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New York's new work plan offers audit cheat sheet

The detailed work plan released on April 22 by New York's Office of the Medicaid Inspector General (OMIG) offers valuable guidelines for New York providers. It also gives clues to what may be in store in other regions of the country, says **Ed Kornreich,** partner at New York City–based Proskauer Rose, LLP.

"In most other states, there is already an awareness of some of the issues featured in this work plan, such as quality, because of national initiatives," Kornreich says. "I do think this kind of approach, using Medicaid Inspector Generals and work plans, will be replicated in other states and will eventually become the standard."

Complete picture

New York's OMIG states that its work plan is one component of a strategy to improve the quality of care for Medicaid enrollees and combat billing fraud and abuse at the same time. The OMIG's description of the work plan as "a road map of where we plan to go in the future" is accurate, says **Judith Waltz,** partner at Foley & Lardner, LLP, in San Francisco.

The New York OMIG work plan is the first of its kind. It represents a significant divergence because it provides such a high level of detail, including more than 60 focus areas and information on risk factors, Waltz says.

"They go through every type of provider that receives funds from the state and give information about whom and what they will focus on," she explains. "It's like the federal OIG *Work Plan* in terms of how complete it is, and that's very unusual because state Medicaid plans are usually not very transparent."

> **"I do think this kind of approach, using Medicaid Inspector Generals and work plans, will be replicated in other states and will eventually become the standard."**
>
> *—Ed Kornreich*

The 34-page document is divided into sections for each type of provider and lists priority concerns for oversight. For example, regarding adult day health care (ADHC) providers, the OMIG says it will review ADHC billings to ensure they are in compliance with Medicaid billing requirements. It will also scrutinize education, certification, and licensure of staff members.

For hospitals, the OMIG says it will conduct reviews to determine whether Medicaid providers are upcoding diagnoses to receive higher levels of reimbursement.

Quality of care

One overarching focus of the OMIG work plan is quality of care and linking quality to payment, Waltz says. That's not surprising, considering New York's Medicaid Inspector General is James Sheehan, a former assistant U.S. attorney from Philadelphia who has become

> *continued on p. 2*

HCPro

IN THIS ISSUE

Work plan

< continued from p. 1

known for exhaustively pursuing quality initiatives and linking infractions to violations of the False Claims Act.

For example, quality is a clear priority in areas such as home health, assisted living, and ADHC, says **Amy Bailey-Muckler,** health consulting manager at Hooper Cornell Healthcare in Boise, ID.

"That's consistent with the federal government's increasing focus on quality, and their indications that they are moving toward a system of reimbursement based on quality of care," Bailey-Muckler says.

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New York is in a unique position, says **Glenn Jones,** special counsel at Fulbright and Jaworski, LLP, in Washington, DC, and former special assistant attorney general in the Medicare Fraud Control Unit of the New York State Attorney General's Office. Prior to the creation of the OMIG in November 2006, the state's cash-strapped health department was in charge of this type of oversight, Jones says.

The team was understaffed and underfunded. "Now, with the OMIG, they have more resources," says Jones. "They can put a lot more focus on investigating home health and skilled nursing facilities—areas where Medicaid is spending increasingly more dollars and where there is a lot of room for fraud and abuse."

Data mining

Another major component of the work plan is the heightened focus on data mining as a means to recoup payments, Jones says. As part of its Managed Care/Data Mining Project, the OMIG will review payments for deceased enrollees to recover Medicaid managed care capitation payments made after the recipients' deaths.

In addition, the work plan mentions reviews of incarcerated enrollees, recipients who have moved out of state, prior-to-date-of-birth payments, improper retroactive Supplemental Security Income capitation payments, and stop-loss payments.

"The data mining initiative is a surprise just because of the size and scope of the project," Bailey-Muckler says. "Because it covers so many things and will necessitate some really sophisticated programming, it will be a very difficult task to accomplish. If they do it, though, it will be very effective at detecting fraud."

Beneficial for providers

Although the extensive work plan could potentially be viewed as burdensome by some providers, it's a useful tool that will hopefully alleviate worries of inevitable reviews, Waltz says.

"The audit process is unavoidable, but this tells every provider in New York what the OMIG is going to focus on so they can see ... areas of vulnerability and correct them," Waltz says. "In some ways, that is more effective enforcement for the state because providers fix problems early. The state has less to do and, in some cases, may not have to get involved at all."

In fact, providers in New York should use the work plan as a comprehensive tool because it outlines all of the biggest risk areas for their operation, Bailey-Muckler says.

"They should look at all of the items on the work plan carefully and make sure they are in compliance and have all of the appropriate controls in place," she says.

In other states

Whether other states will adopt a similar plan will largely depend on each state's level of funding, says Waltz. For example, California is in the midst of a budgetary crisis and would be hard-pressed to finance an initiative of this scale.

"I do think this will be the gold standard, and if other states can put forth something like this, they will," Waltz says. "It will be interesting to see the results because if New York does recover a lot of money, it will motivate other states to do something like it. But again, this is a very big investment."

It is just another example of a changing culture of enforcement, which is moving rapidly toward self-policing and voluntary disclosure among providers, Jones says.

"I think it all comes down to developing a strong culture of compliance," she says. "Providers are realizing that it's much better to have a strong program from the start, and they're using tools like this to be more proactive." ■

OIG increases oversight for Medicaid mental health

The Deficit Reduction Act of 2005 (DRA) brought significant changes to reimbursement for medical care and increased scrutiny of healthcare compliance. Included with these changes are new Medicaid rules that mental health professionals must follow.

Not all the changes proposed in the DRA are currently in effect. The rehabilitation requirements presently under legislative moratorium are scheduled to take effect June 30.

The potential cost of failing to comply is huge compared to the penalties of the past. Previously, if CMS detected a billing error, the cost was normally limited to the amount of the error—this is no longer the case, says **Terry Haru,** chief compliance officer at Heritage Behavioral Health Center in Decatur, IL.

For example, take the OIG's audit of Illinois community mental health providers for fiscal year 2003. Out of 200 randomly selected service items, the OIG found 33 with one or more payment errors, totaling an overpayment of $1,269.

The state Medicaid payments to community mental health providers totaled $170.5 million that year; of that total, $89 million was federal money. Extrapolating from the audit sample, the OIG determined that Illinois' total Medicaid overpayments for these services amounted to nearly $11.5 million, and it told the state to repay nearly $6 million.

"Immediately, the Deficit Reduction Act is going to result in far more scrutiny," Haru says.

Given the potential for findings like these, many states plan to do extrapolation audits of their own to determine problem areas before the OIG examines claims, Haru says, adding that, previously, there were roughly eight full-time OIG employees performing Medicaid audits, but the DRA calls for nearly 100, at a cost of hundreds of millions of dollars.

"They are expecting to recover that many times over," Haru says, with some suggesting an estimated savings of $12 billion in the next five years.

> *continued on p. 4*

Medicaid

< *continued from p. 3*

Challenges to conquer

Providers of mental health services face several obstacles on the way to compliant billing. If a patient breaks a leg, the medical treatment is straightforward, and the outcome is easily documented. However, neither the course of treatment nor reasonable expectations for recovery are as easy to quantify for a patient who suffers from depression.

Such inherent difficulties of mental health treatment make billing and medical necessity documentation far more complex than other medical procedures. CMS continues to complicate compliance concerns. It remains unclear whether Medicaid Integrity Contractors (MIC)—who started audits this spring—will disallow claims that already met state Medicaid plan criteria. MICs may not be familiar with each state's specific rules.

To further complicate things, it remains unclear how auditors will rule on a host of questions, from who is qualified to provide treatment to what treatment is appropriate to how cases should be managed and by whom.

With the states auditing most claims, providers were on solid ground as long as billing met state regulations, says **Charles Ingoglia,** vice president of the Public Policy National Council for Community Behavioral Healthcare in Rockville, MD.

"It's a different ball game now," he says.

The effect of the added scrutiny can be felt in several ways, from the number of errors detected to how the OIG judges the mistakes its auditors find. The OIG or the DOJ might view errors repeated over time, but never detected, as evidence of fraud, Haru says.

"There are indeed providers … who knowingly and deliberately try to rip off the government," he says. "But the real vulnerability, the real risk for most of us, is not the willful or intentional stuff; it's the inadvertent stuff."

Providers face civil action in cases of fraud, Haru says, and the threshold for proving fraud is far lower than for criminal behavior. All that is required is a pattern or a practice that exhibits "reckless disregard or willful ignorance," he says. "If it goes on long enough, there's your pattern—specific intent is not relevant."

Civil judgments add to the cost of repaying the government for billing errors, Haru notes. Thus, most providers choose to settle out of court regardless of whether fraud occurred, because it is cheaper in the long run.

Case management compliance complications

The proposed rule governing targeted case management was published March 30, and CMS plans to publish the final rule in August. Some problem areas may be adjusted by then, Ingoglia says. But targeted case management and rehabilitation need to remain high on the mental health compliance watch list.

Case management can no longer include direct delivery of medical, educational, or social services referred to a patient. No federal matching Medicaid funds can be applied to case management services if there is any other third party available to pay for them.

Further, only one case manager per patient should bill for services. This could cause providers to compete over

Illustration by David Harbaugh

"Doctor, it's Maggie in coding. I finally finished your documentation on psychiatric services and I hope Medicare will pay for my psychiatric recovery."

who gets to bill for services, says **Dean True,** compliance officer at Butte County Department of Behavioral Health in Chico, CA.

The rule may give rise to quality-of-care concerns, True says. One case manager with expertise in a specific area should not necessarily preside over a patient's entire range of mental healthcare. For example, an HIV patient with behavioral problems may also need services for bipolar disorder. One case manager may not know how to treat both of these diseases.

Documentation and preparation prove critical in such situations, Haru says. The federal government outlines the four categories that constitute targeted case management as follows:

- Assessment
- Treatment planning
- Referral and linkage
- Follow-up

Medical necessity requirements blur lines

Documenting medical necessity of treatment is another problem area, True says.

A patient diagnosed with depression might have "angst about life, but can still get up and go to work," True says. But in order to bill for treatment, CMS asks: "Where is the significant effect of the depression?"

Payments based on rehabilitation documentation pose particular problems for mental healthcare providers. Different providers may evaluate rehabilitation according to different standards.

A key problem lies in the Medicaid requirement that providers prove the service they provided actually helped the patients, Ingoglia says.

"You may not always be able to show forward progress," he says. "The question is what will be the standard" for the industry to measure the successful treatment of a mental health patient.

Conversely, Ingoglia says, if the mental health patient's condition deteriorates, will CMS allow payment or deny the claim under these more stringent payment rules?

For example, in the case of a patient with schizophrenia, True asks: "How do you measure progress from point A to point B?"

One provider may work to assist the client in overcoming barriers to using public transportation, whereas another may focus on reducing specific negative symptoms. If documented properly, either of these treatment areas is valid for claiming by CMS within individually approved Medicaid plans.

However, the question is whether auditors will have the appropriate training and knowledge to understand plan differences as they move from provider to provider or, more importantly, state to state. If they don't, there may be significant numbers of disallowances for legitimate services.

The federal interpretation of what constitutes sufficient progress toward rehabilitation varies. Providers have not received much guidance from the federal interpretation.

Credentialing barriers

Mental health treatment, particularly in residential settings, may be done by providers without a medical license, or by those whose training might not at first seem directly related to the care provided. However, unlicensed caregivers are allowed to participate in treatment plans,

> *continued on p. 6*

Medicaid

< continued from p. 5

say Haru and True. They may even perform a majority of a patient's treatment. "The question becomes how much training people get, the quality of training, the supervision they get," Haru says. Residential staff members typically have a high school education, he adds, and there is a "degree of inconsistency" in their training.

To get around this, Haru's facility established a standard curriculum to ensure staff members have a minimum amount of training, Haru says. Providers have to document what level of training and experience care providers have to justify billing for those services.

The uncertainty increases mental health professionals' "paranoid factor," Ingoglia says, adding that CMS hasn't "done a real good job of explaining what the expectations are."

CMS will consider alternatives to some of the new policies, but Ingoglia says no one knows what they might be—the indecision threatens to stifle innovation. ■

OIG attention on DSH payment program escalates

The OIG has focused its attention on the Medicaid Disproportionate Share Hospital (DSH) Payment Program in its annual *Work Plan* for the past several years. This year is no different. Prompted by rapidly growing state DSH expenditures, the OIG highlighted several areas it is focused on this year.

The DSH requirement mandates additional funds from state Medicaid programs for hospitals that serve a disproportionate number of low-income patients—known as a DSH payment adjustment—in order to supplement their revenue stream.

CMS gives each state significant leeway in both defining DSH hospitals and its methods of DSH payment.

However, states must provide, at the very least, DSH payments to hospitals that have a Medicaid inpatient use rate at least one standard deviation above the mean—a figure determined using a ratio of Medicaid inpatient days and total inpatient days—or a low-income utilization rate of more than 25%.

"The first thing that providers need to do is review and understand the definitions and regulations in their state," says **Eric Weatherford,** an attorney at Brown McCarroll, LLP, in Dallas. "Some DSH rules can seem counterintuitive, but once providers are familiar with those data elements, they can start developing the right procedures to review them."

OIG items

In its 2008 *Work Plan,* the OIG states that it will examine several aspects of the DSH program. First, it plans to review hospital eligibility for Medicaid DSH payments to ensure funds go to hospitals that meet state and federal requirements. "During several prior reviews, we found that states had made DSH payments to hospitals that did not meet the eligibility standards," the OIG says. "We will determine whether states are appropriately determining hospitals' eligibility for Medicaid DSH payments."

In addition, the OIG says it will review states' use of DSH payments to assess the amount of federal funds being used for individuals in state-run mental institutions.

"DSH payments to an individual hospital may not exceed that hospital's uncompensated care costs," the OIG says. "Some states have provisions in their state Medicaid plans that allow DSH payments to hospitals for the cost of services provided to persons not covered by the Medicaid program, including individuals between the ages of 21 and 64 residing in Institutions for Mental Disease."

Provider strategies

For hospitals, the benefits of becoming familiar with state-specific Medicaid DSH requirements are twofold, Weatherford says. First, it will help them support the data they report. Second, it will allow hospitals to verify the information states use in calculations. In that respect, hospitals can actually check on the state to ensure accuracy, he adds.

For example, in Texas, the Department of Health and Human Services issues a Medicaid DSH qualification report, and hospitals have a limited amount of time to contest the data.

"If you understand the data elements that you report to the state, then you can establish some protocols internally to make sure you represent those accurately," Weatherford says. "At the same time, the state uses that data to calculate your DSH status, so you can use that information to make sure the state correctly reports it."

Weatherford says that, every year, at least one of his clients identifies incorrect data in the DSH qualification report and appeals for changes.

Future oversight

OIG audits like those in Missouri and New Hampshire will likely continue, Weatherford says, and avoiding scrutiny won't be an option. The best strategy is to think of DSH payments like any other area of compliance, which means identifying the people who compile DSH data, understanding the method of capture, and adding appropriate controls, he says.

"If, during the course of an internal audit, providers determine their methodology is flawed, they can analyze the data to see if anything that was reported incorrectly had an impact on their DSH status," Weatherford says. "In addition to needing auditable data to verify state reports, maintaining vigilance as to how DSH-related data is developing will allow hospitals to estimate their future DSH status and budget accordingly." ■

Recent DSH audits outline path for providers

One of the best sources of guidance regarding the Medicaid Disproportionate Share Hospital (DSH) Payment Program requirements are sample audits from the OIG. Although each state differs in the manner in which it calculates eligibility for DSH payments—and the OIG audits take this into account—they are still a valuable tool for all providers because they demonstrate potential target areas.

Take the following recent audits as examples of what to watch for and what to audit for when it comes to ensuring your compliance with DSH reimbursement rules.

Missouri

In a 2007 report, "Review of Missouri's Determination of Medicaid Disproportionate Share Hospital Eligibility for State-Owned Institutions for Mental Diseases [IMD]," the OIG assessed Missouri's provision of mental health services to see whether the state had correctly determined DSH payment eligibility during 2003–2005.

The OIG found that although Missouri had correctly identified seven state-owned IMDs as eligible for DSH payments, the hospitals' Medicaid inpatient utilization rate (MIUR) had been calculated incorrectly. This was partially because the state was classifying individuals who had been sentenced to time in an IMD as patients rather than as incarcerated individuals.

"The state incorrectly computed the MIURs because it did not comply with federal regulations concerning the exclusion of inpatient days related to unallowable age groups and incarcerated individuals," the OIG said in the report. "In addition, the state included unallowable inpatient days related to accounting errors for the [fiscal years] 2003–2005

> *continued on p. 8*

DSH audits

< *continued from p. 7*

DSH eligibility determination. The state also lacked adequate controls concerning the acquisition, review, and maintenance of contemporaneous documentation to support the MIUR calculations."

Although the OIG found that Missouri could not support its MIUR calculations, the MIURs were never below the 1% threshold—the number needed to be a Medicaid DSH. Therefore, all seven hospitals were still eligible for DSH payments. However, in the future, problematic MIUR calculations could lead the state to incorrectly categorize IMDs as DSH hospitals, the OIG says. In order to improve the situation, the OIG recommended that Missouri:

- Comply with federal regulations concerning the exclusion of unallowable inpatient days from the MIUR calculations
- Strengthen controls to eliminate accounting errors
- Acquire, review, and maintain contemporaneous documentation to support the original Medicaid DSH MIUR calculations

In response, Missouri said it would increase controls to ensure only allowable patient days were used in calculating the MIURs. The state commented on the OIG's interpretation of patients as incarcerated individuals, arguing that IMDs were not penal institutions, and individuals who had been sentenced to a period of time in a state-run psychiatric hospital were not guilty by reason of their illness.

New Hampshire

In a second 2007 Medicaid DSH audit, the OIG examined New Hampshire's 2004 state agency claims to determine whether they were in compliance with federal and state DSH requirements.

In its review, the OIG concluded that of the more than $194 million that the state agency claimed during fiscal year 2004, only about $123 million was allowable—leaving more than $70 million in unallowable payments.

The government referenced a 1994 letter from CMS to state Medicaid directors, which stated that costs of services included in a hospital's DSH limit could not be greater than the amount that is allowed under Medicaid's principles of cost reimbursement.

"Specifically, the cost-to-charge ratios that the state agency used in determining allowable costs were inflated because they overstated costs by including unallowable costs," the OIG said. "We attribute the excess DSH payments to the state agency's lack of policies and procedures to ensure that its methodology for developing the cost-to-charge ratios used to calculate hospital-specific DSH limits complied with federal requirements and the state plan."

The government recommended that New Hampshire's state agency refund more than $35 million to the federal government, work with CMS to evaluate DSH payments distributed after the audit, and craft policies and controls to accurately calculate DSH payments and stay in compliance with requirements.

In response, New Hampshire's state agency disagreed with the OIG's findings and recommendations. It argued that Medicaid principles of cost reimbursement, which the OIG used in its review, were not laws and should not be taken into consideration when determining DSH limits.

In a letter to the OIG, John Stephen, New Hampshire's Department of Health and Human Services commissioner, stated:

> *New Hampshire's methodology for calculating the costs of uncompensated care was designed to take [into] account the real costs of treating the low-income individuals whom the DSH program is designed to assist. The state's current methodology has been in place for over 10 years. In all these years, the state has been completely forthright about the method it employs to calculate DSH payments, and CMS has never challenged the state's approach. CMS and the state have worked together to make certain changes to the DSH methodology and other components of state law, and the state is always willing to cooperate with CMS concerning possible future changes, but it is improper to propose a retroactive disallowance as to an approach that we have always understood to be an appropriate means of determining the costs of serving Medicaid and the uninsured.*

Patient status: Five tools to conduct internal audits

Editor's note: This article is the first in a two-part series on patient status.

In an era of greater accountability and enforcement, hospitals and treating physicians will be increasingly responsible for complying with Medicare's medical necessity criteria for admissions and determining patient status.

Exercise oversight methods

To improve patient care and reduce the occurrence of claims denials or underpayments, hospitals need to employ several careful oversight procedures, including:

- Retrospective guidance of its utilization review (UR) committee
- Internal audits
- Prospective guidance of case management protocol (CMP)

Medicare is aggressively reviewing cases retrospectively, says **Robert Corrato, MD,** president and CEO of Executive Health Resources in Newtown Square, PA. Such examinations mean "providers will see a more frequent and critical assessment of their admission status determinations," he says.

Before the facility assesses a patient's condition, it must determine where each patient needs to be treated: admitted as an inpatient into the hospital, treated and released as an outpatient, or held temporarily to determine whether care is needed as an observation patient.

"Hospitals must define a process and criteria against which they will assess the medical necessity and appropriateness of the setting in which services are rendered," Corrato says.

Determine patient needs and status

Once a patient enters the hospital, caregivers must assess the patient's condition and determine the most appropriate setting for the care of that patient and medical necessity of their ailment.

The decision to define an admission to inpatient status as medically necessary is complex and includes several factors, including:

- Current needs of the patient
- Severity of signs and symptoms
- Existence of comorbidities
- Intensity of services
- Predictability of the clinical course
- Potential for adverse complications
- Availability of diagnostic services

Following the discharge of a patient, Medicare and its contractors can determine retrospectively whether the treatment a patient received was reasonable and medically necessary.

"Hospitals must define a process and criteria against which they will assess the medical necessity and appropriateness of the setting in which services are rendered."

—Robert Corrato, MD

Even when Medicare criteria are met, prevailing medical policies or evidence-based standards of clinical practice may limit coverage for the care provided.

Use decision support systems

As a first-tier medical necessity screening, many hospitals use InterQual, Milliman, or another proprietary system to determine patient status. These evidence-based clinical decision support systems apply severity of illness and intensity of services (SI/IS) criteria to the patient's presenting condition. Hospitals use these tools for self-monitoring internal audits as well.

Although useful, many of the criteria within such screening tools are similar for observation and inpatient status determination, presenting a conundrum to the case manager trying to make a differential status determination.

> *continued on p. 10*

Patient status

< continued from p. 9

Inpatient admission SI/IS criteria generally require a higher level of acuity than observation status.

Be careful not to use the computer systems as the only means to determine patient status, Corrato says. "Screening criteria should never be considered dispositive or final in terms of medical necessity determinations" without the case manager consulting a physician to make a final decision, he says.

Develop an effective UR committee

In more complex care cases, determination of patient status should go to a second-tier review by the UR committee.

A typical hospital UR committee is composed of medical staff leaders, such as the chief medical officer and chiefs of service. Hospital administrators, such as health information management, case management, or other department directors, may also serve.

An effective UR team must have knowledge about:

- The clinical criteria for care and admission status
- The relationship between the criteria and a given payer and insurance requirements

The UR team must have access to pertinent patient information, particularly in cases with potentially questionable admission status.

Employ a physician champion

A physician with regulatory and clinical expertise, such as a physician adviser, should review questionable cases incorporating:

- The treating physician's clinical impressions
- The patient's current needs
- Medical history
- Documentation in the medical record
- Severity of the patient's signs and symptoms (taken from the screening tool)
- Predictability of an adverse outcome relative to care
- Findings on diagnostic studies

The role of UR team physician advisers serving on the UR team is to:

- Provide the level of expertise necessary to properly identify patient status
- Assist hospitals in appealing claim denials
- Help prepare for Medicare audits

The physician adviser can be involved in a review of admissions, which may be performed before, during, or after a status determination, but before discharge from the hospital.

Physician advisers "can serve as credible liaisons between case managers and the medical staff and between

hospitals and payers, dedicated to improving the timeliness and accuracy of documentation and clinical compliance," says Corrato.

As effective communicators and collaborators between treating physicians and case managers, physician advisers can serve in expanded roles as physician champions.

These champions lead initiatives such as increasing the number of case managers in the emergency department during critical weekend hours or implementing a CMP to properly identify patient admission status.

A physician adviser can also consult with the UR committee to target problem areas for audits.

In order to fulfill Medicare's *Conditions of Participation,* a facility must establish a UR plan internally through its policies and procedures and UR committee. CMS also says facilities may use a binding entity, such as a quality improvement organization or physician adviser. Under any of these scenarios, the hospital remains responsible for its UR activities, including the medical necessity of hospital admissions. ■

Effective use of patient status audits can result in valuable policy changes

Use your internal audits to inform status decisions and reduce medically unnecessary inpatient admissions. Michigan's Peer Review Organization (MPRO) conducted a focused audit of one-day-stay admissions as part of CMS's Hospital Payment Monitoring Project. Often, one-day stays within certain DRGs have high rates of claims denials.

Kristy Wietholter, RN, MS, CPHQ, MPRO's director of Medicare quality review, and her colleagues at MPRO established interventions to reduce medically unnecessary short-stay inpatient admissions for chest pain (DRG 143) at participating hospitals.

Hospitals were advised to educate physicians and patients about the differences in patient status by participating in monthly educational calls organized by MPRO on topics to address inpatient admission versus observation placement.

"Physicians have to understand that they are the drivers behind determining whether a patient is admitted to inpatient observation. But they are not incentivized to care about it," Wietholter says.

Based on its audit, MPRO also recommended that hospitals:

- Identify gaps in case management and/or utilization review coverage in the emergency department
- Work with hospitalists who make patient admissions decisions
- Install case managers during peak patient hours

"Case managers are very helpful in going back to the physician to say, 'You don't have proper criteria and documentation to support this admission. Can you look at it again or consider observation?' " Wietholter says. In the end, claims-denied admissions may justify the cost of adding case manager hours.

"Hospitals successful at reducing inappropriate admissions have used highly capable [RN] case managers to assist physicians in making status determinations," says **Suzanne K. Powell, BSN, RN, MBA, CPHQ, CCM,** of Florida's Quality Improvement Organization.

Strengthening a hospital's operational system as indicated by the results of an audit can help determine proper patient status. MPRO suggested the patient admitting order be placed on the same documentation as the clinical pathways to prevent missing physician orders.

Without proper documentation to support patient status, claims are denied. Wietholter says the use of this integrated form, a minor administrative change in the way the hospital does its business, can potentially lower rates of claims denials.

"The statement that the patient needs to be admitted as an inpatient is smack-dab in the middle of the clinical pathways protocol—preprocedure," she says.

Wietholter and her colleagues also reminded physicians and case managers of their obligation to inform patients of their status determination, especially in hospital settings, where beds, nurses, and treatments may all seem the same regardless of a patient's status.

This way, the patient can understand any effect the determination has on his or her medical coverage or out-of-pocket expenses, the results of which often affect the physician-patient and hospital-patient relationships.

Talk about Medicare's postacute transfer policy

Only 10 DRGs were included when Medicare implemented its postacute transfer policy in October 1998. In 10 years, that grew to include 273 DRGs. Such rapid evolution challenges the hospitals the policy affects.

The postacute transfer policy states that when an inpatient prospective payment system (IPPS) hospital transfers an acute care patient to another facility, such as a skilled nursing facility (SNF), the transferring hospital must take a per diem amount for the services rendered instead of receiving the full DRG payment. The receiving institution then bills for the full DRG payment.

With so many DRGs, this policy is easier said than done, says **Julie Chicoine,** compliance director at the Ohio State University Medical Center in Columbus. "CMS has made this rule more complicated through revisions over the past couple of years," she says, adding that the volume of DRGs "creates an operational challenge for hospitals to monitor and follow." The policy was put in place so the facilities performing the most services receive the full DRG payment, she says.

Another challenge to implementing the policy is when an IPPS hospital transfers a patient to another facility. If the hospital does not know what level of care the patient will receive, it doesn't know what discharge disposition to use, says **Barbara Rodenbaugh, RHIT, CCS,** regional vice president of operations in the inpatient/outpatient division of Laguna Medical Systems in San Clemente, CA.

"For example, I may be a Medicare patient going to a SNF, but the care is going to be hospice," she says. "At the hospital level, they never know that. So they document that I was discharged to a SNF."

Medicare's postacute transfer policy is an item on the OIG's 2008 *Work Plan*. However, there are steps hospitals can take to remain compliant and off the OIG's radar.

Keep talking

Communication between staff members in billing and coding and case management/utilization review (CM/UR) helps ensure that everyone understands their particular roles and responsibilities and how they interact between departments, Rodenbaugh says.

It is important for CM/UR staff members to know why the billing and coding teams need the information they do, and vice versa. Rodenbaugh suggests holding monthly meetings for a while to open up the lines of communication. Then, for example, when case managers don't understand what information is needed in a certain scenario, they can call medical records and ask.

Modify interfacility document

Many hospitals use an interfacility transfer document that accompanies a patient through his or her transfer. Rodenbaugh suggests modifying the document by adding an extra line for a case manager or similar staff member to record the type of care the patient should receive after the transfer. "This would help the coding staff to assign the appropriate patient status code," Rodenbaugh says.

Keep in touch

It is not unusual for a patient to go home instead of to the planned transfer location due to last minute changes, Chicoine says. Without follow-up, the facility could erroneously document a transfer when it should have documented a discharge. A hospital discharge planner or case manager should follow up with the local referral facilities within one week to make sure the transfer took place, Chicoine says.

"Some hospitals have a callback system. The accepting facility contacts the hospital if the patient says they were just discharged from the hospital," she adds. "Hospitals can also contact the patient or his or her family after discharge to ensure that the transfer or discharge went smoothly."

"Like any policy from CMS, you have to understand it, you have to apply it to your organization, and you have to stay on top of it," says **Lena Robins,** partner at Foley & Lardner, LLP, in Washington, DC. ■