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Physician Advisory Services

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Understanding the Value of Concurrent Reviews

Physician advisors can serve as a valuable resource in assisting hospitals to ensure that medical necessity criteria is met for the patients served. Case managers act as the first level of defense. They typically use a screening tool that can help in the level of care (LOC) determinations but the decision should not stop there. The CMS criteria for inpatient vs. outpatient determinations are more subjective and use factors identified in Chapter 1 of the Medicare Benefit Policy Manual. Case managers can rely on physician advisors (PAs) to assist them in making the appropriate level of care decision supported by documentation. Attending physicians often use a "rule out" documentation style to set forth their rationale for particular treatments and/or tests. If they would initially document why the patient needs the level of service being provided the level of care determinations would be much simpler and clear cut. The intervention of a PA becomes valuable for compliance in that the facility determines the appropriate LOC while the patients are still in the hospital. For example, when a patient is admitted for inpatient care, a PA will assist by reviewing the medical record and if the documentation does not clearly state the clinical reasons for the patient to require inpatient care, the PA will attempt to discern the clinical rationale for the attending physician's orders and review all information in the record that may impact the decision. A physician to physician conversation can be instrumental in the PA getting the pertinent information documented on a concurrent basis.

The PA review supports a strong compliance plan by providing an independent, third party opinion regarding the correct level of care. The additional documentation provided by the PA can succinctly document the clinical rationale supporting the level of care.

For more information please contact Ann Purdy at 205-314-8859 or email her at apurdy@medmanagementllc.com.

If there are topics you would like to see addressed in future issues, please email your ideas to:

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Hot Issue: Policies That Can Raise Questions

In some hospitals, administrators may try to make sure they submit claims for patients in the appropriate level of care by asking their case management staff to put all patients in inpatient and sort out the correct level later. This would, supposedly, alleviate the need for case managers and physician advisors to be involved upon admission to determine the appropriate level of care. If it is determined later that the patient should be in an observation level of service a Condition Code 44 could be indicated. However, even though this sounds as if it would be a reasonable approach, a review of the CMS regulations reveals that a practice of this nature would conflict with the intented use of Condition Code 44. CMS transmittal 1803 repeats language that has appeared in previous transmittals stating that "CMS set the policy for use of Condition Code 44 to address those relatively infrequent occasions, such as late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances." It can be deducted from this transmittal that use of Condition Code 44 should be an exception rather than the norm and the repeated use of Condition Code 44 could raise questions regarding the effectiveness of the hospital's utilization management policies. Therefore, it is recommended that efforts be made to place patients in the appropriate level of care as close to the time that services are begun as possible. Transmittal 1803 goes on to state that "use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report Condition Code 44 should become increasingly rare."

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Region A-DCS
http://www.dcsrac.com/issues.html
Region B-CGI
http://racb.cgi.com/Issues.aspx?st=1
Region C-Connolly Healthcare
http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx
Region D-HCI
https://racinfo.healthdatainsights.com/Public/NewIssues.aspx

To access the other RAC FAQs on the CMS website visit : http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_pv=4.497

RAC UPDATE - DECEMBER AND JANUARY BUSY MONTHS FOR RACS

CMS has approved for complex review of Medicare claims by RACs. New issues were steadily posted by the RACs during the months of December and January, bringing the combined total of approved issues to 233, with the breakdown as follows:

Region A: 14 issues
Region B: 48 issues
Region C: 77 issues
Region D: 94 issues

While the majority of the issues focus on MS-DRG coding and DRG validation rather than medical necessity, it is important to note that medical necessity may be reviewed in the future as part of the DRG analysis. The description of the review cited by Connolly on almost every DRG validation issue currently is as follows: "DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS-DRG [XXX], previously DRG [XXX], principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG."

Also of note this month, issues have been posted by HDI for review of underpayment. They are the first contractor to post such issues, although the statement of work for the RACs includes this type of review as part of their contract with CMS.

With the abundance of new developments occurring each week, it is advised that facilities continue to monitor the regional RAC websites, where a comprehensive listing of issues and descriptions can be accessed. Links to the sites are provided on the left of this page.

If you have questions, please contact Ann Purdy at 205-314-8859 or apurdy@medmanagementllc.com.

RAC FAQS - EXCERPTS FROM CMS WEBSITE

Will providers be required to submit a UB-92 with medical records to the Recovery Audit Contractors? The decision to request a UB-92 will be up to the individual RAC. If this information is needed it will be notated on the medical record request letter.

If I receive a demand letter from a Recovery Audit Contractor because a service didn't meet Medicare's medical necessity criteria for an inpatient level of service, can we re-bill all the services on an outpatient claim? Providers can re-bill for Inpatient Part B services, also know as ancillary services, but only for the services on the list in the Benefit Policy Manual. That list can be found in Ch. 6, Section 10: http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf. Rebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the national program. The time limit for re-billing claims is 15-27 months from the date of service. These normal timely filing rules can be found in the Claims Processing Manual, Chapter 1, Section 70: http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

Will the timing of appeals by the Medicare contractors be the same for the Recovery Audit Contractors? Yes. The timeframe for filing an appeal remains the same.

If a provider repays or Medicare recoups an alleged overpayment identified by the Recovery Audit Contractors and the provider later wins an appeal, will CMS reimburse the provider with interest? At certain times, CMS is required to pay interest when an appeal decision is favorable to the provider. The payment of interest in response to a favorable provider appeal decision is determined by CMS' interpretations of the appeal regulations. These regulations determine the process for all overpayments, not just RAC identified overpayments.