RAC Medical Necessity Review—Preparation and Response

August 3, 2011—Web Seminar

CALIFORNIA HOSPITAL ASSOCIATION

Welcome & Program Overview

Liz Mekjavich
Matt Absher
California Hospital Association

Agenda

- Centers for Medicare & Medicaid Services
- TMF Health Quality Institute
- Recovery Audit Contractor—Health Data Insights
- Medicare Administrative Contractor—Palmetto, GBA

Centers for Medicare & Medicaid Services

LCDR Brian Elza

Presenter: LCDR Brian Elza

Brian Elza is the Lead Project Officer for RAC Region D at the Centers for Medicare & Medicaid Service and has been with CMS since 2008. Brian holds both Masters and Doctorate degrees in Physical Therapy and is Board Certified as an Orthopedic Clinical Specialist, and Strength and Conditioning Specialist.

Recovery Audit Contractor (RAC)
RAC and Region D
New Issue Update

LCDR Brian Elza
Lead Project Officer

Narcessa Chesil
Project Officer

Agenda

Updates

- RAC Program
- New Issues

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Review Approval

- CMS New Issue Review process
  - New Issue Review Team
  - Recovery Auditor Validation Contractor
  - New Issue Review Board (NIRB)

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CMS Contact Information

- CMS RAC Website:
  www.cms.hhs.gov/RAC
- CMS RAC Email:
  RAC@cms.hhs.gov

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Thank you

From Centers for Medicare & Medicaid Services:

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TMF Health Quality Institute

Kimberly Hroher, MHA, RHIA, CHC

Presenter: Kim Hrehor

Kim Hrehor has been employed with TMF Health Quality Institute for 13 years. As a project director, Kim provides hospital-specific comparative data reports to hospitals, Medicare Administrative Contractors and Fiscal Intermediaries. These reports are intended to assist with the identification and prevention of improper Medicare payments.

Program for Evaluating Payment Patterns Electronic Report

An Introduction to PEPPER

Hospital Comparative Billing Reports

August 3, 2011

Kimberly Hrehor, MHA, RHIA, CHC

Program for Evaluating Payment Patterns Electronic Report

Agenda

- What is PEPPER?
- How can I use PEPPER?
- How is PEPPER distributed?
- PEPPER Settings and Target Areas

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Program for Evaluating Payment Patterns Electronic Report

What is PEPPER?

- PEPPER stands for "Program for Evaluating Payment Patterns Electronic Report."
- PEPPER is a Microsoft Excel workbook containing one hospital's Medicare claims data statistics for the target areas.
- It compares the hospital's data to other hospitals in the state, MAC/FI jurisdiction and nation.
- It identifies where the hospital is an outlier.

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Program for Evaluating Payment Patterns Electronic Report

History of PEPPER

- PEPPER was developed for hospitals in 2003, and was originally distributed by Quality Improvement Organizations.
- PEPPER is now distributed by TMF.
- NEW: Reports available for critical access hospitals (CAHs), inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs).

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Using PEPPER

- PEPPER does not identify improper payments, but can help hospitals focus on areas in which they may be at risk.
- Using the data tables and graphs, look for trends and sudden spikes.
- Identify root causes of trends.
- Review medical records.
- Implement improvements based on findings.

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Program for Evaluating Payment Patterns Electronic Report

How is PEPPER Distributed?

- PEPPER is distributed electronically via My QualityNet to hospital My QualityNet administrators and to those who have a basic user account with a PEPPER recipient role.
- For more information visit PEPPERresources.org and see the “PEPPER Distribution” page.

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Target Area

- Area identified as at risk for improper payments specific to each setting.
- Constructed as a ratio:
  - Numerator = discharges identified as problematic (likely to be miscoded or admitted unnecessarily).
  - Denominator = larger reference group that contains the numerator.
- Target area percents used to generate percentiles.
- Percentiles are used to identify outlier status.

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Program for Evaluating Payment Patterns Electronic Report

ST & CAH Coding Areas

- Stroke Intracranial Hemorrhage
- Respiratory Infections
- Simple Pneumonia
- Septicemia
- Unrelated OR Procedures*
- Medical DRGs with CC or MCC
- Surgical DRGs with CC or MCC
- Excisional Debridement*
- Ventilator Support*

* ST Only

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ST & CAH Admission Necessity Areas

- Transient Ischemic Attack*
- Chronic Obstructive Pulmonary Disease
- PTCA with Stent*
- Syncope
- Other Circulatory System Diagnoses*
- Other Digestive System Diagnoses*
- Medical Back Problems
- Swing Bed Transfers (CAH only)
- 3-day SNF-qualifying Admissions

* ST Only

ST & CAH Admission Necessity Areas, cont.

- 30-day Readmissions to Same Hospital or Elsewhere
- 30-day Readmissions to Same Hospital
- 2DS Other Vascular Procedures*
- 2DS Heart Failure and Shock
- 2DS Cardiac Arrhythmia
- 2DS Esophagitis Gastroenteritis
- 2DS Nutritional & Metabolic Disorders
- 2DS Renal Failure*
- 2DS Kidney & UTI
- 1DS Excluding Transfers
- 1DS Medical DRGs
- 1DS Chest Pain and Atherosclerosis

* ST Only

Long-term Acute Care Hospital Target Areas

- Admission-focused:
  - Rehabilitation
  - Short stays
- Coding-focused:
  - Septicemia
  - Excisional debridement

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Program for Evaluating Payment Patterns Electronic Report

Inpatient Psychiatric Facility Target Areas

- Admission-focused:
  - Outlier Payments
  - 3- to 5-Day Readmissions
  - 30-Day Readmissions
- Coding-focused:
  - Comorbidities

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Inpatient Rehabilitation Facility Target Areas

- Admission-focused:
  - Miscellaneous CMGs
  - CMGs at Risk for Unnecessary Admissions
  - Outlier Payments
  - STACH Admissions following IRF Discharge

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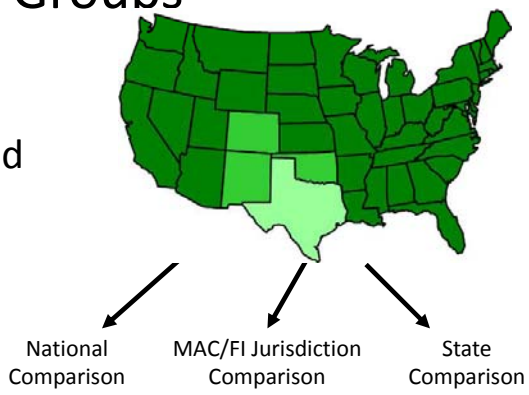
Program for Evaluating Payment Patterns Electronic Report

Comparison Groups

- State, MAC/FI jurisdiction and national comparisons
- Provides context



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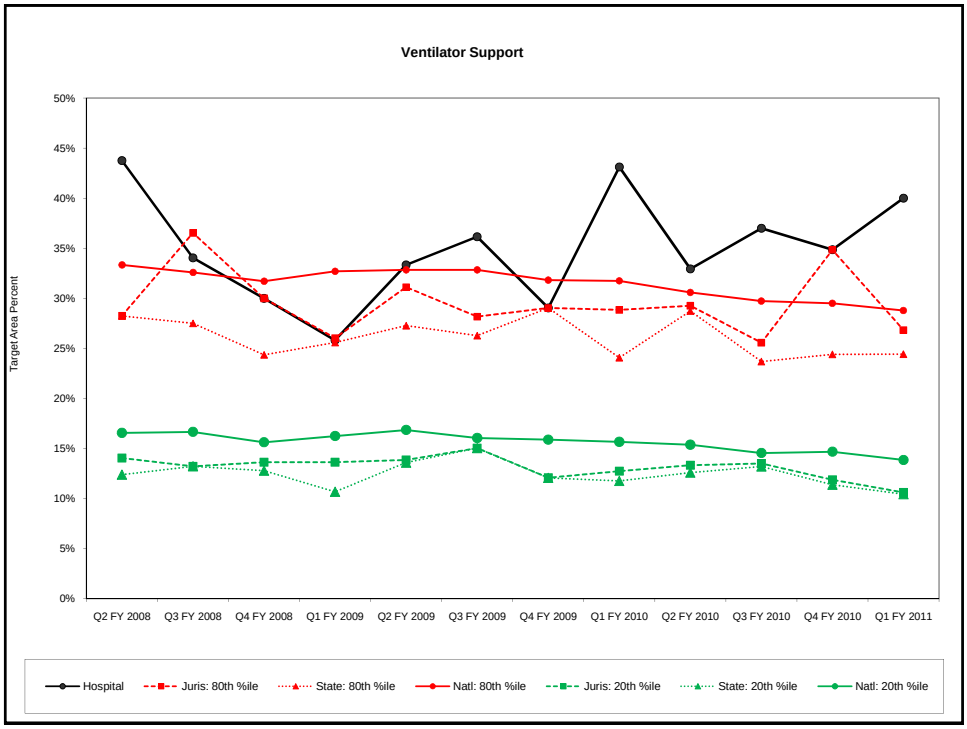

PEPPER

Program for Evaluating Payment Patterns Electronic Report

Questions & Resources

- Please submit questions and requests for assistance through the Help Desk at PEPPERresources.org.
- See PEPPERresources.org for PEPPER User's Guides, recorded web-based training sessions, FAQs, and other resources.

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Thank you

From TMF Health Quality Institute:

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Recovery Audit Contractor Health Data Insights (HDI)

Mary Woon
Ellen Evans, MD

Presenter: Mary Woon

Mary Woon is vice president of Account Management RAC at Health Data Insights (HDI). Mary has over 30 years of operational and management experience in the health insurance industry with over a decade of that experience in Medicare managerial positions. In addition to commercial insurance and Medicare operations, she has specialized in the management of Medicare Provider Outreach and education, claims and customer service areas.

Presenter: Ellen Evans, MD

Dr. Ellen Evans is the corporate medical director for HDI. At HDI, she is focused on new issue development and clinical coordination of each of the organization's various contracted endeavors: PERM, CMS, and commercial healthcare claims. In addition, Dr. Evans provides clinical review oversight and expertise in development of healthcare claim new issues as well as direction, process improvement, and critical analysis of quality aspects of the complex review team. Dr. Evans has been a practicing geriatrician since 1986.


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HealthDataInsights
August 3, 2011
Mary Woon
Margaret Evans, MD
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Agenda
• Types of Reviews
• New Issue Development and Approval
• CMS Policies and Guidelines
• Review Results and Demand Letter Process
• Discussion Process
• Questions
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Types of Reviews

- Automated
  - Based on claims data
- Complex
  - Medical record review necessary
- Semi-Automated
  - Findings are a high probability based on claims data
  - Informational letter to provider outlining potential finding
  - Provider can submit documentation to support the original billing
  - Claims processed as improper payment if no documentation submitted or documentation does not support original claim

New Issue Development And Approval

New Issue Development

- Where does RAC get its query ideas?
  - Data Analysis
    - SAS analysis, data mining, trending
  - Policy/ Rules and Regulations
    - Local Coverage Determinations
    - National Coverage Determinations
    - Internet Only Manual
    - CMS Change Requests
    - Federal Regulations

New Issue Development

- Where does RAC get its query ideas?
  - Reports (Outcomes)
    - Office of the Inspector General Reports
    - Quality Improvement Organizations
    - Government Accountability Office Reports
    - CMS Publications
    - RAC Vulnerability Calls and other Known Vulnerabilities

New Issue Development

- Where does RAC get its query ideas?
  - Industry and Practice Experience
    - Provider Associations (underpayments)
    - HDI Industry Experience

New Issue Approval Process

- New Issue is submitted to CMS for review and approval
- Once approved the New Issue is posted to the HDI website (www.racinfo.com)

CMS Policies and Guidelines

Medicare Acute Hospitalization

- Minor Surgery and other treatment billed as Acute Hospitalization: CMS IOM, Publication 100-02, Medicare Benefit Policy Manual Chapter 1, Section 10
- Inpatient Hospital Services covered under Part A: Pub 100-02, Ch 1, § 10
- Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital: Pub 100-08, Medicare Program Integrity Manual, Ch 6, § 6.5.2

Medicare Acute Hospitalization

- Determining Medical Necessity and appropriateness of admission: Pub 100-08, Medicare Program Integrity Manual, Ch 6, § 6.5.2, A
- Determining whether covered care was given at any time during a stay in a PPS hospital: Pub 100-08, Medicare Program Integrity Manual, Ch 6, § 6.5.2, B
- Medicare Policies: Pub 100-08, Medicare Program Integrity Manual, Ch 13, § 13.1; 13.1.1; and 13.1.3

Review Results and Demand Letter Process On Complex Review

Review Results and Demand Letter Process – Complex Review

- Medical records requested
  - Provider has 45 days to submit records
- RAC has 60 days to review records
- Claim determination is made
  - RAC issues Review Results Letter to provider
    - Discussion Process begins after provider receives Review Results Letter

Review Results and Demand Letter Process – Complex Review

- Claim is sent for adjustment
  - Claim is adjusted, accounts receivable is established and Remittance Advice with Code N432 is sent to provider
- Demand Letter is issued
  - Demand Letter must be dated the same date as the accounts receivable.
- Recoupment takes place on day 41

Discussion Process On Complex Review

Discussion Process on Complex Review

- Discussion Period begins with Review Results Letter
- Discussion Process does not stop recoupment
- Discussion Period is viable until Recoupment (day 41 after date on Demand Letter)

Thank you

From Health Data Insights:

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Questions

Online questions:
Type your question in the
Q & A box, hit enter

Phone questions:
To ask a question hit *1
To remove a question hit *2

Medicare Administrative Contractor
Palmetto, GBA

Ruby Reed-Knighton
Harry Feliciano, MD

Presenter: Ruby Reed-Knighton

Ruby Reed-Knighton is an ombudsman in the Provider Outreach and Education Department for Palmetto GBA, the Jurisdiction 1 A/B Medicare Administrative Contractor. As a Part A ombudsman, Ruby provides education and problem-solving assistance to providers primarily in California. She is a member of the Association of Registered Health Care Professionals as a Registered Medical Coder.

Presenter: Harry Feliciano, MD

Dr. Feliciano has served for 14 years as Contractor Medical Director at Palmetto, GBA, the Medicare Administrative Contractor. He is a specialist in internal medicine, geriatrics, preventive medicine and public health. Dr. Feliciano's special areas of interest include process improvement and tertiary prevention in populations with chronic, disabling conditions.

Recovery Audit Contractor Appeals Process

Presented by

Ruby Reed-Knighton
Palmetto GBA – J1 MAC
Provider Outreach and Education

Palmetto GBA
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Topics

- Appeals
- Recovery Audit Contractor Appeals
- Part A 935 Overpayments
- Reporting of Recoupment on the Remittance Advice
- Resources

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Five Levels of Appeals

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Five Levels of Appeals

- Redetermination
- Reconsideration
- Administrative Law Judge
- Department Appeals Board (DAB)/Appeals Council
- Federal District Court Review

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Redetermination

- First level of appeal after an initial determination
  - A request to have a second determination
  - Reviewed by different personnel than those who made the initial determination

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Redetermination

- Must be received within 120 days of the initial determination
- Palmetto GBA effectuates the claim if initial determination is reversed
  - If the claim is paid or partially paid
    - Payment will be sent with a Remittance Advice (RA)
  - If no payment made or decision not reversed, provider will receive a letter

Reconsideration

- Second level of appeal after Redetermination
- Conducted by a Qualified Independent Contractor (QIC)
- Must be received within 180 days from the Redetermination letter
- QIC will give detailed explanation of the decision

Administrative Law Judge (ALJ)

- Third level of appeal
- Conducted by the appropriate Office of Medicare Hearings and Appeals (OMHA)
- Generally held by video teleconference or by telephone
  - Provider may request in-person hearing

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Administrative Law Judge

- Must be requested within 60 days of the date of the QIC decision
- Appellants must send notice of the ALJ hearing to all parties to the QIC
- ALJ will issue their decision in writing to the Appellant

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Department Appeals Board (DAB)

- Fourth level of appeal
- Must be requested within 60 days of the date of the ALJ decision
- Must specify issues and findings being contested
- Decision generally issued within 90 days

Federal District Court Review

- Final level of appeal
- Must be filed within 60 days of receipt of the Medicare Appeals Council decision or declination of review by the Council
- Minimum amount in controversy $1,260

Recovery Audit Contractor (RAC) Appeals

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Appeals

- The RAC appeal process is the same as the appeal process for MAC denials
- Providers have two options:
  - Initiate a discussion with the RAC
  - File an appeal with the MAC

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Appeals

- Do not confuse RAC Discussion Period with the appeals process
- If you disagree with a RAC determination
  - Do not stop with sending a discussion letter
  - File an appeal before the 120th day after the demand letter

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Part A 935 Process for Overpayments

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935 Process

- Section 935 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) provides limitations on the recoupment of Medicare overpayments
- Appeal rights are now allowed on contractor-initiated adjustments
- Contractors may not recoup overpayments until a decision on redetermination/reconsideration has been made

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Overpayments Affected

- Overpayments subject to process:
  - Post-pay denial of claims for benefits under Part A for which a written demand letter was issued
  - Palmetto GBA Medical Review
  - Comprehensive Error Rate Testing (CERT)
  - Recovery Audit Contractor (RAC)
  - MSP recovery where provider received duplicate primary payment
  - MSP recovery based on provider's failure to file proper claim with third-party payer

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Demand Letter

- Triggered by adjusting a claim
  - Letter explains the amount of overpayment and the claim involved
  - Explains rebuttal and the appeal process
  - Explains recoupment process and timeframe
  - IMPORTANT NOTE — Providers will see the adjustment on the remittance advice when the letter is generated – but funds will not be recouped at that time

Rebuttal Process

- If you do not agree with the proposed recoupment, you must submit a statement within **15 days** of the notice of the impending recoupment action
  - Rebuttal process occurs prior to a provider requesting an appeal
  - Rebuttal process is not an appeal

First Level Appeal — Redetermination

- Recoupment can proceed on day 41 after the 1st demand letter if:
  - Payment is not received in full
  - Acceptable request for an extended repayment schedule
  - Valid request for redetermination is not date stamped by day 30 from the demand letter
  - IMPORTANT — If request isn't received before 30th day, Medicare can begin to recoup money on 41st day after the Medicare demand letter

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First Level Appeal — Redetermination

- Upon receipt of a valid request for redetermination of overpayment:
  - Stops the recoupment
  - Retain amounts recouped if already recouped funds, and apply it first to interest and then to principal
  - Continue to collect other debts owed, but not withhold or place in suspense any monies related to this debt, while in appeal status

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Second Level Appeal — Reconsideration

- File reconsideration to the QIC with 60 days of the appropriate letter
  - Stops the recoupment
  - Retain any amounts recouped
  - Continue to collect debts not related to this debt while in appeal status

After the Reconsideration Level

- There are no further delays in the recoupment process if the reconsideration decision is partially favorable or affirmed
- Palmetto GBA continues to recoup until the debt is satisfied in full
- The provider can make the payment of request an extended repayment plan

Reporting of Recoupment for Overpayment on the Remittance Advice

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Reporting of Recoupment on the Remittance Advice (RA)

- CMS Change Request 6870, effective July 1, 2010
- Instructions for reporting a recoupment when there is a time difference between the creation and the collection of the recoupment of an overpayment
- MLN Matters Number: MM6870

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Remittance Advice

- RA has to report the actual recoupment in two steps:
  - Step One
    - Reversal and correction to report the new payment and negate the original payment
      - Actual recoupment of money does not happen here
  - Step Two
    - Report the actual recoupment

Overpayments on the RA

- Recovered amounts reduce the total payment and are clearly reported in the RA to providers
- CMS made the changes to enable providers with more details to help them reconcile Medicare records
- The refund request is sent to the provider in the form of an overpayment demand letter
  - The demand letter includes an Document Control Number (DCN)

Overpayments on the RA

Step I

- Claim Level:
  - The original payment is taken back and the new payment is established
- Provider Level:
  - PLB03-1 – PLB reason code FB (Forward Balance)
  - PLB 03-2 shows the detail:
    - 1-2:CS
      3-19: Adjustment DCN#
      20:30:HIC#

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Overpayments on the RA

Step II

- Claim Level:
  - No additional information at this step
- Provider Level:
  - PLB03-1 – PLB reason code WO (Overpayment Recovery)
  - PLB 03-2 shows the detail:
    - 1-2:CS
      3-19: Adjustment DCN#
      20:30:HIC#

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Resources

Resources

- CMS Medicare Appeals Process Brochure:
  - www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf
- CMS RAC Program
  - www.cms.gov/RAC
- Palmetto GBA Web Site
  - www.PalmettoGBA.com/J1A

Thank You!

The information provided in this web seminar was current as of 07/20/2011. Any changes or new information superseding the information in this web seminar will be provided in articles and publications and publication dates after 07/20/2011 posted at www.PalmettoGBA.com/J1A

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Going Beyond DIAGNOSIS®

Going Beyond Diagnosis in a Changing Healthcare System

Harry Feliciano, MD, MPH
Contractor Medical Director
August 3, 2011

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Overview

- Challenging customer requirements
  - Increase quality
  - Decrease cost
  - More efficient healthcare delivery system
- Palmetto GBA projects to reduce errors
  - Going Beyond Diagnosis® Blog
  - Twitter @BeyondDx
  - Palmetto GBA/ASQ Pilot

Going Beyond DIAGNOSIS®

Healthcare Provider Goal

- Provide a high quality of care and communicate clinical need for services
  - Amount
  - Type
  - Frequency
  - Duration

Going Beyond DIAGNOSIS®

Third-Party Payer Goal

- Minimize claims payment errors and communicate results of administrative review
  - Coverage
  - Reimbursement
  - Quality

Healthcare Delivery System

- Goal:
  - Reduce costs and increase quality
  - Value = Quality/Cost
- Objectives:
  - Patient-centered, information-driven care

Healthcare Delivery System

- Currently limited by:
  - Poorly organized health records
  - Incomplete health records
  - Limited understanding by healthcare professionals of how health information technology (HIT) can help

Consequences

- Healthcare provider
  - Additional Development Requests (ADRs)
  - Claim denials
  - Costly appeals
  - Delayed payment

Consequences

- Third-party payer
  - Need for costly medical/utilization review
  - Review staff must maintain competency in the review of a variety of clinical services
  - Increased volume of appeals
  - Potential for adversarial relationships

Going Beyond DIAGNOSIS®

Consequences

- Healthcare delivery system
  - Inefficient use of resources
  - Ineffective communication
  - Insufficient information to support the Learning Healthcare System envisioned by Institute of Medicine (IOM)

Going Beyond DIAGNOSIS®

A Changing Healthcare System

- Requires:
  - Innovation
  - Collaboration
  - Communication

Going Beyond DIAGNOSIS®

1-Day Acute Inpatient Stays for Chest Pain

- Identified by CMS as being error-prone
- Identified by Comprehensive Error Rate Testing (CERT) as being error-prone
- For J1 MS-DRG 313 - Chest Pain (CP) represents $4.2 million of the $85.1 million reimbursed for Medical 1-Day Stays in Qtr 1 – Qtr 4 2010

Going Beyond DIAGNOSIS®

J1 AB MAC Compliance Officer Workgroup Recommendations

- Examine organization-specific **P**rogram for **E**valuating **P**ayment **P**atterns **E**lectronic **R**eport (PEPPER)
- Examine organizational processes for evaluation and management of chest pain in the Emergency Department
- Improve and control potential root causes for errors

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Going Beyond DIAGNOSIS®

Palmetto GBA Promotes Sustainable Process Improvement

- Going Beyond Diagnosis® (GBD) Blog
  - http://palmgba.com/gbd/
- Blog post addressing 1-Day Stays for CP
  - http://wp.me/p1Bzak-1R
- Twitter @BeyondDx
  - Most recent “tweets” listed on the right-hand side of GBD Blog

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Going Beyond DIAGNOSIS®

Collaborative Plan

- Use the GBD Blog and Twitter to actively engage physicians, hospitals and other healthcare providers
- Promote the implementation of sustainable improvement in the claims payment error rate

Summary

- George Bernard Shaw is quoted as having said “the single biggest problem in communication is the illusion that it has taken place”
- Going Beyond Diagnosis® is working to implement true innovation by promoting effective communication

Thank you

From Palmetto, GBA:

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Questions

Online questions:
Type your question in the
Q & A box, hit enter

Phone questions:
To ask a question hit *1
To remove a question hit *2

Upcoming Programs

- **Principles of Consent & Advance Health Care Directives**
  September 8, 2011, Web Seminar
- **Disaster Planning for California Hospitals Conference**
  September 19-21, 2011, Sacramento
- **Post-Acute Care Fall Seminar**
  October 25, 2011, Pasadena
- **Behavioral Health Care Symposium**
  December 5-6, 2011, Huntington Beach

Evaluation

Thank you for participating in today's seminar. An online evaluation will be sent to you shortly.

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.

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