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Balancing act
Can hospital CFOs square their medical necessity risks with revenue goals? Here's how.

Deloitte Center for Regulatory Strategies

There's a lot of push-and-pull these days between hospitals and federal regulators regarding what's medically necessary — and therefore, what's reimbursable by Medicare. As hospital CFOs know, this is no minor issue. A considerable amount of capital can be tied up in Medicare reimbursements at any given moment. Moreover, Medicare is denying reimbursements at a higher rate than in years past.[1] In 2012, 38 percent of Medicare Recovery Audit Contractor (RACs) medical record requests were denied compared to 29 percent in 2010.[2] Government auditors are reviewing claims for potential overpayments and expensive appeals often end up going nowhere. Risks for medical necessity denials are often focused on common diagnoses (see Figure 1).

Figure 1. Top five medical necessity denials by Diagnosis-related group (DRG)[3]

DRG	DRG Description
247	PERC CARDIOVASC PROC W DRUGELUTING STENT WO MCC
312	SYNCOPE & COLLAPSE
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC
313	CHEST PAIN
491	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC

Note: As reported by participating hospitals in the AHA Quarterly RACTrac survey. Based upon the percent of hospitals identifying each DRG by top dollar impact for medical necessity denials.

With medical necessity, particularly for short-stay admissions under scrutiny by Medicare, hospitals are not only attempting to better understand and anticipate what Medicare is likely to reimburse, they're also trying to pick the right focus areas when it comes to appealing Medicare denials. While Medicare and its cost savings and quality focus are the main drivers of this issue, Medicaid and other payers are beginning to follow suit. For many hospitals, that translates into an effort to better understand what criteria are being applied to place patients as inpatients or outpatients and when those criteria are actually being applied — all the while seeking to deliver the highest standard of care. Although the balancing act between quality of care and management of costs is not a new challenge for hospitals, the issue of medical necessity has raised the stakes for getting it right. The risks from denials by RACs are growing:

- Over 1 million medical records were requested for review in the 1st quarter of 2013, 40 percent more than the fourth quarter of 2012.[4]
- 38 percent of medical record requests were denied in 2012, up from 32 percent in 2011.[5]
- Total denials grew by 167 percent from 2011-2012.[6]
- The average dollar value of complex denials was over $5,400 per medical record.[7]

If CFOs want to reduce revenue losses and compliance challenges associated with medical necessity missteps, they should start getting answers to tougher questions covering a range of issues. In this article, we've outlined five core areas where CFOs should consider focusing on compliance and revenue protection. In each area, we've also included for consideration some of the tough questions they and their teams should be answering.

Getting it right

How Medicare defines "medical necessity" leaves a lot of room for interpretation — and misinterpretation. What a physician might determine as "reasonable and necessary" in their diagnosis and treatment of a patient may be vastly different than what a government regulator or auditor may have in mind.

One common example is a patient who presents with chest pain, a symptom. These patients are now considered by the Centers for Medicare & Medicaid Services (CMS) to be appropriate for observation level of care (and are no longer appropriate for inpatient level of care or reimbursement). This is because CMS views a "work up" to rule out a myocardial infarction (MI), as an outpatient work up. However, if the patient is being treated for the diagnosis of Acute Coronary Syndrome (ACS), even though the cardiac enzymes have not come back positive, and the physician documentation in the medical record supports this, an inpatient level of care may very well be

[1] American Hospital Association, "AHA RACTrac Quarterly Survey", results from 2010-2012 4th Quarterly surveys.
[2] American Hospital Association, "AHA RACTrac Quarterly Survey", results from 2010-2012 4th Quarterly surveys.
[3] American Hospital Association, "AHA RACTrac Quarterly Survey, 2013 1st Quarter", June 2013.
[4] American Hospital Association, "AHA RACTrac Quarterly Survey, 2013 1st Quarter", June 2013.
[5] American Hospital Association, "AHA RACTrac Quarterly Survey", results from 2011-2012 4th Quarterly surveys.
[6] American Hospital Association, "AHA RACTrac Quarterly Survey", results from 2011-2012 4th Quarterly surveys.
[7] American Hospital Association, "AHA RACTrac Quarterly Survey, 2013 1st Quarter", June 2013.

appropriate. Under some circumstances, and with good documentation, a patient who is a "rule out MI" but is treated with IV drips (as if the patient had an MI), would be appropriate as an inpatient. Often, patients with significant cardiac histories are placed on IV drips, even though they have not been ruled in for an MI.

Every day, hospital employees and executives are dealing with this changing reality. They're not only making critical decisions regarding the appropriate level of care for patients, they now also have to keep one eye on the impact to the bottom line. Any misstep in patient status or procedure codes could mean lower reimbursements or denial of claims.

Reality for CFOs is that they may have to live with a certain amount of uncertainty in the near future. However, some are beginning to implement new and effective ways to improve compliance and reduce denials of claims — while still providing the same level of patient care. This will likely require operational changes, additional investment, and shifting tactics.

Redefine the role of case managers

With patients coming into hospitals from many different points of entry, many hospitals may need a better process to review patient admissions. Case managers should be at the center of this process, and they should be responsible for recommending a patient's level of care quickly, using input from care providers.

Considerations for case management

- What kind of controls, if any, does a case management (CM) department have in place, and are they effective?
- How is the CM department staffed, and does it have a leadership role in the organization?
- What clinical guidelines have been implemented to support placement into the appropriate patient status/level of care?
- How are we managing the throughput of emergency department (ED) patients from triage through discharge/admission and review processes? Is this hindering the flow of patients and constraining capacity?
- Do we have dedicated case management resources to help determine the appropriate patient status? What type of model do we have for CM?
- What changes have we made to address the census changes in the ED?
- Are physician advisors providing sufficient support?

> "Case management at time of admission is integral because it's the reality of the patient admission process. It's important from a compliance/regulatory perspective as well as denial avoidance. Our view is patients are assessed into appropriate level of care at time of admission."

Neville Zar, Vice President Revenue Cycle, Steward Healthcare LLC

Since the ED is the source of such a high percentage of admissions, that's a natural place to start. Patients can also be admitted into a hospital from other sources, including doctors' offices, outpatient clinics, outpatient surgical sites, catheterization or colonoscopy labs, and other places that provide outpatient procedures. In these situations, an "admissions case manager" would be the point person to decide a patient's right level of care.

Admissions case managers should work closely with the admissions office and bed placement staff, and communicate frequently with physicians and nurses to determine a patient's level of care. For example, when a private physician calls up a hospital's admissions office to get a bed assignment for a patient, the admissions case manager could review the request and seek more information to determine if the patient would be admitted or placed into observation.

Admissions case managers should also review elective surgical admissions to assess the status of patients before their scheduled procedure. Essentially, case managers would doublecheck that such patients are either scheduled as inpatients with the correct procedure code or scheduled as outpatients so the hospital can bill Medicare appropriately.

It is also critically important for case managers to partner with the hospital's physician advisor and Utilization Review Committee when physicians disagree with CM recommendations.

Use existing data to establish the baseline

As with virtually everything else that falls under their purview, CFOs will want to establish a baseline for evaluating their progress on medical necessity issues. However, up until now, many have yet to take this step. Either because circumstances didn't warrant it, or because the challenge of gathering information to set such a baseline required too much effort.

Considerations for data analysis

- What is the breakdown between patients in observation and those admitted to the hospital?
- How does our breakdown compare with benchmarks (internal or external)?
- Do our systems capture revenue streams and applicable costs appropriately?
- What does the denial data related to short-stay admission claims and denials show?

Fortunately, many hospitals already have a starting point — one that is often overlooked. The Program for Evaluating Payment Patterns Electronic Report (PEPPER), which is issued quarterly, provides Medicare claims data on inpatients for each hospital (PEPPER does not provide data about outpatients). Although the data is six months old and reaches back the previous three years, hospitals can compare how they stack up against their peers over that period.

These comparisons provide context so a hospital can see areas where it might be at higher risk for improper Medicare payments and then take the appropriate corrective action. Yet, many hospital executives do not use PEPPER out of the belief that the data is dated. The performance improvement/quality team should also establish action plans to address outlier areas.

Hospital executives can benefit from analyzing their own data. By compiling and analyzing their top 10 patient diagnoses, for instance, hospitals can then see the number of patients placed in observation status and those actually admitted into the hospital as inpatients. As an example, if a hospital analyzes all patients who were seen for chest pain, it can then establish a baseline for the number of patients who were placed in observation versus those admitted to the hospital. That way they can monitor, on a monthly basis, changes in the data for patients who complain of chest pains.

By tracking this historical data, hospital executives are armed with insight to conduct better ongoing internal reviews and audits before they submit bills to Medicare.

"The most important consideration in denial avoidance is providing operations with accurate and timely information on patient status. We implemented exception reports which are monitored daily to review that patients are in appropriate level of care."

Neville Zar, Vice President Revenue Cycle,
Steward Healthcare LLC

Focus on measuring and monitoring

There are steps hospitals can take to reduce their compliance risk with medical necessity and short inpatient stays. Hospitals should consider creating a multi-disciplinary "short stay work group" to tackle monitoring and compliance — one department cannot do it alone.

Within the work group, roles and responsibilities should be clearly defined. The group should first determine what data will be monitored and reported (e.g., one-day stays, all short stays up to 48 hours, observation stays exceeding 48 hours, etc.). This group can monitor data related to short stays, receive and evaluate ongoing internal chart audit results, and ensure there are cross-departmental processes and controls in place to validate the accuracy of short stay claims prior to submitting claims to Medicare. When necessary, this group can also provide suggestions to enhance compliance controls including adding resources where needed, creating or updating policies and procedures, and implementing technology solutions to enable compliance.

Considerations for measurement and monitoring

- What mechanisms are in place to support ongoing monitoring?
- What type of "dashboard reports" do we have available to measure key performance indicators?
- What do we do with the results of the monitoring?

Create a document trail and have a defensible process

Many hospitals established clinical documentation improvement programs to enhance the quality and specificity of clinical documentation, which often has a positive impact on reimbursement.

Traditionally, Clinical Documentation Nurses focused on patients with longer lengths of stay and may not have reviewed a patient's medical record or discussed with a physician until the patient's second day. More and more hospitals are realizing the value in use of Clinical Documentation programs in the emergency room or with patients with shorter lengths of stay to improve the clinical documentation to support medical necessity.

Further, it's not enough for physicians to just write "admit" in their orders anymore. Today, physicians need to clearly spell out the reasons why a patient is being admitted. This information could include the severity of symptoms, a differential diagnosis, and the likelihood that something detrimental will happen to the patient.

Hospitals executives are aware that this is a fundamental shift in the documentation process, which may require some operational changes and shifting of resources. While some CFOs have questioned why case managers, who already help determine the right level of care for patients, couldn't assist in the documentation process as well, CFOs are beginning to view clinical documentation nurses as a more appropriate resource to handle the process.

Considerations for documentation

- Do physicians provide clear and specific orders to support inpatient admissions?
- What kind of documentation do we have that supports a patient's hospitalization status (inpatient or observation)?
- Are current order sets for the most common short-stay admissions in the commercial payer population clinically effective and aligned with admissions criteria?
- How have we adjusted our clinical documentation excellence workflows and focus areas as physician adoption and service mix have changed?

> "If CMS changes the definition of an inpatient as they are proposing to do in FY14, it takes the clinical decision-making out of this completely and will just lead to some other perversion of the system."
>
> **Lawrence Magras, MD, MBA, VP and Assistant Medical Director for Clinical Effectiveness, Care Coordination, and Physician Integration, Catholic Health Services of Long Island**

Be more selective about appeals

In the past, many hospital executives had a simple strategy for all Medicare claims that were denied: appeal everything.

Considerations for appeals

- How will the recently proposed CMS rules affect appeals strategies?
- How should I change my appeals strategy if I have only one year to re-bill from when patient services were provided?
- What kind of resources do I need to effectively appeal denials? Where and how much should I invest?

This represents a significant administrative burden (e.g., legal and other external services), requiring more resources than hospitals can spare since there are five levels of appeals they can go through. In the first quarter of 2013, hospitals spent on average over $30,000 on external legal services and nearly $60,000 on utilization management consultants for RAC processes.[8] It becomes easier to make the case that not all appeals are worth the effort.

CMS issued on March 13, 2013 a temporary administrative ruling and a proposed rule change that may benefit hospitals in the near term.[9] Currently, Medicare Administrative Contractors (MACs), RACs, and other regulatory bodies that audit Medicare claims are allowed to reject claims if they determined that patient care was provided in the wrong setting — that is, as an inpatient rather than as an outpatient — not whether care should have been provided. The temporary ruling allows hospitals to rebill the Medicare claim under Part B — instead of Part A — so they can recoup some money without regard to the one year timely filing requirement. However, the proposed rule, once finalized, puts back in place the one year timely filing requirement.

[8] American Hospital Association, "AHA RACTrac Quarterly Survey, 2013 1st Quarter", June 2013.

[9] Centers for Medicare and Medicaid Services (CMS), "CMS-1455-R," http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf, March 2013.

Bottom line

Hospitals can no longer wait to address the challenges of short stays because Medicare enforcement has escalated and other payers are also turning their focus to short-stay patients given their current cost savings and quality focus. As the financial and compliance risks from medical necessity denials only continue to grow, hospitals should take steps to address this challenge now, so they are able to continue to provide quality, cost effective care in the right setting, for which they are appropriately reimbursed.

Hospitals should not wait to put in place the right strategies — they should assess the impact of short-stay patient regulations, understand the impact to the bottom line, and figure out how they will continue to efficiently and effectively treat short-stay patients. By utilizing existing data and some of the strategies described above, hospitals can begin to make the operational and leadership changes needed to help balance the heightened regulatory scrutiny with revenue protection. Hospitals will want to move quickly — waiting may hold significant risk.

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Acknowledgements

We would also like to thank Wendy Gerhardt, Ryan Carter, S.R. Sadashiva, Kiran Jyothi Vipparthi, and the many others who contributed to the preparation of this report.

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