1-,2,3 day stay (Highest audit risk)

- med obs

*High Risk DRGs: 56 57 69 182 190 191 192 249 253 254 291 292 293 302 308 312 313 314 315 316 393 551 552 640 682 683 684 689 811

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Weekend Review

Admit Month	Weekday Cases	Weekend Cases	Total Cases	Weekday Referrals	Weekend Referrals	Total Referrals	Referral Rate All	Referral Rate Weekends
Oct-09	536	143	679	53	18	71	10.5%	12.6%
Nov-09	535	142	677	27	7	34	5.00%	4.90%
Dec-09	562	154	716	17	6	23	3.20%	3.90%
Jan-10	537	175	712	13	6	19	2.70%	3.40%
Feb-10	526	144	670	18	4	22	3.30%	2.80%
Mar-10	645	142	787	23	6	29	3.70%	4.20%
Apr-10	586	161	747	20	9	29	3.90%	5.60%
May-10	547	175	722	30	7	37	5.10%	**2.00%**
Jun-10	527	137	664	46	4	50	7.50%	**2.90%**
Jul-10	541	172	713	27	8	35	4.90%	**2.70%**
Aug-10	528	153	681	34	3	37	5.40%	**2.00%**
Sep-10	433	121	554	17	2	19	3.40%	**1.70%**
Total	**6503**	**1819**	**8322**	**325**	**80**	**405**	**4.9%**	**4.4%**

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Surgery Procedures

St Elsewhere Surgery Procedures - Medicare

Procedures	Inpt	Outpt	Totals
?????	98%	2%	613
?????	92%	8%	1,318

St Nowhere Cardiac Procedures – Medicare

Procedures	Inpt	Outpt	Totals
?????	59%	41%	454
?????	68%	32%	1,169

Limited to:

-Traditional Medicare
-Elective or Scheduled
-Overnight Stays

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Medicare Billing Status Alignment

Recommended Patient Level of Care

Billed	PA=IP	PA=OBS	PA=OP
IP	304	2	2
OBS	4	64	4
OP	0	1	0

IP Billing Alignment Demonstrated in the Data: 98.7%

OBS/OP → IP Discrepancy:	**4**	1.3% of IP bills inconsistent with Physician advisor recommendations
IP/OBS → OBS/OP Discrepancy:	**5**	6.8% of OBS/OP bills inconsistent with physician advisor recommendations
Overall Status Alignment:	**368**	96.6% best practice across all patient status types

Service Dates July 2011 – January 2012

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"Compliance Dashboard"

- Overall observation rate
- Commercial medical observation rate
  - Key Payors
- Medicare
  - Medical observation rate
  - Inpatient high-risk case count per month
  - Surgery: inpatient vs. observation vs. outpatient
- IQ failure rate
- IRR (inter-rater reliability)

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"Surgery Dashboard"

- Inpatient vs. Outpatient metrics:
  - Payor
- Traditional Medicare
  - ER vs. Elective
  - Same-day DC vs. Overnight Stay vs Longer
  - By Physician (blinded)
  - By Department

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MAC Activity

- Primary responsibility is processing claims
- Now auditing hospitals and physicians
  - Mobile audits
  - Prepayment reviews
  - Focusing on medical necessity
  - 'Probe and Educate' program: Oct. 1, 2013 – March 31, 2015
    - Focus on Inpatient claims less than 2-midnights
    - MACs will select a sample of 10 claims for prepayment review for most hospitals (25 claims for large hospitals)
    - Link for more information: www.cms.gov/medical-review
- Increased denial activity, especially during contract renewal periods
- Frequently, guidance provided appears to be inconsistent with statutes, regulations, and manuals

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Probe & Educate

	Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October – March 2014)		
	No or Minor Concern	Moderate to Significant Concerns	Major Concerns
10 Claim Sample	0-1	2-6	7 or more
25 Claim Sample	0-2	3-13	14 or more
Action	• Deny non-compliant claims • Send results letters explaining each denial • No more reviews will be conducted under Probe and Educate Process	• Deny non-compliant claims • Send results letters explaining each denial • Offer 1:1 Phone Call • REPEAT Probe & Educate process with 10 or 25 claims	• Deny non-compliant claims • Send results letters explaining each denial • Offer 1:1 Phone Call • Repeat Probe & Educate • If problems continue, repeat P&E with increased claim volume of 100-250.

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Reserves Considerations

Every facility will have a different “correct” reserve amount. So, this must be done on a hospital by hospital basis. Here are general guidelines to consider when performing your calculation:

- Base calculation on Medicare FFS data only
- Identify the population subject to audit exposure
- Determine the potential audit volume
- Determine the net error rates assumed during an audit
- Calculate the potential repayment liability

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UR Committee Basics

- Determine that the hospital has a UR plan that addresses the utilization of services furnished by the hospital and its medical staff to Medicare and Medicaid patients
  - Optimally, the UR plan should define the roles & responsibilities of the members
- Verify through review of records and reports, and by interviews with the chair and members that the daily activities (admission review) and other functions are being performed as described in the UR plan per regulation and guidance
- Verify that there is consistent reporting and follow up of accountabilities
  - Ensure that minutes contain dates, members in attendance, and extended stay reviews with approval or disapproval noted in a status report of any actions taken

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Potential UR Committee Areas for Review

- LOS by CMI, MD, Diagnosis
  - Outliers/types and causes
- PA Reports-good and poor performers and a call to action when appropriate
- Utilization of high cost/at risk services: labs, PET, etc
- ABN, HINN, any kinds of notices Discharge dispositions-% to levels of care so that we were appropriately providing care
- Readmission rates per high level DRG-should refine this to "unplanned"
- Avoidable days by service, physician
- Certification

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Potential UR Committee Areas for Review

- PEPPER review with audit of outlier areas
- Sample of RAC charts pulled and opportunities identified as hospital appeals charts
- Condition Code 44 rates
- Readmissions issues with trend analysis
- In-patient conversion rate / OBS rates for all payors
- Observation cases with LOS greater than 48 hours: trends, opportunities and action plan
- Internal audits done (high risk areas)
  - Medicare patients discharged to SNF after 3 in-pt days
  - Observation patients – see if there was opportunity to convert to in-pt
  - One-day Medicare inpatient cases
  - CM assessment done in timely manner as per the hospital policy
- Commercial denied days by payer source and opportunities for improvement
  - Pre-certification
  - Peer to peer discussion

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UR Committee Responsibilities

- Denials overturned concurrently and post-discharge
- Number of cases discharged before expected LOS
- Review and revise UR plan at least once a year
- Peer review cases appropriate for UR committee
- Condition Code 44 and how to minimize its use
- Important managed care contracts
- For some using contracted Medical Services to help with UR, appeal functions… the UR committee may be asked to evaluate their services for Quality of care
- Use Press Ganey or other tools used to measure patient satisfaction

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Recommended Utilization Review Plan & Components

- Record key communication from and to UR Committee
  - Correspondence to physicians and their response to request for additional information to support ordered level of care
  - Correspondence from local QIO related to utilization management or other direction from the QIO
  - Any correspondences sent to the QIO or other governmental bodies from the UR Committee
- Communicate identified CMS transmittals and potential impact on utilization management
- Trend compliance with key federal areas of concentration

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Questions?

Stephen Leb, MD, FACS

Senior Medical Director
sleb@ehrdocs.com

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