

PHYSICIAN ADVISOR SERVICES

INSIDE THIS ISSUE:

<i>CMS Provides Guidance on Hospital Inpatient Decisions</i>	1
<i>RAC FAQs - Excerpts from CMS Website</i>	2
<i>MedManagement on the Speaking Circuit</i>	2

QUICK MEDMANAGEMENT CONTACT LIST:

Joan Ragsdale, 205-970-8804
jragdale@medmanagementllc.com

Ann Purdy, 205-314-8859
apurdy@medmanagementllc.com

Pam VanEngelenhoven, 205-970-8815
pvanengelenhoven@medmanagementllc.com

Gregory Palega, MD, JD, 205-313-6648
gpalega@medmanagementllc.com

Questions? Contact us at:

MedManagement, LLC

1500 Urban Center Drive

Suite 325

Birmingham, AL 35242

205-970-8800

Visit our website at:

www.medmanagementllc.com

CMS PROVIDES GUIDANCE ON HOSPITAL INPATIENT DECISIONS

On January 21, 2011 CMS issued a special edition Medicare Learning Network (MLN) article as educational guidance for hospitals in addressing medical necessity determinations. This article is in response to concerns expressed by hospitals regarding the use of screening criteria by Recovery Audit Contractors (RACs), MACs, FIs and the Comprehensive Error Rate Testing Contractor (CERT) to determine medical necessity. The article pointed out that that “there are several commercially available screening tools that Medicare contractors in specific jurisdictions may use to assist in the review of medical documentation to determine if a hospital admission is medically necessary. These include Interqual, Milliman, and other proprietary systems.” However, CMS directs hospitals to the **Medicare Program Integrity Manual** (PIM) and the **Medicare Benefit Policy Manual** (MBPM) for medical necessity determination.

The PIM requires that contractor review staff use the following when making a medical necessity determination:

- > Admission criteria;
- > Invasive procedure criteria;
- > CMS coverage guidelines;
- > Published CMS criteria; and
- > Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community).

The PIM states “(I)n all cases, in addition to screening instruments, the reviewer shall apply his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.”

The use of screening criteria is considered by CMS as “only **one** tool that should be utilized by contractors to assist them in making an inpatient hospital claim determination.”

Chapter 6 of the PIM goes into more detail as to what the medical record should include to support that inpatient care is “medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.” Click [here](#) for the link to more guidance in the PIM Chapter 6, Section 6.5.

The MBPM gives additional guidance and defines an inpatient “as a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.” The article reiterates the guidance that physicians should use a 24-hour period benchmark, however the decision is a complex medical judgment which can

be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- > The severity of the signs and symptoms exhibited by the patient;
- > The medical predictability of something adverse happening to the patient;
- > The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- > The availability of diagnostic procedures at the time when and at the location where the patient presents.”

Click [here](#) for more guidance in Chapter 1, Section 10 of the MBPM.

The entire MLN Matters article Number SE 1037 can be accessed by clicking [here](#).

If you have questions, please contact Ann Purdy at apurdy@medmanagementllc.com.

RAC FAQs - EXCERPTS FROM CMS WEBSITE

Region A-DCS

<http://www.dcsrac.com/IssuesUnderReview.aspx>

1-866-201-0580

Region B-CGI

<http://racb.cgi.com/Issues.aspx?st=1>

1-877-316-7222

Region C-Connolly Healthcare

http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

1-866-360-2507

Region D-HDI

<https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx>

866-590-5598 (Part A)

866-376-2319 (Part B)

Link to Provider Options Chart:

<http://www.cms.gov/RAC/Downloads/ProviderOptionsChart.pdf>

What happens if the recovery auditor does not meet the 60 day requirement?

The recovery auditors have 60 days from receipt of the medical records to make a determination and issue a written notice of that determination to providers. The 60 day requirement can be found in the Statement of Work used in the Recovery Audit Program. Lack of adherence to the 60 day requirement of notification does not negate the improper payment finding or the recoupment of the improper payment by CMS. Lack of adherence to the 60 day requirement is a performance issue between CMS and the recovery audit **contractor**.

What is the difference between the RAC discussion period and the Rebuttal and Redetermination process?

The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It

also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period. You always contact the RAC for this option. The timeframe is between day 1 and 40 and will begin with receipt of the demand letter for automated review and from receipt of the review results letter for complex review. The timeframe ends on day 40. Offset will occur on day 41.

The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment action will cause financial hardship and should not take place. A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal

should not duplicate the redetermination process. You will always contact the contractor/MAC for this option. The timeframe is between day 1 and 15 from the date of the demand letter. The timeframe ends on day 15.

A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on day 41. You will contact the contractor/MAC for this option. The timeframe is between day 1 and 120 upon receipt of the demand letter. It must be submitted within 120 days of the receipt of demand letter. To prevent offset on day 41 the Redetermination must be filed within 30 day. The timeframe ends on day 120.

A helpful chart on this Q&A can be found by clicking [here](#). To view all of the RAC FAQs on the CMS website click [here](#).

MEDMANAGEMENT ON THE SPEAKING CIRCUIT

Joan C. Ragsdale, JD, CEO of MedManagement will speak at the American Health Lawyers Physicians and Physician Organizations Law Institute on February 10th and the Hospitals and Health Systems Law Institute on February 11th in Las Vegas. Joan will be speaking with Timothy P. Blanchard. Their presentation is titled, "Documentation of Medical Necessity: Avoiding Overpayments, Penalties and Fraud Allegations."

The sessions will focus on the following:

- Medical Necessity documentation standards
- Government review of Medical Necessity
- Tips for audits, investigations and appeals
- Proactive compliance program strategies

Also, on March 3, MedManagement Physician Advisor, Dr. Gregory Palega will present a webinar with Deborah Hale, CEO of ACS, LLC, on "Preparing Effective Appeals for Admission Denials" The learning objectives of the session are:

- Determine whether the

auditor's rationale for denials is consistent with regulatory guidance for inpatient admission

- Recognize evidence that will support the preparation of an effective appeal
- Describe the necessary steps in the appeal process and the hospital's responsibility associated with each step.

If you would like for a MedManagement representative to speak at your event, please contact Ann Purdy by clicking [here](#) or by calling 205-314-8859.



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