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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Compliance and Medical Review: Collaboration at Its Best

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Agenda

- Why is Medical Review needed?
- How does Medical Review operate?
- What are some of the challenges?
- What are the physician's/compliance officer's roles?
- How can we do a better job?

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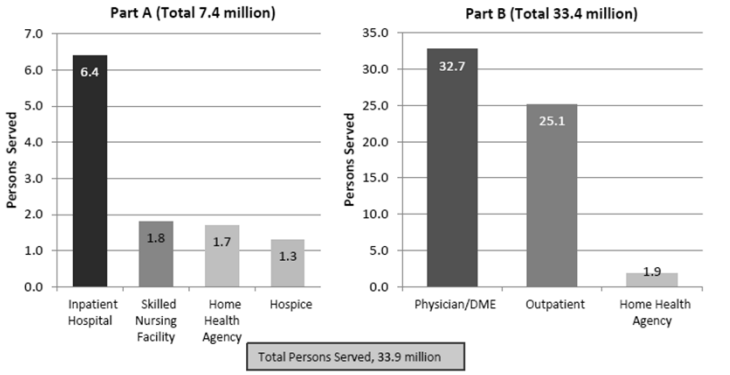
Why is MR Needed?

CMS Fast Facts — July 2016 Version

Original Medicare Persons Served (in Millions) by Type of Service
Calendar Year 2014



Total Persons Served, 33.9 million

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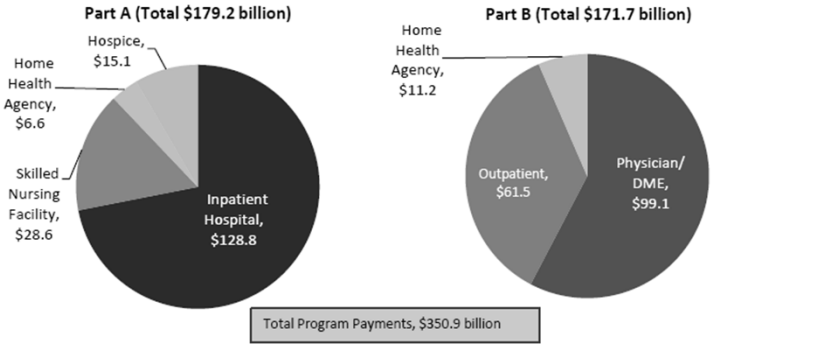
Why is MR Needed?

Original Medicare Program Payments (in Billions) by Type of Service
Calendar Year 2014



Total Program Payments, $350.9 billion

Total = Parts A and/or B

SOURCE: CMS/Office of Enterprise Data & Analytics

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Why is MR Needed?

- 2015 CERT Improper Payment Rate:
  - 12.1% (percentage of Medicare dollars paid incorrectly)
  - Estimated $43.3 billion paid in error between July 2013 and June 2014
  - Targets for lowering improper payment rates:
    - 11.5% by FY 2016
    - 10.4% by FY 2017
    - 9.4% by FY 2018

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Why is MR Needed?

- "Defined benefit" – services and payment:
  - Statutory – Social Security Act ("medical necessity" – section 1862(a)(1)(A))
  - May limit number of covered days, frequency, setting or types of services covered or not covered
  - May be irrespective of patient need
  - Benefit categories – coverage

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Why is MR Needed?

- Requirements for coverage:
  - Statutory
  - Federal (CMS-level)
  - Local (Medicare contractors)
- Documentation as a condition for coverage
- Purpose of documentation – treatment/orders vs. medicolegal vs. Medicare payment
  - Care, protection, reimbursement

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Why is MR Needed?

- Documentation challenges and consequences:
  - Impact on coverage and payment
  - Data analysis and involvement of multiple Medicare contractors
  - Further scrutiny – OIG, GAO, CERT, Congress, Recovery Auditors, MACs, etc.

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How Does MR Operate?

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How Does MR Operate?

- Review criteria:
  - Statutes
  - Code of Federal Regulations
  - CMS Rulings
  - National Coverage Determinations (NCDs)
  - CMS Guidance – Internet-Only Manuals (IOMs)
  - Local Coverage Determinations (LCDs)
  - Peer-reviewed publications
  - Compendia/FDA

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How Does MR Operate?

- Role of clinical review judgment at CGS:
  - Efforts to reduce the paid claims error rate
  - Fewer claims denied inappropriately; fewer claims appealed
  - Fewer "dead-end" referrals to the Zone Program Integrity Contractor (ZPIC)
  - Reduce the "hassle factor" for providers
  - Not "forgiveness" for poor/inadequate documentation
  - Does not include re-interpretation or reinvention of existing policy to cover the care provided

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How Does MR Operate?

- Determines whether a service is:
  - A covered benefit
  - Reasonable and necessary
  - Accurately coded
- Is not:
  - A means to deny claims
  - Fraud investigation
  - "Street justice"

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How Does MR Operate?

- Assumptions:
  - Medical Review believes in the "honor system"
  - The provider delivered the service billed and the documentation is accurate
  - The provider submits the claim honestly
  - Clinical judgment should be applied appropriately to pay the claim when payable

CERT Claim Selection

- A stratified random sample is taken by claim type:
  - Part A (excluding acute inpatient hospital services)
  - Part A (acute inpatient hospital services only)
  - Part B
  - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Claims are selected on a semi-monthly basis
- The final CERT sample is comprised of claims that were either paid or denied by the MACs

2015 Improper Payments ($ in Billions)

Claim Type	Total Payment	Projected Improper Payment	Improper Payment Rate	95% Confidence Interval
Part A (Total)	$260.0	$28.7	11.0%	10.2% - 11.8%
Part A (Excluding Hospital IPPS)	$147.4	$21.7	14.7%	13.4% - 16.0%
Part A (Hospital IPPS)[7]	$112.6	$7.0	6.2%	5.6% - 6.8%
Part B	$90.4	$11.5	12.7%	11.8% - 13.6%
DMEPOS	$8.0	$3.2	39.9%	35.5% - 44.4%
Overall	**$358.3**	**$43.3**	**12.1%**	**11.4% - 12.7%**

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Revised October 19, 2016

CERT Errors

Top 20 Service Types with Highest Improper Payments: Part A Excluding Hospital IPPS - NATIONALLY
Based on November 2015 Reporting Period
Date Range: 07/01/2013 - 06/30/2014

			Type of Error					
Part A Services Exluding Hospital IPPS (TOB)	Projected Improper Payments	Improper Payment Rate	No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	Percent of Overall Improper Payment
Home Health	$10,081,911,400	59.0%	0.3%	94.8%	4.1%	0.3%	0.5%	23.3%
SNF Inpatient	$3,510,926,699	10.4%	0.2%	78.7%	1.6%	8.3%	11.2%	8.1%
Hospital Outpatient	$2,526,045,543	4.9%	0.1%	79.1%	11.5%	5.6%	3.6%	5.8%
Hospital Inpatient (Part A)	$1,838,847,595	29.7%	0.2%	27.2%	71.4%	0.0%	1.1%	4.2%
Nonhospital based hospice	$1,428,981,208	10.7%	0.0%	51.3%	44.9%	3.8%	0.0%	3.3%
Clinic ESRD	$880,079,457	7.9%	0.0%	100.0%	0.0%	0.0%	0.0%	2.0%
SNF Inptaient Part B	$360,947,440	19.4%	0.0%	49.2%	19.7%	0.0%	31.1%	0.8%

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Revised October 19, 2016

What Are Some of the Challenges?

- Appropriate setting (i.e., inpatient vs. outpatient):
  - Hospital IPPS improper payment rate for the 2015 report period = 7.4%
  - Improper payment rate for inpatient hospital stays of one day or less = 27.8%

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What Are Some of the Challenges?

- Appropriate setting (i.e., inpatient vs. outpatient):
  - Resulted in A/B rebilling process:
    - Allows hospitals to bill for all Part B services that would have been payable if a beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient
    - Exception: Services that specifically require an outpatient status (e.g., outpatient visits, emergency department visits, and observation services)
  - "A/B Rebilling: Timeline and Claim Submission Instructions": http://cgsmedicare.com/parta/pubs/news/2014/0814/cope26474.html

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What Are Some of the Challenges?

- Observation vs. inpatient (2MN rule):
  - Certification:
    - Reason for inpatient or observation admission
    - No specific format required
  - Order:
    - Who can write the order?
    - Timing of orders
    - Authentication
    - Specificity
  - Expected length of stay:
    - Reasonable and necessary
    - Rationale

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What Are Some of the Challenges?

- Observation vs. inpatient:
  - An order simply documented as "admit" is vague.
  - A clearly worded order, such as "inpatient admission" or "place patient in outpatient observation", will ensure appropriate patient care and prevent hospital billing errors.
  - Order should match medical needs and rationale as documented in the record.

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What Are Some of the Challenges?

- Elective admissions, one day stays, IP only list
- Medical co-morbidities and risk
- Outpatient procedures
- Skilled Nursing Facility (SNF) qualifying stay
- Diagnostic studies & how results affect further care
- Ignored specialty consultations
- Documentation of medical decision making

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What Are Some of the Challenges?

- Documentation:
  - Demonstrate medical necessity and reflect care provided
  - Nature/type of service provided
  - Clear rationale
  - Consistency of information throughout the record
  - "Technical" requirements (e.g., dated signature, order specificity)
  - Part A documentation that does not prove medical necessity

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Physician/Compliance Officer Roles

- Cloning and templating:
  - Documentation is exactly the same from beneficiary to beneficiary (i.e., “cloned”).
  - It would not be expected that every patient had the exact same problem, symptoms, treatment, etc.
  - Templated records all look the same.
  - It would not be expected that a patient had the same findings at each visit.
  - This type of documentation can result in a medical necessity denial and recoupment of payment.

Physician/Compliance Officer Roles

- Timeliness, changes and addenda:
  - We **strongly encourage** all health care providers to enter information into the patient’s medical record at the time the service is provided to the patient; that is, **contemporaneously**.
  - Changes and addenda should be dated and properly authenticated.
  - The nature and intent of any addendum must be clear.

Physician/Compliance Officer Roles

- Coding:
  - Role of coders: Select CPT/HCPCS codes, modifiers and ICD-10 codes based on physician's documentation **and with physician's input.**
  - A correct ICD-10 code ≠ medical necessity.
- Responding to ADRs:
  - **Who gathers and copies documentation? – trained staff, timeline for responses, what to send and to whom, quality control**
  - Addressing insufficient documentation errors

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Physician/Compliance Officer Roles

- Coding
- Clinical review judgment
- Consistency across disciplines
- Cloning, EMR, templating and scribing
- Certification: PT/OT/SLP plans of care, SNF, IRF

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Insufficient Documentation

- Different from “Not Medically Necessary”
- What’s missing?
  - Portions of the Part A record
  - Part B record (or summary thereof) documenting conservative therapy
  - Missing orders/missing signatures
  - Untimely entries

Resources

- CGS website: http://cgsmedicare.com
  - CERT
  - Medical Policies
  - Medical Review Contractors
- CGS quarterly compliance meetings
- CMD.inquiry@cgsadmin.com
- Provider Outreach and Education: J15_PartA_Education@cgsadmin.com