AHC Media

Thursday, July 23rd, 2015

CMS & TJC Compliance Responsibilities for the Case Manager: Part II

CMS Mandates a Utilization Management Committee, Is Yours Doing what it Should?

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FACULTY

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and international conferences and workshops. She has published extensively including the fourth edition of her book, "Nursing Case Management: From Essentials to Advanced Practice Applications," the second edition of "The Case Manager's Survival Guide: Winning Strategies for Clinical Practice" which won the AJN Book of the Year award, "Survival Strategies for Nurses in Managed Care" and her newest book: "Core Skills for Hospital Case Managers".

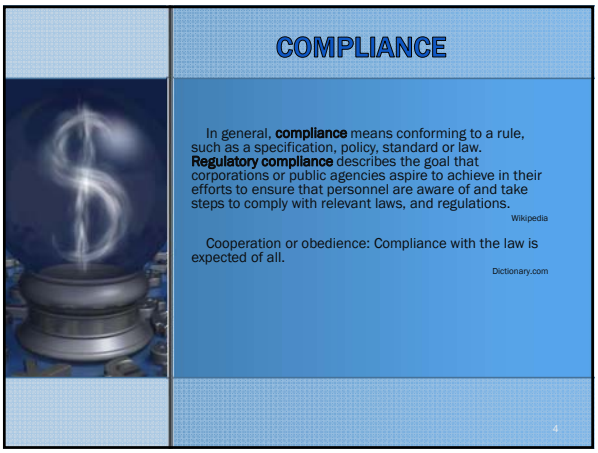
Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board.

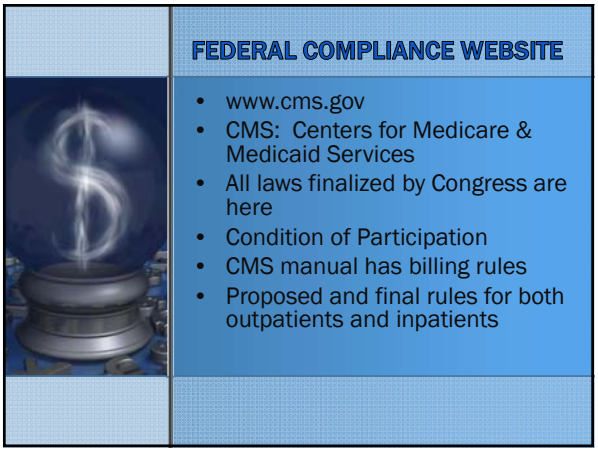
Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor students in a Master's of Healthcare Administration program.

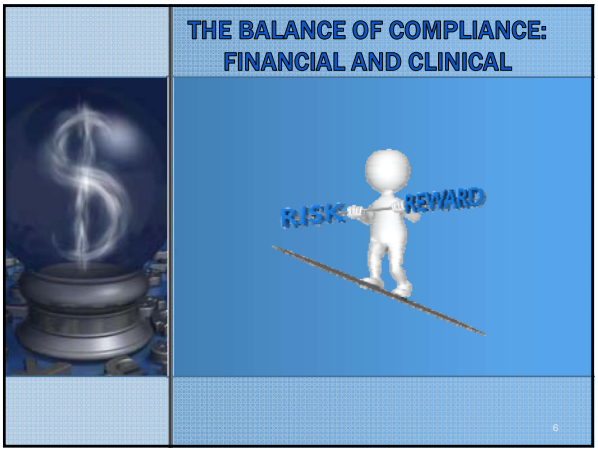
Bev is a well-known speaker in the Case Management field. Her publications include a chapter CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. Bev has a BSN from Pittsburg State University, Pittsburg, Kansas and a Master of Science, Nursing Major, from the University of Oklahoma.

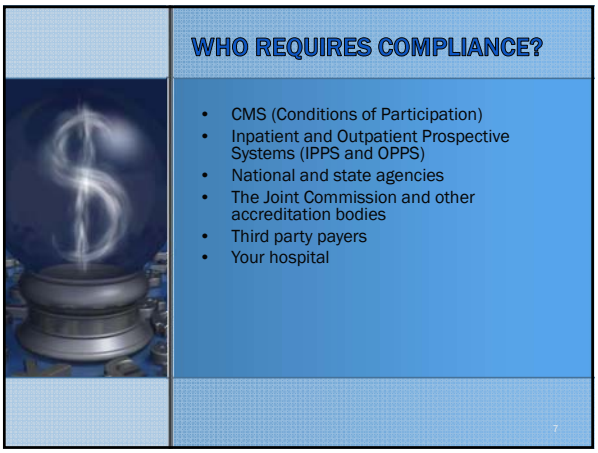
OBJECTIVES

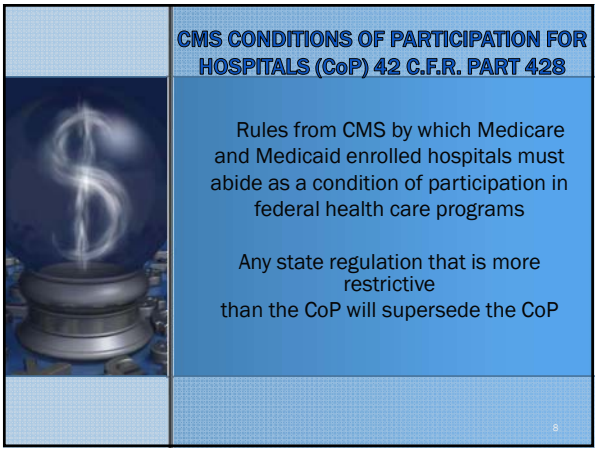
1. Explain the role of case management in meeting CoPs for utilization review.
2. Describe what CMS CoP Section 482.30 requires of your hospital.
3. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
4. Evaluate case management protocols and penalties.

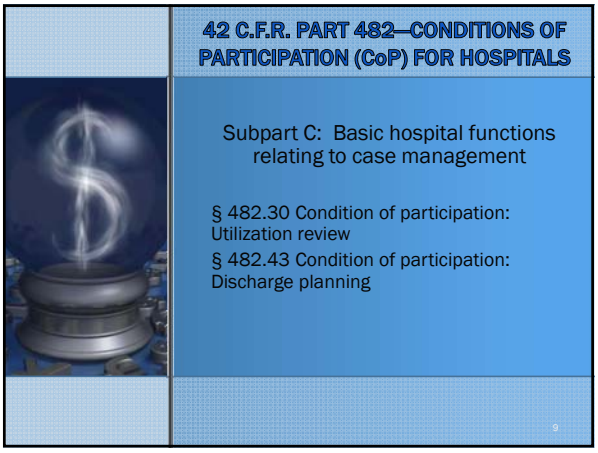

COMPLIANCE
In general, **compliance** means conforming to a rule, such as a specification, policy, standard or law. **Regulatory compliance** describes the goal that corporations or public agencies aspire to achieve in their efforts to ensure that personnel are aware of and take steps to comply with relevant laws, and regulations.
Wikipedia
Cooperation or obedience: Compliance with the law is expected of all.
Dictionary.com
4


FEDERAL COMPLIANCE WEBSITE
• www.cms.gov
• CMS: Centers for Medicare & Medicaid Services
• All laws finalized by Congress are here
• Condition of Participation
• CMS manual has billing rules
• Proposed and final rules for both outpatients and inpatients


THE BALANCE OF COMPLIANCE: FINANCIAL AND CLINICAL
RISK
REWARD
6


WHO REQUIRES COMPLIANCE?
• CMS (Conditions of Participation)
• Inpatient and Outpatient Prospective Systems (IPPS and OPPS)
• National and state agencies
• The Joint Commission and other accreditation bodies
• Third party payers
• Your hospital
7


CMS CONDITIONS OF PARTICIPATION FOR HOSPITALS (CoP) 42 C.F.R. PART 428
Rules from CMS by which Medicare and Medicaid enrolled hospitals must abide as a condition of participation in federal health care programs
Any state regulation that is more restrictive
than the CoP will supersede the CoP
8


42 C.F.R. PART 482—CONDITIONS OF PARTICIPATION (CoP) FOR HOSPITALS
Subpart C: Basic hospital functions relating to case management
§ 482.30 Condition of participation: Utilization review
§ 482.43 Condition of participation: Discharge planning
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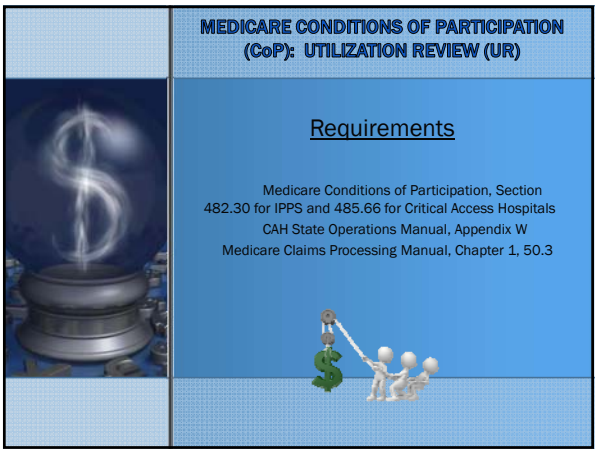
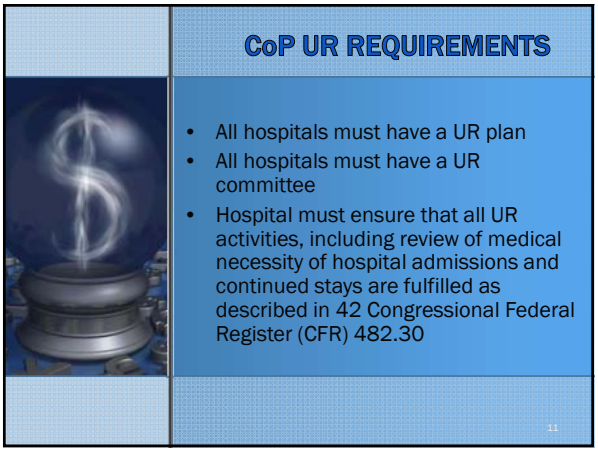

MEDICARE CONDITIONS OF PARTICIPATION
(CoP): UTILIZATION REVIEW (UR)
Requirements
Medicare Conditions of Participation, Section
482.30 for IPPS and 485.66 for Critical Access Hospitals
CAH State Operations Manual, Appendix W
Medicare Claims Processing Manual, Chapter 1, 50.3


CoP UR REQUIREMENTS
• All hospitals must have a UR plan
• All hospitals must have a UR committee
• Hospital must ensure that all UR activities, including review of medical necessity of hospital admissions and continued stays are fulfilled as described in 42 Congressional Federal Register (CFR) 482.30
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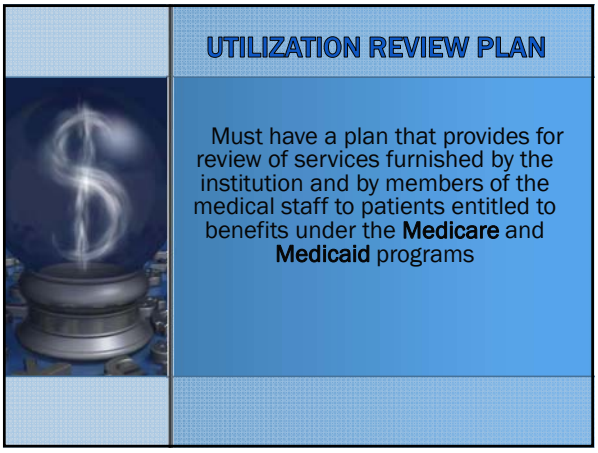
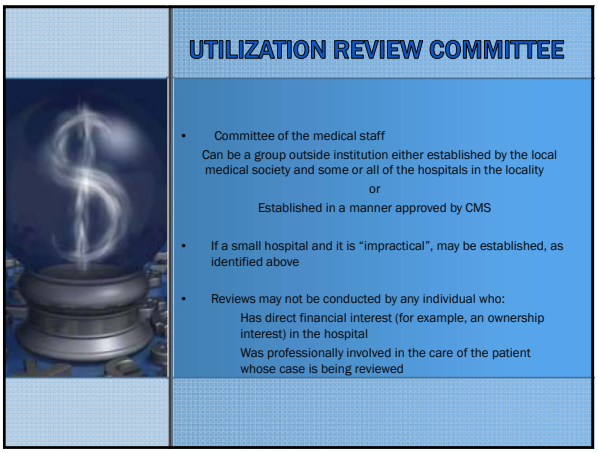
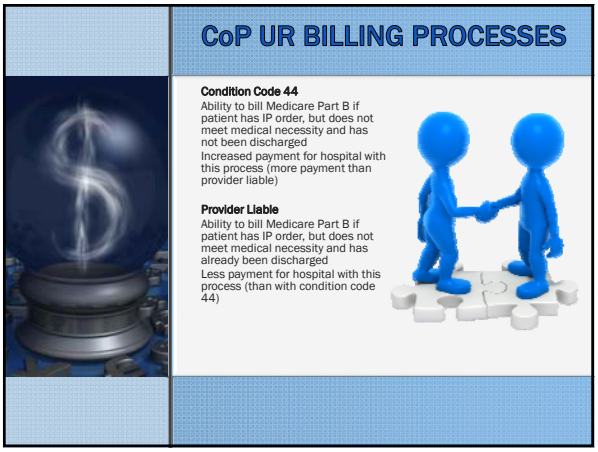

UTILIZATION REVIEW PLAN
Must have a plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs


UTILIZATION REVIEW COMMITTEE
Committee of the medical staff
Can be a group outside institution either established by the local medical society and some or all of the hospitals in the locality
or
Established in a manner approved by CMS
If a small hospital and it is "impractical", may be established, as identified above
Reviews may not be conducted by any individual who:
Has direct financial interest (for example, an ownership interest) in the hospital
Was professionally involved in the care of the patient whose case is being reviewed


CoP UR BILLING PROCESSES
Condition Code 44
Ability to bill Medicare Part B if patient has IP order, but does not meet medical necessity and has not been discharged
Increased payment for hospital with this process (more payment than provider liable)
Provider Liable
Ability to bill Medicare Part B if patient has IP order, but does not meet medical necessity and has already been discharged
Less payment for hospital with this process (than with condition code 44)


BILLING PROCESS WHEN PATIENT DOES NOT MEET MEDICAL NECESSITY
Case Manager review medical necessity and patient does not meet
Physician agrees patient does not meet
Condition Code 44 if patient not yet discharged (and attending agrees)
Provider Liable if patient already discharged

SURVEYING FOR CoP COMPLIANCE

- Hospital accreditation bodies with deemed status for CMS
- CMS routine surveys
- CMS validation surveys

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

UTILIZATION REVIEW

- If the hospital has a QIO contract to assume binding review an agreement must be maintained for review of the following—related to inpatient services for Medicare patients:
  - Admissions
  - Quality
  - Appropriateness
  - Diagnostic information
- Surveyors must view the signed and dated agreement
- From CMS Interpretive Guidelines 482.30(a)

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

UTILIZATION REVIEW COMMITTEE

- Review composition of UR Committee
- Determine if governing body has delegated to committee authority and responsibility to carry out UR function
- Verify that small hospitals delegate UR function to outside group if impractical to have a staff committee
- Ascertain that committee members not financially involved in hospital (ownership of 5% or greater) nor participants in execution of patient's treatment plan
- From CMS Interpretive Guidelines 482.30(b)

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

Scope and Frequency of UR Plan Review

- Ask if hospital is reviewing outlier cases
- In instances where there was no other review of outlier cases, the question is whether it was reasonable for hospital not to have known the cases were, in fact, outliers. Some medical judgement might be required to determine whether reasonable for hospital to assume a patient fell into a DRG other than the one eventually assigned by intermediary. This would be an issue in long stay outlier cases where hospital did not review because hospital erroneously assumed that patient was in a DRG under which the case would not have been an outlier.

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

Scope and Frequency of UR Plan Review (cont)

- Examine UR plan to determine that medical necessity or Medicare and Medicaid patients is reviewed with respect to admission, duration of stay and professional services furnished (IPPS hospitals only)
- Verify the following are reviewed:
  - Duration of stay in cases reasonably assumed to be outlier cases
  - Professional services in cases reasonably assumed to be outlier cases
- From CMS Interpretive Guidelines 482.30(c)

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

Admission and Continued Stays

- When a physician makes an initial finding that written criteria for extended say are not met, the case must be referred to the committee, or subgroup thereof which contains at least one physician
- If the committee or subgroup agrees, after reviewing the case that admission or extended stay not medically necessary, attending physician notified and allowed opportunity to present vies and any additional information relating to patient's needs for admission or continued stay
- When physician member of committee performs initial review and finds that admission or continued stay not necessary, no referral to committee or subgroup is necessary and he may notify attending directly
- If attending does not respond or contest findings of committee or subgroup, the findings are final

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

Admission and Continued Stays (cont.)

- If physician contests the findings, at least one additional physician member of the committee must review case. If the two physician members determine stay not medically necessary or appropriate (after reviewing all findings), their determination is final
- Written notification of this decision must be sent to attending physician, patient (or next of kin), facility administrator and the single State agency (in the case of Medicaid) no later than 2 days after final decision and in no event later than 3 working days after end of assigned extended stay period.
- In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

Admission and Continued Stays (cont.)

- Surveyor will review sample of "medically unnecessary" decisions involving admissions or continued stays that are not medically necessary and determine these decisions are made per CoP regulations
- Review a sample of "medically unnecessary" decisions and verify that physician or practitioners were informed of the committee's expected decision and given an opportunity to comment
- Review sample of "medically unnecessary" cases and verify all parties were notified of the decision that care is medically not necessary (no later than two days following the decision)
- From CMS Interpretive Guidelines 482.30(d)

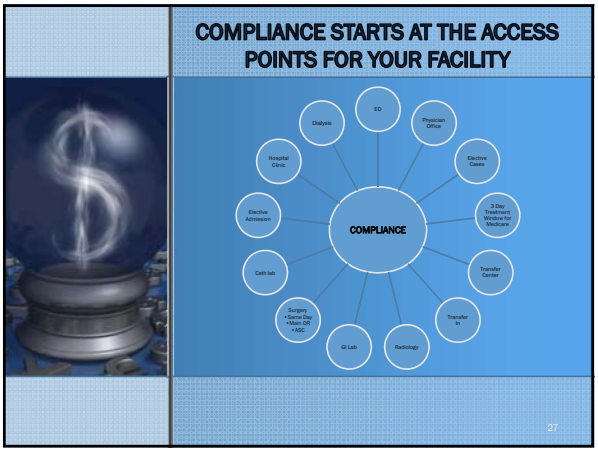
CoP INTERPRETIVE GUIDELINES FOR SURVEYORS

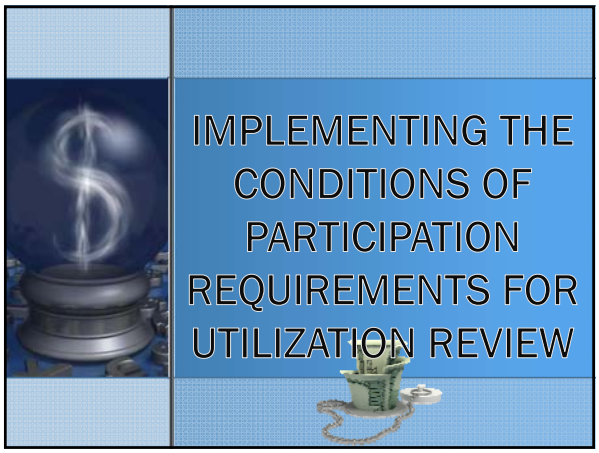
Extended Stay Review

- Review facility's definition of extended stay in the UR plan
- Verify UR plan requires periodic review of each Medicare/Medicaid inpatient receiving hospital serves of extended duration and that review is carried out at specified time stated in facility's UR plan
- If committee uses different number of days for different diagnoses or functional categories for period of extended say, surveyor must verify that there is a written list with lengths of stay designated for each diagnosis of functional category
- IPPS hospitals need only review cases reasonably assumed to be outlier cases and extended stay that exceeds outlier threshold for the diagnosis
- Review minutes of UR committee to determine that periodic reviews of extended stay are carried out on or before expiration of stated period and no later than 7 days after the day required in the hospital's plan
- From CMS Interpretive Guidelines 482.30(e)

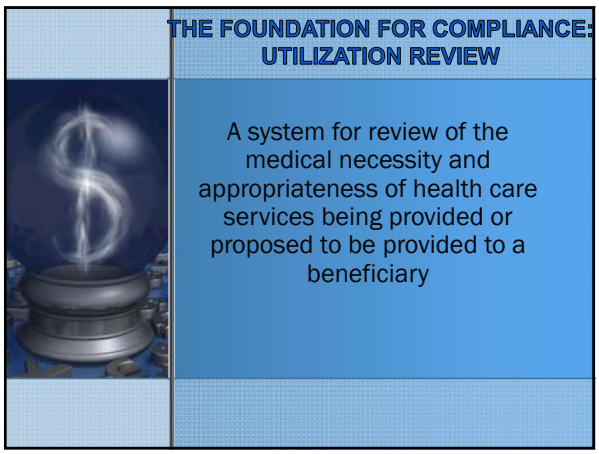

CoP INTERPRETIVE GUIDELINES FOR SURVEYORS
Review of Professional Services
• Review for medical necessity and efficient use of available health facilities and services; examples of committee topics to review may include:
Availability and use of necessary services— underused, over used, appropriately used
Timeliness of scheduling of services: operating room, diagnostic
Therapeutic procedures
• Review committee minutes to determine review of professional services occurs
• From CMS Interpretive Guidelines 482.30(f)


COMPLIANCE IS MORE THAN RULES AND REGULATIONS
• Clinical compliance
• Value-based purchasing
• Readmission penalties
• Hospital never events
• Hospital acquired conditions
• Standards
• Evidence-based clinical guidelines
26


COMPLIANCE STARTS AT THE ACCESS POINTS FOR YOUR FACILITY
COMPLIANCE
ED
Physician Office
Elective Cases
3 Day Treatment Window for Medicare
Transfer Center
Transfer In
Radiology
GI Lab
Surgery • Same Day • Main OR • ASC
Cath lab
Elective Admission
Hospital Clinic
Dialysis
27


IMPLEMENTING THE CONDITIONS OF PARTICIPATION REQUIREMENTS FOR UTILIZATION REVIEW


LACK OF COMPLIANCE
=
LACK OF REIMBURSEMENT
29


THE FOUNDATION FOR COMPLIANCE: UTILIZATION REVIEW
A system for review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to a beneficiary

UTILIZATION MANAGEMENT

Operationalizing utilization review

THREE TYPES OF UTILIZATION REVIEW

- Prospective
- Concurrent
- Retrospective

PROSPECTIVE REVIEW

Occurs before services rendered

For example, if the health plan requires the provider to request preauthorization for hospital admission, the request would trigger prospective utilization review

CONCURRENT REVIEW

Occurs while services are being rendered

For example, a provider's request for hospital days beyond those approved triggers concurrent review

RETROSPECTIVE REVIEW

Occurs after services have been rendered

A QUICK REVIEW OF OBSERVATION

"Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

Internet-Only Manual (IOM), Publication 100-04, Chapter 4, Section 290

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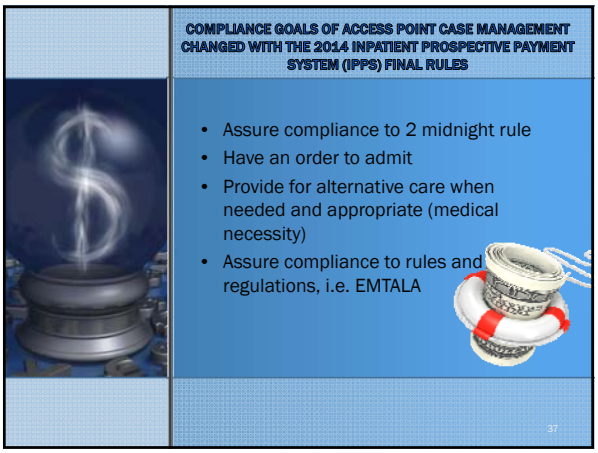
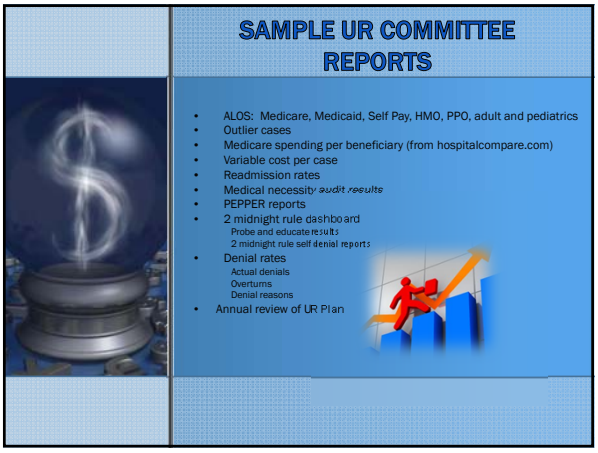
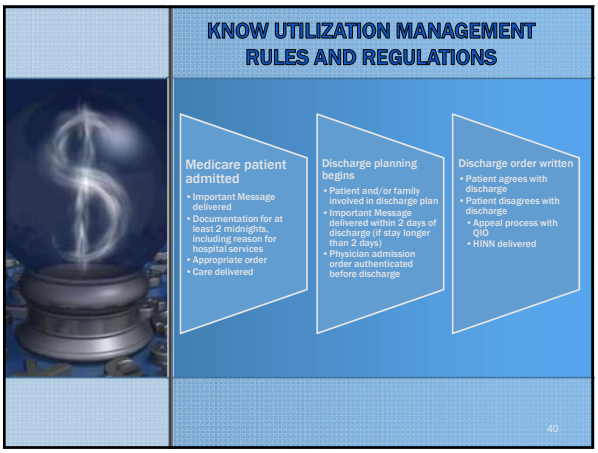
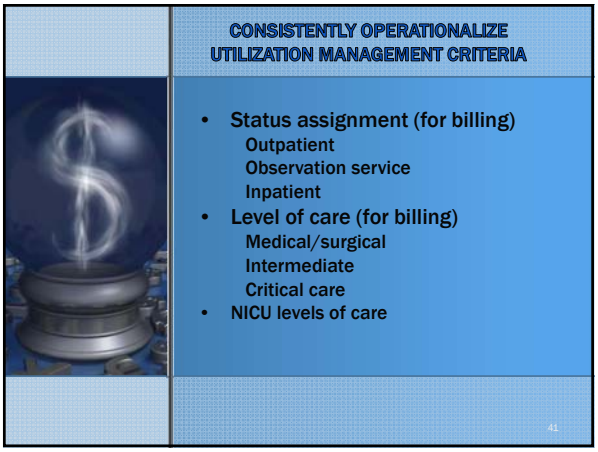
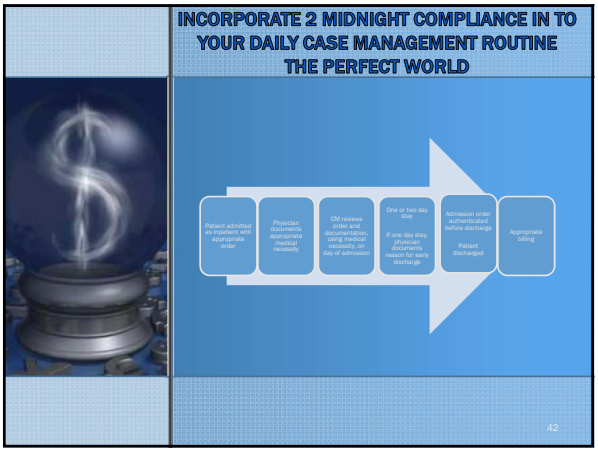

COMPLIANCE GOALS OF ACCESS POINT CASE MANAGEMENT CHANGED WITH THE 2014 INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) FINAL RULES
• Assure compliance to 2 midnight rule
• Have an order to admit
• Provide for alternative care when needed and appropriate (medical necessity)
• Assure compliance to rules and regulations, i.e. EMTALA
37

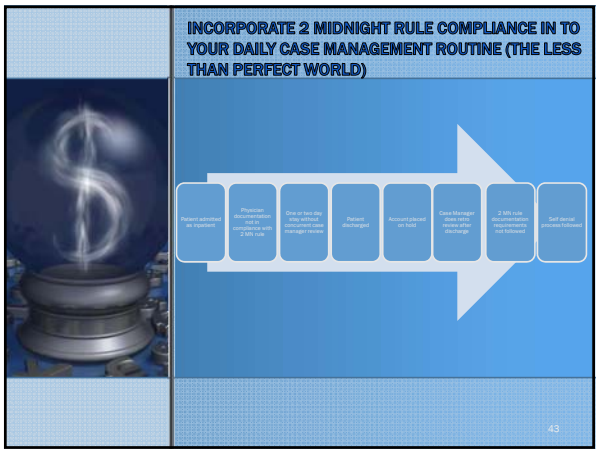

SELLING THE UR COMMITTEE TO YOUR EXECUTIVES
• Compliance requirement for committee
• Requirement to be medical staff committee
• Membership of committee
• Support of utilization management function of case management
• CMS efficiency measures: spending per Medicare beneficiary


SAMPLE UR COMMITTEE REPORTS
• ALOS: Medicare, Medicaid, Self Pay, HMO, PPO, adult and pediatrics
• Outlier cases
• Medicare spending per beneficiary (from hospitalcompare.com)
• Variable cost per case
• Readmission rates
• Medical necessity audit results
• PEPPER reports
• 2 midnight rule dashboard
Probe and educate results
2 midnight rule self denial reports
• Denial rates
Actual denials
Overturns
Denial reasons
• Annual review of UR Plan

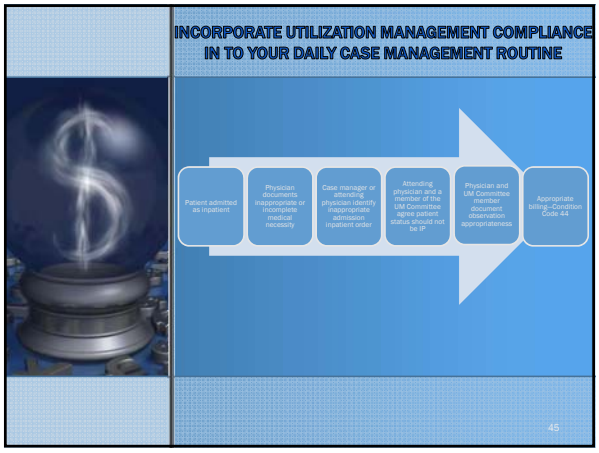

KNOW UTILIZATION MANAGEMENT RULES AND REGULATIONS
Medicare patient admitted
• Important Message delivered
• Documentation for at least 2 midnights, including reason for hospital services
• Appropriate order
• Care delivered
Discharge planning begins
• Patient and/or family involved in discharge plan
• Important Message delivered within 2 days of discharge (if stay longer than 2 days)
• Physician admission order authenticated before discharge
Discharge order written
• Patient agrees with discharge
• Patient disagrees with discharge
• Appeal process with QIO
• HINN delivered
40

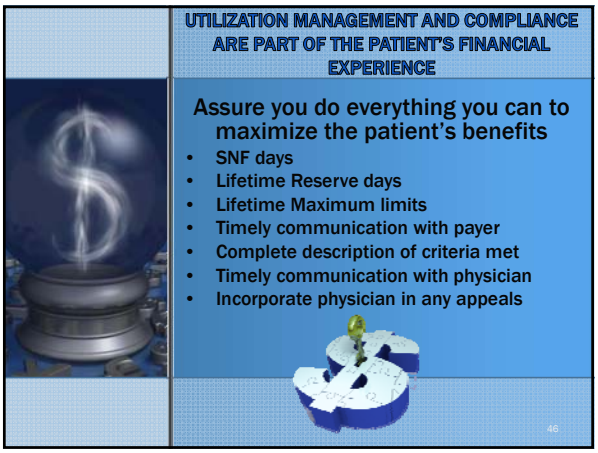

CONSISTENTLY OPERATIONALIZE UTILIZATION MANAGEMENT CRITERIA
• Status assignment (for billing)
Outpatient
Observation service
Inpatient
• Level of care (for billing)
Medical/surgical
Intermediate
Critical care
• NICU levels of care
41

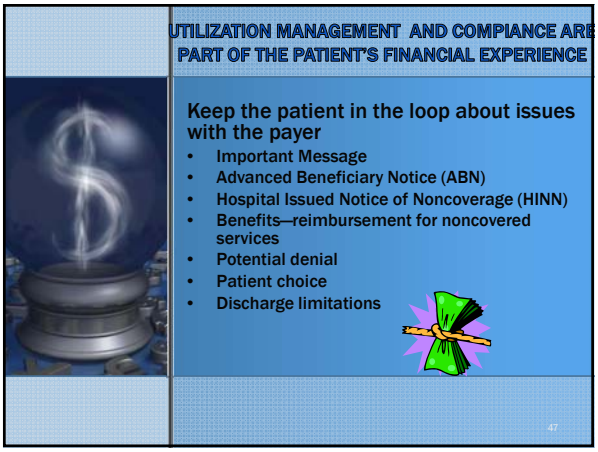

INCORPORATE 2 MIDNIGHT COMPLIANCE IN TO YOUR DAILY CASE MANAGEMENT ROUTINE THE PERFECT WORLD
Patient admitted as inpatient with appropriate order
Physician documents appropriate medical necessity
CM reviews order and documentation, using medical necessity, on day of admission
One or two day stay
If one day stay, physician documents reason for early discharge
Admission order authenticated before discharge
Patient discharged
Appropriate billing
42

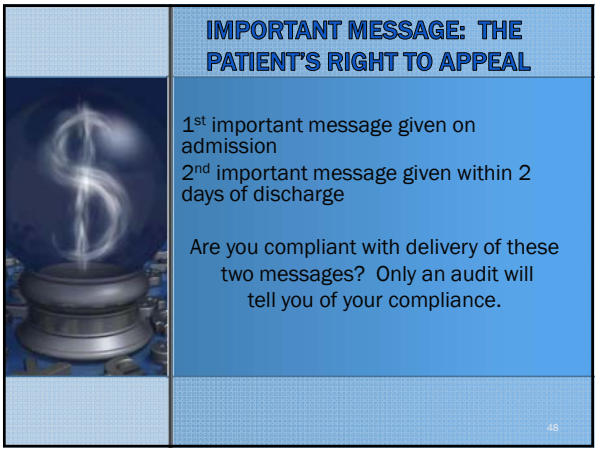

INCORPORATE 2 MIDNIGHT RULE COMPLIANCE IN TO YOUR DAILY CASE MANAGEMENT ROUTINE (THE LESS THAN PERFECT WORLD)
Patient admitted as inpatient
Physician documentation not in compliance with 2 MN rule
One or two day stay without concurrent case manager review
Patient discharged
Account placed on hold
Case Manager does retro review after discharge
2 MN rule documentation requirements not followed
Self denial process followed
43

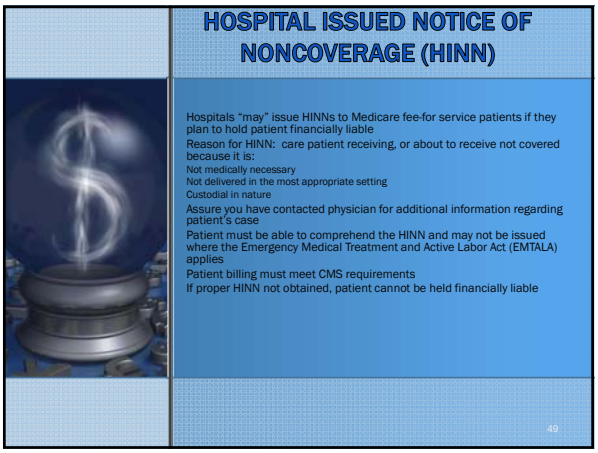

SELF DENIAL PROCESS: MEDLINE MATTERS (MLN MATTERS) MM 8445
Released February 2014, but effective for discharges beginning October 1, 2013
44


INCORPORATE UTILIZATION MANAGEMENT COMPLIANCE IN TO YOUR DAILY CASE MANAGEMENT ROUTINE
Patient admitted as inpatient
Physician documents inappropriate or incomplete medical necessity
Case manager or attending physician identify inappropriate admission inpatient order
Attending physician and a member of the UM Committee agree patient status should not be IP
Physician and UM Committee member document observation appropriateness
Appropriate billing--Condition Code 44
45


UTILIZATION MANAGEMENT AND COMPLIANCE ARE PART OF THE PATIENT'S FINANCIAL EXPERIENCE
Assure you do everything you can to maximize the patient's benefits
• SNF days
• Lifetime Reserve days
• Lifetime Maximum limits
• Timely communication with payer
• Complete description of criteria met
• Timely communication with physician
• Incorporate physician in any appeals
46


UTILIZATION MANAGEMENT AND COMPIANCE ARE PART OF THE PATIENT'S FINANCIAL EXPERIENCE
Keep the patient in the loop about issues with the payer
• Important Message
• Advanced Beneficiary Notice (ABN)
• Hospital Issued Notice of Noncoverage (HINN)
• Benefits—reimbursement for noncovered services
• Potential denial
• Patient choice
• Discharge limitations
47


IMPORTANT MESSAGE: THE PATIENT'S RIGHT TO APPEAL
1st important message given on admission
2nd important message given within 2 days of discharge
Are you compliant with delivery of these two messages? Only an audit will tell you of your compliance.
48



HOSPITAL ISSUED NOTICE OF NONCOVERAGE (HINN)

Hospitals "may" issue HINNs to Medicare fee-for service patients if they plan to hold patient financially liable

Reason for HINN: care patient receiving, or about to receive not covered because it is:

Not medically necessary

Not delivered in the most appropriate setting

Custodial in nature

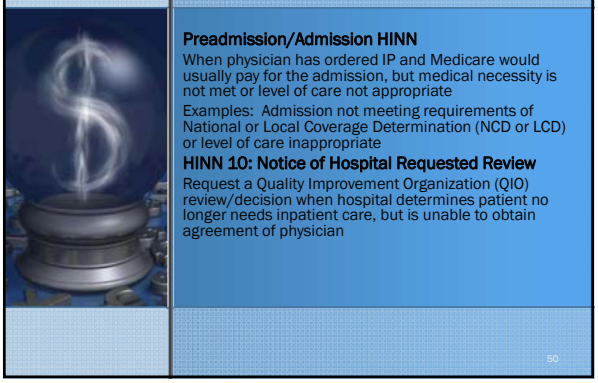
Assure you have contacted physician for additional information regarding patient's case

Patient must be able to comprehend the HINN and may not be issued where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies

Patient billing must meet CMS requirements

If proper HINN not obtained, patient cannot be held financially liable

49



HINN: WHICH ONE AND WHEN?

Preadmission/Admission HINN

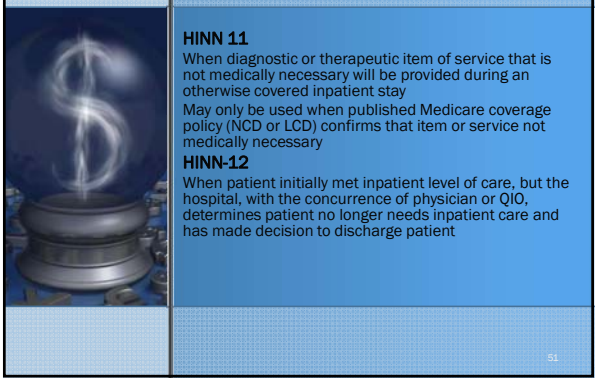
When physician has ordered IP and Medicare would usually pay for the admission, but medical necessity is not met or level of care not appropriate

Examples: Admission not meeting requirements of National or Local Coverage Determination (NCD or LCD) or level of care inappropriate

HINN 10: Notice of Hospital Requested Review

Request a Quality Improvement Organization (QIO) review/decision when hospital determines patient no longer needs inpatient care, but is unable to obtain agreement of physician

50



HINN: WHICH ONE AND WHEN?

HINN 11

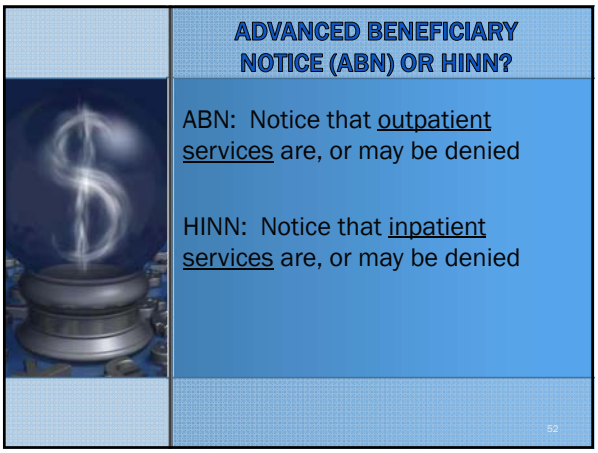
When diagnostic or therapeutic item of service that is not medically necessary will be provided during an otherwise covered inpatient stay

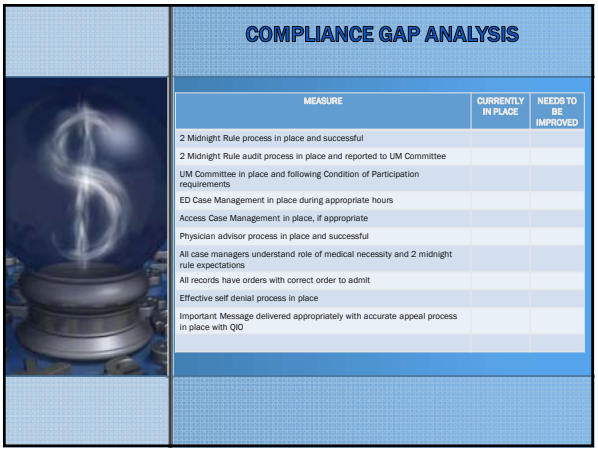
May only be used when published Medicare coverage policy (NCD or LCD) confirms that item or service not medically necessary

HINN-12

When patient initially met inpatient level of care, but the hospital, with the concurrence of physician or QIO, determines patient no longer needs inpatient care and has made decision to discharge patient

51


ADVANCED BENEFICIARY NOTICE (ABN) OR HINN?
ABN: Notice that outpatient services are, or may be denied
HINN: Notice that inpatient services are, or may be denied
52


COMPLIANCE GAP ANALYSIS
MEASURE
CURRENTLY IN PLACE
NEEDS TO BE IMPROVED
2 Midnight Rule process in place and successful
2 Midnight Rule audit process in place and reported to UM Committee
UM Committee in place and following Condition of Participation requirements
ED Case Management in place during appropriate hours
Access Case Management in place, if appropriate
Physician advisor process in place and successful
All case managers understand role of medical necessity and 2 midnight rule expectations
All records have orders with correct order to admit
Effective self denial process in place
Important Message delivered appropriately with accurate appeal process in place with QIO


Resources
Important Message: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1257CP.pdf
Conditions of Participation: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
HINNS: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HINNs.html
www.oig.hhs.gov
www.justice.gov
Condition Code 44: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1760CP.pdf
Medicare Claims Processing Manual: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

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IT'S TIME FOR QUESTIONS!

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