



## *Hospital Peer Review*

**April 2010**

*Hospital Peer Review is a monthly newsletter sponsored by the Rural Healthcare Quality Network to alert Critical Access Hospitals regarding findings from the Peer Review Program. Summarized are a few of the key findings and best practices that would be helpful for other critical access hospitals to be knowledgeable about. This newsletter is edited by Myron Bloom, Medical Director and he can be reached at [drmbloom@msn.com](mailto:drmbloom@msn.com).*

### **Preserve and Improve Hospital Value by Utilization Review and (Case) Management**

Hospital and medical staff members often use the phrases "utilization review" and "utilization management" as interchangeable; however, understanding the nuances helps clarify the meaning. Utilization review by definition is backward looking - considering whether the care was appropriately applied after the healthcare services have concluded and therefore after the fact, not adding to the value of the care that was provided and carrying a pejorative connotation. With the proper execution of pre-admission and concurrent review of individual cases, utilization review has morphed into utilization management. Utilization management is a proactive process of ongoing evaluation of the medical necessity, appropriateness, effectiveness, and efficiency of the healthcare services thereby maximizing value benefiting the patient, the doctor, the hospital, and the payer.

The proper application of retroactive utilization review and proactive case utilization management has become critical to the financial survival of healthcare providers and the Medicare and Medicaid programs, which are being restructured as insurance programs and not the social and healthcare safety net of the past. Unfortunately, the details of the "contract" between those "entitlement" programs, the beneficiaries (patients), and providers have not been clearly presented or well understood; leading to non-covered services being billed and thereby contributing to the depletion of the "trust fund" financial reserves. Moreover, having failed to educate their patient customers, they now have conscripted the providers (doctors and hospitals) to present the painful details of the hospital bill.

Rural practitioners have been particularly vulnerable to the non-covered needs of their patients given the limited alternative healthcare and social resources available to their patients with whom they may have had years of a physician-patient relationship. In the past, there has been little adverse consequence for physicians or hospitals when "admission" decisions have conflicted with the interpretation of the rather vague and ever changing Medicare/Medicaid regulations for services that should have been presented to the patient as not being a "covered service." *No longer!*

Now, along come revenue recovery programs [with eponyms like PEPP, MAC, and RAC for (revenue) recovery audit contractors], which are trolling through closed hospital records of Medicaid and Medicare payments to healthcare providers [which, this year, will include physician E & M billings]. Similarly, data mining techniques are already being employed by the major commercial medical insurers to identify, deny, or recover medical claim payments; and they will have to escalate their efforts as the cost shifting from public to private programs increases. Thus, the intensity of the scrutiny will only amplify in the future for both inpatient and outpatient services.

Utilization review has been a regulatory requirement since the inception of Medicare during the Johnson presidency, entered into the Federal Register as 42CFR482.30(c)(1): “Standard: Scope and Frequency of Review.” The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of (i) Admissions to the institution; (ii) The duration of stays; and (iii) Professional services furnished, including drugs and biologicals.” This concept of utilization review was supported by physicians and the American Medical Association.

The emerging concept of utilization review has one compelling justification—it is the way in which doctors, working together and accountable to each other, can assure that each patient in medical need will have fair access to and an optimum use of scarce and expensive facilities. In implementing the new law, the Social Security Administration will do everything possible to accommodate and encourage existing practices—however variable they may be—so long as they give promise, under professional direction, of assuring quality care to patients through sound utilization of hospital facilities and services.

*Source: JAMA. 1966; 196(11):995-998.*

Utilization review has also been required since the inception of Critical Access Hospitals as stated in the State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (Rev. 05-21-04) under §485.641 stating “The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed” and “the CAH must have an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes.”

Medicare is required by law to pay claims to health care providers for services provided to beneficiaries within 30 days after the claim is submitted, as long as the claim meets Medicare’s rules. After the claim is paid, CMS, or its contractors, can review the claim to ensure that the items or services were medically necessary. If the claim was not submitted according to the rules, they check to see if the claim was submitted in error or may be potentially fraudulent. Those claims that could be fraudulent are referred to law enforcement (the Office of the Inspector General, OIG) for further investigation. Thus, these rules are in fact doctors’ business as well as the hospitals’.

The Tax Relief and Health Care Act of 2006 made the RAC Program permanent and required the Secretary to expand the program to all 50 states by this year. On February 4, 2009, the Recovery Audit Contractor (RAC) contracts were finalized (we are in Region D: HealthDataInsights, Inc.). The contractors will eventually be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, physician, and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi) as well as physician–hospital billing matches.

Therefore, an effective UR/UM process with concurrent review by trained case managers and educated physician advisers supported by the administrative leadership; health information management; and patient financial services and with the cooperation of the attending physicians is obligatory. It is necessary to optimize actual patient care delivery as well as to help prevent inappropriate billings for unsupported inpatient admissions or other services that should have (unfortunately perhaps not always could have) been provided in an alternative healthcare setting, or at least presented as being the patient's financial responsibility - a matter of who pays the bill, and not a deprivation of services.

The UR/UM case managers and physician advisers must be personally invested in the process and knowledgeable regarding medical standards of care, efficiency and decision support programs (Milliman, InterQual, Compliance 360, etc.), day-to-day UR issues, and the evolving federal regulations. Points of particular hospital RAC financial vulnerability are the initial admission "intent" status, stays of one day or less, the third day of inpatient stay as potentially incurring a Medicare/Medicaid skilled nursing home stay, and independently each and every day of an inpatient stay.

While the "admission intent" decision belongs to the attending physician, who considers factors like the severity of the patient's signs and symptoms, the therapies to be provided, and the predictability of something adverse happening to the patient, the story and treatment plan must be adequately presented in the chart to support the decisions made upon review from an indifferent, if not adverse, revenue recovery auditor.

Many doctors do not know that the coding is based on the "Principal Diagnosis" which is defined as the condition chiefly responsible for admission to the hospital and not necessarily the most serious or important of the patient's problems. However, the other medical conditions should also be accurately documented to adjust the "case mix index" and thereby, help to explain any deviations from the statistically expected clinical outcomes or costs when the data is mined. Documentation drives coding and payment. The documentation must be accurate, complete but concise, recording the co-morbidities and complications and mentioning the risk characteristics that affect clinical decision making.

Physicians need to understand that documentation serves multiple masters and is no longer just for their purposes. It is necessary to communicate the condition of the patient and treatment plan, support the coding necessary for billing, and to explain and defend any unexpected outcomes. Specifically, two issues must be addressed:

- 1) the "Severity of Illness" or why this patient is sick enough to require admission to the hospital, and
- 2) the "Intensity of Service" required to properly care for this patient on a day by day basis.

Daily documentation about the condition of the patient and the treatment plan must continue to support the current placement status of the patient, with a timely transfer to an alternate level of care intensity (and cost) as conditions change. For example, when a patient has been in observation status for 24 hours, documentation in the progress notes must include either: 1) a statement of need to continue observation status with a plan for discharge within the next 12 to 24 hours, 2) need to convert to inpatient status, documenting the medical necessity for admission, or 3) medical stability for discharge and follow-up plan as needed.

Progress notes need to cover:

- the patient's response to care given,
- the status of unresolved problems,
- abnormal lab/imaging/testing results with comment (not simply "K↓"),
- proposed adjustments in the plan of treatment, as well as,
- an explanation of any contradictory observations made by other caregivers or untoward or unexpected events.

Following each patient admission, case managers determine whether Medicare (or other third party payers) would consider the admission medically necessary, according to the patient's severity of illness and intensity of service, using accepted screening criteria. This is a billing reimbursement function. The case managers may also compare the treatment plan to preprinted order sets or protocols/care maps that have been accepted by the medical staff to find unintended (or unexplained) variances. Meeting with the healthcare team (nurses, therapists, discharge planners, social workers, etc.) to coordinate the care, the case managers follow the clinical progress and periodically communicate with the physician to discuss the patient in an effort to make the care more efficient, as well as, to ensure proper continued reimbursement.

Occasionally, the medical record may not adequately support (continued) inpatient status and the physician may have additional information that has not yet, or not thoroughly, been recorded in the patient's chart. When that happens, the case manager may make suggestions as to the pertinent information that would substantiate continued inpatient status or suggest an alternate level of care.

When an admitted patient may not meet, or fails to continue to meet, the criteria for inpatient status according to the guidelines the case manager is using and the attending physician disagrees, a review by a physician member of the Utilization Review Committee is requested to assist in reaching a correct and compliant admission medical-necessity status determination. When the attending physician and the UR physician do not agree, a review for billing/reimbursement purposes may be requested of the insurer's financial intermediaries (Qualis and Noridian for Medicare).

Effective communication between the case manager and physician is critical to the assurance of thorough charting and efficient care. The traditional mantra of utilization review has been that "discharge planning begins at admission," but effective case management also tries to identify and mitigate issues that may have contributed to the patient requiring an admission to prevent unnecessary readmissions (that most likely will not be paid for in the future).

As hospitalizations have been compressed in time and the intensity of care has accelerated, supervising the care of the patient and managing the utilization of resources has become too complex for physicians to manage alone. Thus, the case manager, assisting with the coordination of care, benefits the patient, supports the physician, and ensures the hospital will be paid, while minimizing the costs to society.

***If hospital "inpatient status" is denied for a surgery usually done as an outpatient because the surgeon ordered inpatient status without adequate documentation of an actual complication (can not simply predict that one will occur), the hospital may even be prohibited from rebilling the care as an outpatient, losing most of the revenue (for the surgery, anesthesia, recovery etc.) except for ancillary services.***