Compliance and Medical Review: Collaboration at Its Best

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CGS J15 Chief Medical Officer

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?
Why is MR Needed?

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

Part A (Total 7.4 million)
- Inpatient Hospital: 6.4
- Skilled Nursing Facility: 1.8
- Home Health Agency: 1.7
- Hospice: 1.3

Part B (Total 33.4 million)
- Physician/DME: 32.7
- Outpatient: 25.1
- Home Health Agency: 1.3

Total Persons Served: 33.5 million

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

Part A (Total $179.2 billion)
- Inpatient Hospital, $128.8
- Skilled Nursing Facility, $28.6
- Home Health Agency, $6.6
- Hospice, $15.1

Part B (Total $171.7 billion)
- Outpatient, $63.5
- Physician/DME, $99.1
- Home Health Agency, $11.2

Total Program Payments, $350.9 billion

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

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
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

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.
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
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

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”
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)

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Total Payment</th>
<th>Projected Improper Payment</th>
<th>Improper Payment Rate</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A (Total)</td>
<td>$250.0</td>
<td>$28.7</td>
<td>11.0%</td>
<td>10.2% - 11.8%</td>
</tr>
<tr>
<td>Part A (Excluding Hospital IPPS)</td>
<td>$147.4</td>
<td>$21.7</td>
<td>14.7%</td>
<td>13.4% - 16.0%</td>
</tr>
<tr>
<td>Part A (Hospital IPPS)</td>
<td>$112.6</td>
<td>$7.0</td>
<td>6.2%</td>
<td>5.6% - 6.8%</td>
</tr>
<tr>
<td>Part B</td>
<td>$98.4</td>
<td>$11.5</td>
<td>12.7%</td>
<td>11.8% - 13.6%</td>
</tr>
<tr>
<td>DMEPOS</td>
<td>$8.0</td>
<td>$3.2</td>
<td>39.9%</td>
<td>35.5% - 44.4%</td>
</tr>
<tr>
<td>Overall</td>
<td>$358.3</td>
<td>$43.3</td>
<td>12.1%</td>
<td>11.4% - 12.7%</td>
</tr>
</tbody>
</table>

## CERT Errors

### Top 20 Service Types with Highest Improper Payments: Part A Excluding Hospital IPPS - NATIONALLY

Based on November 2015 Reporting Period

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Percent of Overall Improper Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>23.3%</td>
</tr>
<tr>
<td>SNF Inpatient</td>
<td>8.1%</td>
</tr>
<tr>
<td>Hospital Inpatient (Part A)</td>
<td>5.8%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>5.8%</td>
</tr>
<tr>
<td>Nonhospital based hospice</td>
<td>4.2%</td>
</tr>
<tr>
<td>Dialysis (ESRD)</td>
<td>3.3%</td>
</tr>
<tr>
<td>SNF Inpatient Part B</td>
<td>2.0%</td>
</tr>
<tr>
<td>Clinic ESRD</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Data Range: 07/01/2013 - 06/30/2014

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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%

- 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)
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

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.
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

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
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.

- **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

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