



RESOURCE GUIDE TO CASE MANAGEMENT

Optum Executive Health Resources



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Questions to evaluate your admissions program



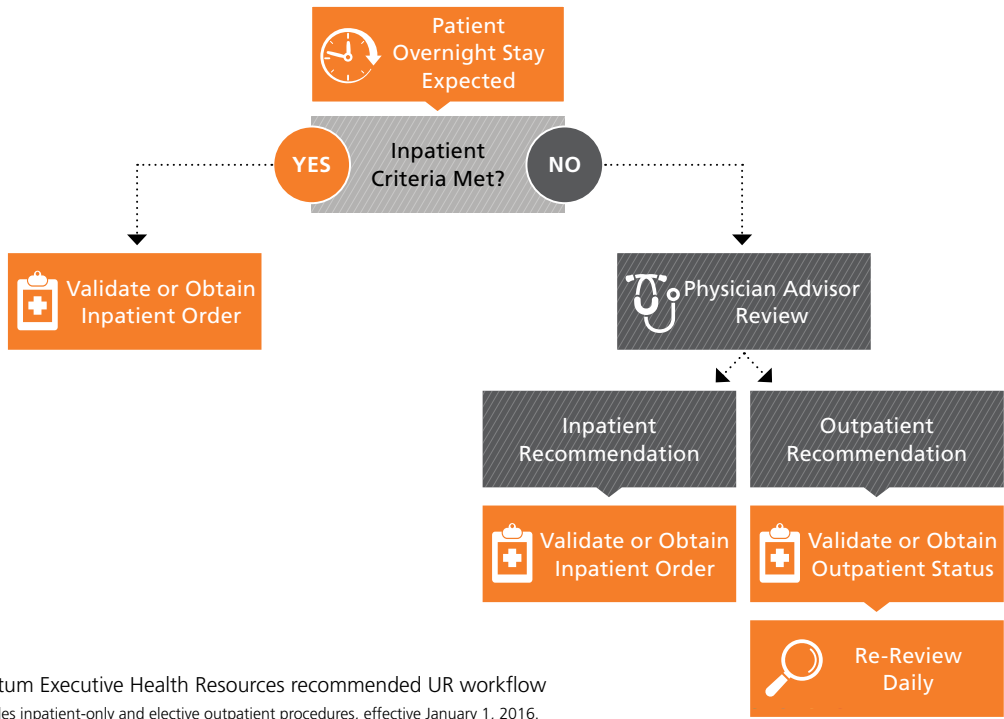
The following questions assist in evaluating current medical necessity admission review programs and provide a checklist for ongoing evaluation of program effectiveness.

1. Does the utilization review (UR) plan reflect a consistent process that is compliant with the UR standards as outlined in the Medicare Conditions of Participation (CoPs)?
2. Does case/utilization management follow a process of strict application of inpatient screening criteria for all Medicare beneficiaries as directed by the Hospital Payment Monitoring Program (HPMP) Compliance Workbook to ensure a two-level medical necessity admission review process?
3. Are expert Physician Advisor reviews completed for all Medicare cases that do not meet first-level UR screening criteria for an inpatient admission?
4. Is case/utilization management using the most updated version of inpatient UR screening criteria?

Questions to evaluate your admissions program [continued]

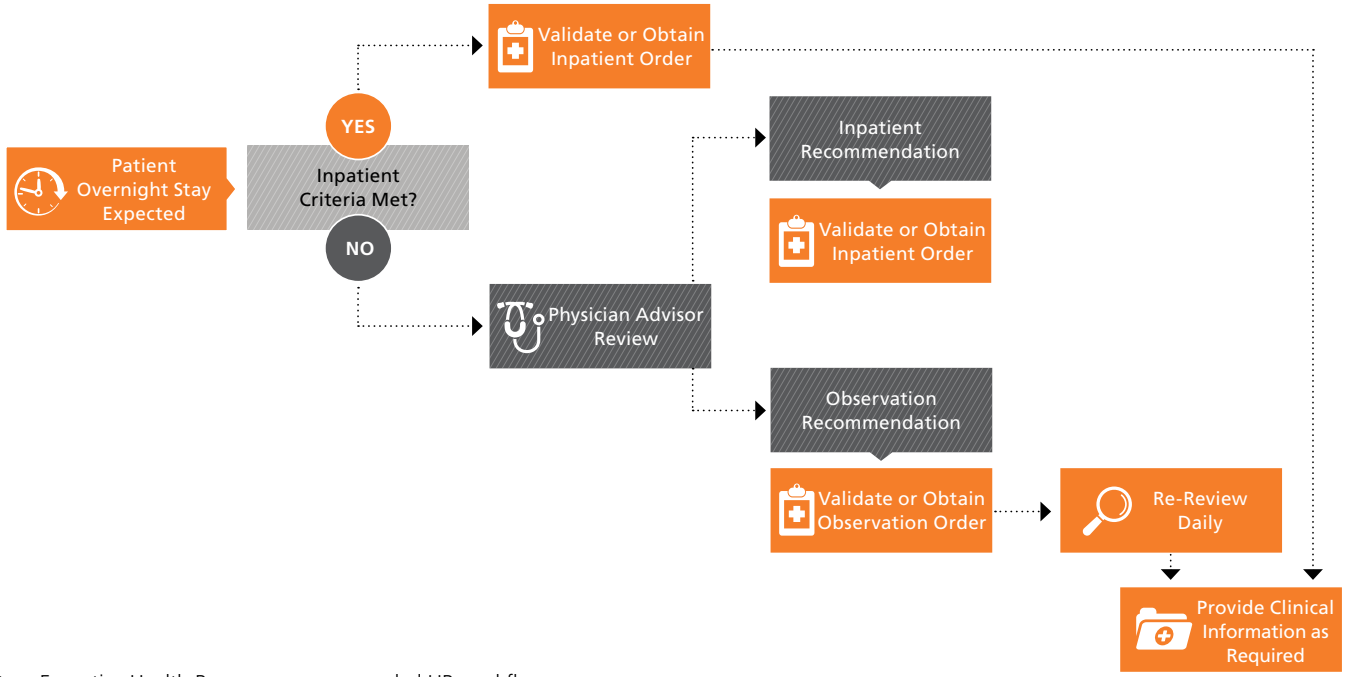
5. Is the medical necessity admission review process in effect 7 days per week, 365 days per year?
6. Is there ongoing training and education available for case/utilization management and Physician Advisor teams?
7. Is there inter-rater reliability testing and quality assurance of case/utilization management?
8. Do the Physician Advisors remain up-to-date on ongoing regulatory guidance changes and the latest evidence-based care guidelines?
9. Is there inter-rater reliability testing and quality assurance of Physician Advisor teams?
10. Are there processes in place to ensure ongoing communication between case management, Physician Advisors and treating physicians?
11. Does the UR process ensure the creation of an enduring and auditable document for each Medicare case that provides permanent evidence of your UR process?
12. Are the treating physicians at the hospital educated regularly on the importance of complete documentation, the need to work closely with case/utilization management and Physician Advisors, and the role they play in ensuring both hospital and physician regulatory compliance?
13. Is a regular analysis of the hospital's Probe and Educate outcomes, PEPPER and other benchmarking data completed to look critically at observation rates to identify areas that may require more attention to meet medical necessity admission criteria?
14. Is there a process to ensure that the treating physician order is concordant with the admission status determination?
15. Is there a process to ensure that the treating physician, hospital and beneficiary are aware of final claim status before patient discharge?

Medicare/Medicaid concurrent admission review workflow*



*Optum Executive Health Resources recommended UR workflow
Excludes inpatient-only and elective outpatient procedures, effective January 1, 2016.

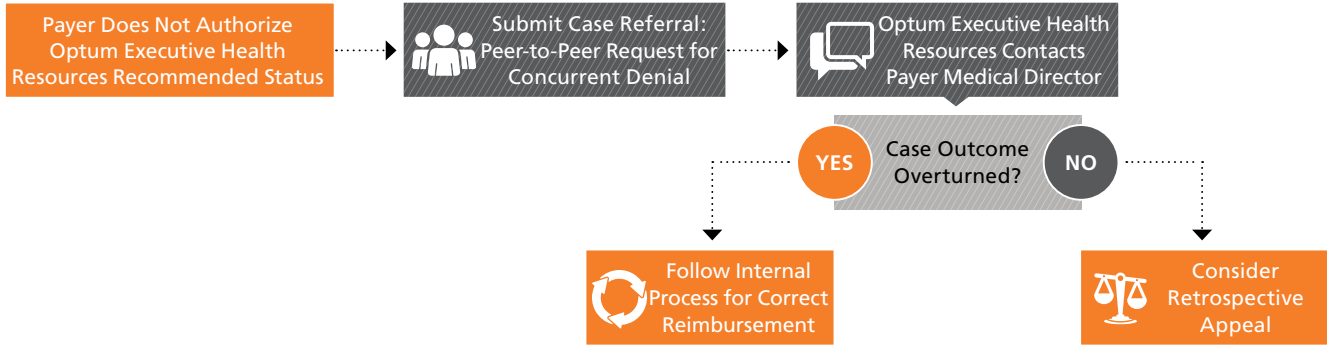
Commercial/Managed Care concurrent admission review workflow*



*Optum Executive Health Resources recommended UR workflow

Commercial/Managed Care Concurrent Denial Workflow

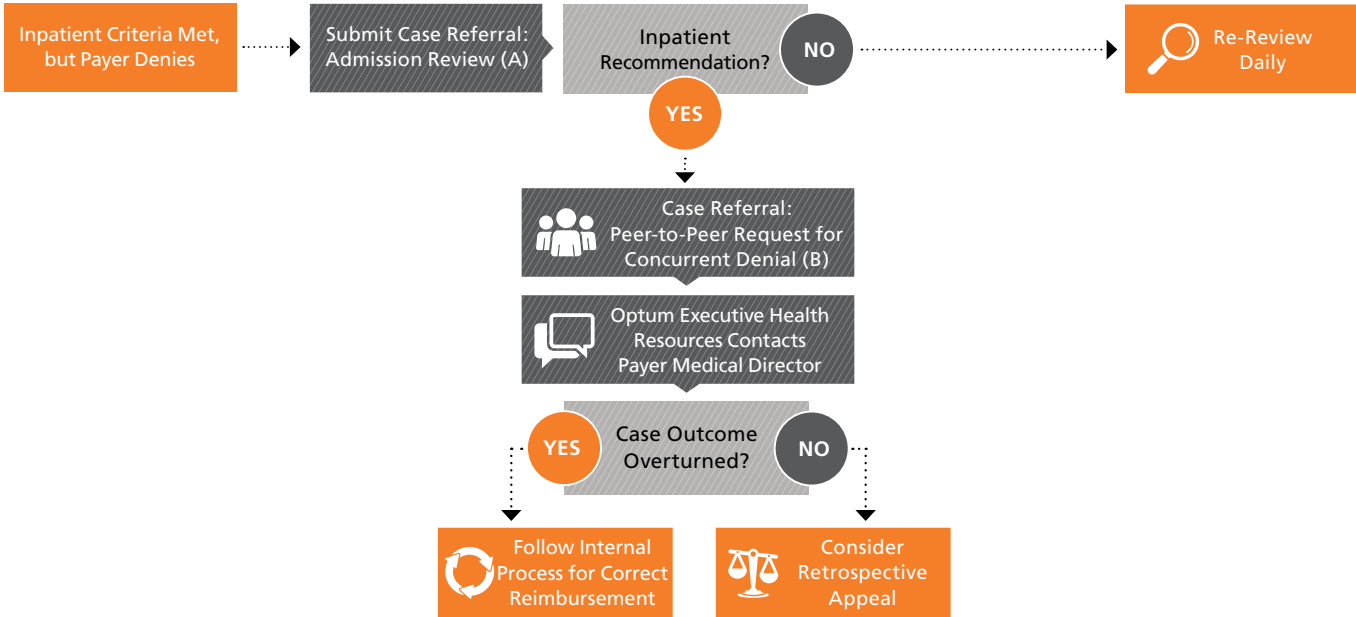
(when Optum Executive Health Resources has completed a second-level review)*



*Optum Executive Health Resources recommended UR workflow

Commercial/Managed Care Concurrent Denial Workflow

(when Optum Executive Health Resources has NOT completed a second-level review)*



*Optum Executive Health Resources recommended UR workflow

Consider these questions as you review your processes against your UR plan



If your UR plan requires that you apply an evidence-based methodology to second-level reviews or a certain criteria set to every first-level review, how many cases did not undergo this review?



How long has it been since your team underwent training on the UR plan? How frequently does the plan require training to occur?



Do your results show that you're meeting all timelines or deadlines?



Are you fully complying with requirements that reflect the Conditions of Participation?



Is your team meeting the performance metrics outlined within the UR plan?

Short inpatient hospital stays

As highlighted in the 2016 Outpatient Prospective Payment System (OPPS) final rule, physician judgment is key to determining inpatient status, supported by documentation in the medical record.

PREVIOUS GUIDANCE

“When a beneficiary enters a hospital for a surgical procedure not specified as inpatient only under § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for only a limited period of time that does not cross 2 midnights, the services would be generally inappropriate for payment under Medicare Part A.”

– 80 FR 39349

CURRENT GUIDANCE

“For stays for which the physician expects the patient to need less than 2 midnights of hospital care and the procedure is not on the inpatient only list or on the national exception list, an inpatient admission **would be payable on a case-by-case basis** under Medicare Part A in those circumstances under which the **physician determines that an inpatient stay is warranted and the documentation in the medical record supports that an inpatient admission is necessary.**”

– 80 FR 70541

Audit risks



WHAT CASES HAVE THE HIGHEST AUDIT RISK?

- **New QIO review process**
- **MAC-targeted Probe & Educate**

WHERE DO YOU BELIEVE THE AUDITS WILL BE?

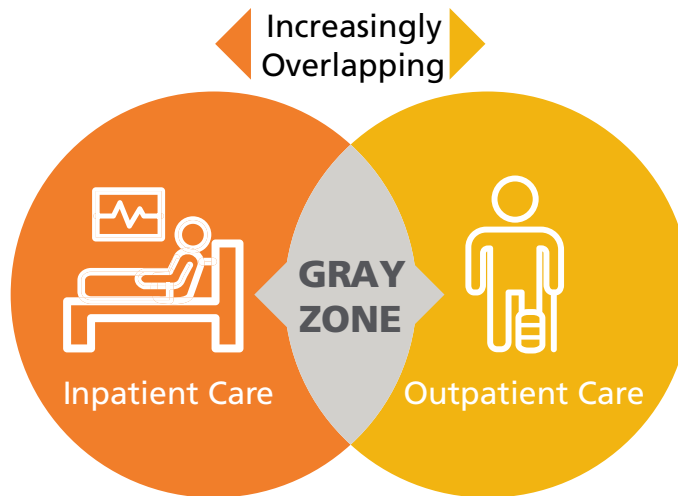
- **Inpatient with length of stay < 2 midnights**
 - Many hospitals use Post-Discharge Review to evaluate cases for self-audit
 - Exceptions and reasonable expectation of 2-MN stay
- **Inpatient with length of stay 2-3 days**
 - Custodial, delay and convenience (CDC)
 - Medically necessary hospital services
 - Signed IP orders

"Gray" or uncertain medical necessity

Cases that may be appropriate for inpatient setting

(screening required):

- Acute MI
- Coronary artery bypass graft
- Open appendectomy
- Acute intracranial bleed
- Valve transplant
- Respiratory failure



Cases that may be appropriate for outpatient/OBS setting

(screening required):

- Scheduled transfusion
- Injection/chemotherapy
- Lymph node biopsy
- Inner ear infection
- Dilation and curettage

"Gray" area — Cases that require individual assessment due to unclear medical necessity

REVENUE/COMPLIANCE RISK:

- Chest pain • Anemia • Dehydration • Syncope • Back pain • Cardiac stent, PTCA, ICDs, etc.
- Mastectomy • Prostatectomy • Laparoscopic appendectomy

Leveraging your PEPPER

The Program for Evaluating Payment Patterns Electronic Report (more commonly known as PEPPER) is a quarterly review of select hospital billing data, which compares each hospital to other hospitals in the same state, the same Medicare Administrative Contractor (MAC) multi-state jurisdiction, and in the entire nation.

CMS chooses the categories in the PEPPER, based on historical errors by hospitals and denials by auditors. These categories are CMS' view of the areas where payments to hospitals are most at-risk for an incorrect bill. Currently, there are 26 of these target areas on the PEPPER report.

If 80 percent or more of other hospitals have a lower coding or medical necessity intensity in a target area, your hospital is defined by CMS as being a "high outlier." These are areas where CMS expects your hospital to review some or all of the cases you've billed to Medicare to make sure that the documentation supports the diagnosis or that the beneficiary met medical necessity criteria for an inpatient admission or for a surgical procedure, such as spinal fusion.

The data in the PEPPER is your own hospital's billing data, along with the billing data from all other hospitals in the nation. Therefore, Medicare auditors, such as the MACs, have this data. A high outlier status could indicate an additional risk for audit and denial.

Ten of the PEPPER categories are focused on coding and documentation, and these DRG validation categories also include a "low outlier" status if your hospital is below the 20th percentile in comparison to other hospitals. This could indicate an area for improvement or opportunity in your physician documentation, which could also have implications in other measurement areas, such as your hospital's Case Mix Index (CMI).

The best practice is to read your PEPPER each quarter and internally review a sample of cases from each area in which your hospital is an outlier. The PEPPER is delivered in a spreadsheet format, which can be very challenging to summarize, and difficult to put together a plan of internal review, to capture the correct cases. Optum Executive Health Resources can provide a complimentary review of your PEPPER with actionable summaries at your request. For more information, contact your Account Manager.

A best-practice approach towards utilization review



DENIAL PREVENTION

- Develop and operate a proactive, consistent, accurate utilization management process.
- Use Physician Advisors to perform concurrent peer-to-peer appeals to reduce retrospective denials.
- Perform routine and continuing documentation, education and training.



COMPLETE DOCUMENTATION

- Clearly articulate clinician concerns.
- Clearly articulate why inpatient care is reasonably anticipated.



DENIAL MANAGEMENT

- Ensure that Case Management and the business office understand key contractual elements for payers.
- Hold health plans accountable by exercising all appeal rights.
- Simplify denial management process when possible.
- Have physicians contribute to and/or write appeal letters for complex and difficult cases.
- Create Joint Operating Committee (includes care management, revenue cycle management and payer relations), meeting regularly to mitigate denials management issues.



TRADITIONAL MEDICARE APPEALS

- Prepare all appeals as if presenting to the Administrative Law Judge (ALJ).
- Address clinical, compliance and regulatory issues.

Document every inpatient admission as if it were a short, less than two-midnight stay

- “We will allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark, ***if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care***” (80 FR 70545) (emphasis added).
- Each inpatient admission, regardless of the length of stay expectation, should have a documented clinical rationale to succinctly explain why the patient requires inpatient hospital care.
- Post January 1, 2016, a claim should no longer be denied solely on the basis that the documentation did not support a reasonable expectation of a hospital stay lasting greater than two midnights.
- Per regulation, claims review should now be two-pronged: (1) Was the patient admitted based on reasonable expectation that he or she would spend at least two midnights in the hospital receiving medically necessary services?; and (2) If the expectation was not reasonable, or documented, does the medical record support the admitting physician’s determination that the patient required inpatient hospital care (based on traditional medical necessity factors outlined in 42 CFR 412.3(d)(3)?
- Each inpatient hospital claim pulled by the QIO for review should undergo a complete medical necessity review and, consistent with existing guidance, the coverage decision should not be based solely on the basis of the expected or actual length of stay.

Maximizing the expertise of your Physician Advisor

The physician advisor in a facility can wear many hats. It is critical to not only know the vast expertise of the physician advisor, but to ensure that role is leveraged to the benefit of your hospital.



Developing your processes



Case managers should have a fundamental knowledge of the messages mandated by the Centers for Medicare and Medicaid in order to develop a clear process for delivery and audit compliance, including:

- **Hospital issued Notice of Non-Coverage (HINN)** – issued to Medicare and Medicare Advantage patients at any time before or during the stay when care may not be covered due to the patient being in the wrong setting, determined to be not medically necessary, or is for patient convenience
- **Advanced Beneficiary Notices (ABN)** – notice to indicate services may not be covered, typically under party B for physician, outpatient Hospitals, labs, supplies, or hospice
- **Important Message from Medicare (IM)** – admission and discharge notices
- **Medicare Outpatient Observation Notice (MOON)** – notice to outpatients receiving observation services and are not inpatients of a hospital or critical access hospital

The content listed above, as well as other important information for case managers can be found under “Beneficiary Notices Initiative (BNI)” at www.cms.gov/Medicare/Medicare-General-Information/BNI/.

Resources at a glance

Centers for Medicare & Medicaid Services

Inpatient Hospital Reviews: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>

Targeted Probe and Educate: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html>

Medicare Fee for Service Recovery Audit Program: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/index.html>

Regulations and Guidance: <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html>

Medicare: <https://www.cms.gov/Medicare/Medicare.html>

Readmissions Reduction Program: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>

Medicare Learning Network: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo>

Office of Inspector General (OIG)

OIG Work Plan: <https://oig.hhs.gov/reports-and-publications/workplan/>

Quality Improvement Organizations (QIOs)

KEPRO BFCC-QIO: <https://www.keproqio.com/>

Livanta BFCC-QIO: <http://www.livanta.com/bfccqio.html>

Resources at a glance [continued]

Recovery Audit Contractors (RACs)

Performant Recovery (Region 1): <https://performantrac.com/audit-regions/region-1/>

Cotiviti (Regions 2/3): <http://www.cotiviti.com/healthcare/who-we-serve/cms-approved-issues>

HMS (Region 4): <https://racinfo.hms.com/Public1/NewIssues.aspx>

Performant Recovery (Region 5): <https://performantrac.com/audit-regions/region-5/>

Medicare Administrative Contractors (MACs)

Cahaba GBA: <https://www.cahabagba.com/part-a/>

CGS: <http://www.cgsmedicare.com/parta/index.html#>

FCSO: <http://medicare.fcso.com/>

National Government Services: <http://www.ngsmedicare.com>

Noridian Healthcare Solutions: <https://med.noridianmedicare.com/>

Novitas: <http://www.novitas-solutions.com>

Palmetto GBA: <http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home>

WPS Government Health Administrators: <https://www.wpsgha.com>

Optum Executive Health Resources

Compliance Library: <http://www.EHRComplianceLibrary.com> (free registration for access)

Optum: <http://optum.com>

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For more information or to join the EHR Learning Network, email us at EHRLN@optum.com or contact your Account Manager.

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- Obtain continuing education credits through member-only educational sessions
- Interact with colleagues through industry blogs and an ELN community forum.
- Membership is free

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For more information, contact your Account Manager

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