How Hospitals Can Arm Themselves in the War on Waste

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In this article...

What can physician executives do to combat inefficiency and poor quality during the war on hospital waste?

As the debate rages about whether and how to effect widespread health care reform in the United States, there is one thing on which everyone agrees: a great deal of money is at stake. Even prior to any reform that may be enacted, the government was spending a lot on health care, much of it on hospital care.

Between the Medicare Modernization Act of 2003 and the far-reaching Tax Relief and Health Care Act of 2006, a host of auditing entities are scrutinizing Medicare and Medicaid payments to ensure payment for only appropriate, covered services.

In order to survive—and potentially thrive—in the face of the "war on waste" waged by the Centers for Medicare & Medicaid Services (CMS), hospitals need to implement scientifically based guidelines and document evidence of best practices to support appropriate coding.

The government is the largest single payer to hospitals. American Hospital Association survey data for 2007 showed that 55 percent of hospital revenue came from government sources: about 40 percent of revenue from Medicare and about 15 percent from Medicaid.

Recent studies conclude that a significant portion of those payments are "wasted." Milliman defines waste or inefficiency in the health care system as treatment that is unnecessary, redundant, or ineffective and is contrary to, or not demonstrably associated with, health care quality and outcomes. Our actuaries have estimated that the amount of waste in the U.S. health care system was in excess of 25 percent of total health care spending, or about $600 billion in 2008.

Separately, CMS estimates that nearly 8 percent of the dollars paid nationally in the 2009 Medicare fee-for-service program do not comply with one or more Medicare coverage, coding, billing, and payment rules. To help identify misspent funds, five separate CMS programs have been commissioned to root out waste, fraud, incorrect payments, and quality issues.

The evolution of CMS auditing

Oversight in traditional (fee-for-service) Medicare began with the establishment of peer review organizations, now known as quality improvement organizations (QIOs). The QIO program was created by statute in 1982, and its purpose was to improve the quality and efficiency of services delivered to Medicare beneficiaries.

In its first phase, QIOs sought to accomplish their mission through peer review of individual cases, attempting to identify instances where professional standards had not been met, for purposes of initiating corrective actions. Since the early 1990s, the QIOs have focused on quality measurement and improvement.

Currently, the QIO program's ninth scope of work includes four major components:

1. Beneficiary protection
2. Care transitions
3. Patient safety
4. Prevention

QIOs review cases to assess the quality of care that was provided, assure safe and effective transitions to the next appropriate level of care, focus on preventing common complications and hospital-acquired conditions, and ensure providers are active in the arenas of preventive testing and of management of diabetes to prevent complications.

Clinical documentation should identify all significant procedures that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training.

Nearly 20 years later, changes to the Medicare program started and will likely continue at a fast pace. The Medicare Prescription Drug Improvement and Modernization Act (MMA), passed in 2003, required that CMS replace its claim payment contractors—fiscal intermediaries and carriers—with new contract entities called Medicare Administrative Contractors (MACs).

In the same act, the Department of Health and Human Services was instructed to conduct a three-year demonstration program to detect and correct "improper payments" in the traditional Medicare program.

Under this authority, CMS began the program in 2005, using Recovery Audit Contractors (RACs) to perform the work of reviewing, auditing, and identifying improper Medicare payments. Initially the program focused on Medicare payments in the states of California, New York, and Florida. The program eventually expanded to Massachusetts and South Carolina before ending in March 2007.

As of March 27, 2008, RACs succeeded in correcting more than $1.03 billion in Medicare improper payments. Approximately 96 percent ($992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent ($37.8 million) were underpayments repaid to providers.

Physicians on the Front Line: The Case for Well-Researched Medical Guidelines

With increased scrutiny by CMS contractors of hospital admission and treatment documentation, scientifically based medical guidelines can be a valuable tool for supporting the physician decision-making process and providing evidence of appropriate care. Whether in reviewing retroactive cases or current billings, contractors will be looking at physician documentation in making their determinations. Supporting records from auxiliary caregivers will count for very little if the physician has not made the right decision and properly recorded it.

As an example, a physician admitted a patient for heart failure, noting respiratory compromise, abnormal renal function (BUN 27 and creatine 2.0), and a blood oxygen saturation level of 96 percent with the patient on low-flow oxygen at 2L/min. The Milliman Care Guidelines® indications for admission for heart failure include documenting worsening renal function and a blood oxygen saturation level below 90. In this instance, the case manager using the Care Guidelines would provide the physician with the following prompts: "Please document the patient's renal function prior to admission" and "Please indicate in your notes the patient's O2 saturation on room air." With these prompts, the physician taking care of this patient could have chosen to admit the patient for observation and then determine if the patient meets the criteria for admission for heart failure.

Well-researched medical guidelines can help hospitals improve and demonstrate best practices in the face of CMS scrutiny. They can be used to:

- Help determine appropriateness for admission
- Prompt physicians to provide documentation to the clinical record
- Provide supporting evidence in case of appeal

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Pull-out graph: Current CMS Contractors

Contractor	Responsibilities	Jurisdiction
RAC	Detect and correct past improper payments (incorrect payment amounts, non-covered or medically unnecessary services or setting, incorrectly coded services, insufficient documentation, and duplicate services)	Medicare Part A and B
MAC	Medical review of acute IPPS hospitals and LTCH claims, on either a pre-payment or post-payment basis	Medicare Part A and B
QIO	Quality of care reviews that are due to complaints from beneficiaries or for cases referred by CMS or CMS contractors, utilization review for hospital-requested higher-weighted DRGs, utilization review for cases referred by CMS or contractors related to transfers and readmissions	Medicare Part A, B and C
MIC	Detect fraud, waste, and abuse	Medicaid
ZPIC	Detect fraud, waste, and abuse	Medicare Part A, B, C and D

Providers appealed 14 percent of RAC adverse determinations, and to date 4.6 percent have been overturned.

The Deficit Reduction Act of 2005 took the partnership between CMS and individual states to a new level by creating the Medicaid Integrity Program. Under this program, for the first time, CMS is involved in identifying, recovering, and preventing inappropriate Medicaid payments.

CMS established the Medicare Integrity Program in 1996 with the goal of reducing fraud and abuse. In 1999, CMS began transferring the responsibility for detecting and deterring fraud and abuse in Medicare Parts A and B from carrier and fiscal intermediary fraud units to Program Safeguard Contractors.

CMS completed this transfer of responsibilities in 2006. More recently, CMS has changed the name of these contractors to the Zone Program Integrity Contractors (ZPICs) and increased their responsibilities. ZPICs will be operational in all U.S. states and territories in the near future.

New entities

Based on the success of its demonstration program, the RAC program was made permanent. In August 2009, the four permanent RAC program contractors announced the first set of issues that each RAC will be addressing.

For calendar year 2009, RACs only performed automated reviews using claim data. This year, they begin reviewing medical records—also called complex reviews. Before a RAC can perform a review of an issue (either automated or complex), it must have the issue approved by CMS and it then must post the issue on its Web site.

RACs are tasked with:

- Detecting and correcting past improper payments
- Identifying incorrect payment amounts, non-covered or medically unnecessary services or settings, incorrectly coded services, insufficient documentation, and duplicate services

Their job is to adjust for Medicare overpayments and underpayments, with jurisdiction over claims that are one to three years old, and they may only review claims that have not already been reviewed by another CMS contractor.

RACs are the only CMS audit contractors paid on a contingency basis, receiving a percentage of all identified overpayments and underpayments. They are mandated to "utilize appropriate medical literature and apply appropriate clinical judgment" in their review activities.

MACs are now tasked with medical review of acute hospitals and long-term-care hospital claims, on either a pre-payment or post-payment basis. Specifically, they ensure that claims are for covered services, are correctly coded, and are for reasonable and necessary services. They may adjust claim payments for services that do not meet these criteria. MACs have taken over the functions of the Hospital Payment Monitoring Program (HPMP) that was handled by the QIOs until July 2008.

In the Medicaid Integrity Program, there are three types of Medicaid Integrity Contractors (MICs). Review MICs analyze

Medicaid claim data to identify aberrant claims and potential billing vulnerabilities. The review MICs provide this information to the audit MICs.

The audit MICs conduct post-payment audits to ensure that claims were for services provided and properly documented, for services billed using appropriate codes, for covered services, and were reimbursed according to state policy rules and regulations. The reviews are done in a combination of desk and field audits.

Finally, the education MICs work with the review and audit MICs to educate providers, state Medicaid officials, and others about Medicaid program integrity issues.

QIOs perform quality-of-care reviews on cases referred directly from CMS or from CMS contractors, and on cases where Medicare beneficiaries or their representatives have filed complaints. They also perform utilization reviews when hospitals have requested higher-weighted diagnosis-related groups (DRGs) and for cases referred by CMS or its contractors related to transfers and readmissions. Finally, they are tasked with developing and implementing provider education on issues related to quality of care.

QIOs often have other lines of business that may include contracts with states for Medicaid utilization and quality reviews, with other federal agencies (such as the Veterans Administration), or with private organizations for peer/utilization review services and consulting (provider/facility), e.g., RAC preparedness.

ZPICs are tasked with detecting fraud, waste, and abuse and will eventually be responsible for ensuring the integrity of all Medicare claims. They will have authority to review not only traditional Medicare Parts A and B (hospital, rehabilitation, nursing, home health, and durable medical equipment), but also Part C (Medicare Advantage), Part D (prescription drugs), and Medicare-Medicaid data matches.

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In addition, scientifically researched medical guidelines can assist physicians in accurately identifying the impact of simple versus complicated or comorbid conditions on the patient and thus the MS-DRG, which, based on the RAC demonstration project, will be an area of focus. The demonstration project history of recoveries revealed value in evaluating a potential difference in reimbursement because of documented complications and comorbidities. The RACs will focus on reviewing the documentation to support the higher-weighted DRG. For example, in a case where a hospital reported a principal diagnosis of 03.89 (septicemia), the medical record showed a diagnosis of urosepsis, not septicemia or sepsis, and the blood cultures were negative.

Changing the diagnosis code to urinary tract infection (UTI) caused the claim to group to a lower DRG, and the RAC subsequently determined that the claim was incorrectly coded, issuing a repayment request letter for the difference between the payment amount for the incorrectly coded procedure and the correctly coded procedure. Prompting from the Care Guidelines could have helped the physician to document a diagnosis that was consistent with the patient findings. One of the reasons for admission of pyelonephritis in the Care Guidelines is sepsis. As a result, the prompting could have been for the physician to document "sepsis" for admission and that would also justify the higher-weighted DRG.

MS-DRGs that will likely be under scrutiny include:

MS-DRG 163	Major chest procedures with major complication/comorbidity (MCC)
MS-DRG 164	Major chest procedures with complication/comorbidity (CC)
MS-DRG 165	Major chest procedures without CC/MCC
MS-DRG 166	Other respiratory system OR procedures with MCC
MS-DRG 167	Other respiratory system OR procedures with CC
MS-DRG 168	Other respiratory system OR procedures without CC/MCC
MS-DRG 207	Respiratory system diagnosis with ventilator support 96+ hours
MS-DRG 255	Upper limb and toe amputation for circulatory system disorders with MCC
MS-DRG 329	Major small and large bowel procedures with MCC
MS-DRG 330	Major small and large bowel procedures with CC
MS-DRG 331	Major small and large bowel procedures without CC/MCC
MS-DRG 372	Major gastrointestinal disorders and peritoneal infections without CC/MCC
MS-DRG 386	Inflammatory bowel disease with CC

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MS-DRG 394	Other digestive system diagnoses with CC
MS-DRG 432	Cirrhosis and alcoholic hepatitis with MCC
MS-DRG 813	Coagulation disorders
MS-DRG 871	Septicemia without mechanical ventilation 96+ hours with MCC
MS-DRG 872	Septicemia without mechanical ventilation 96+ hours without MCC
MS-DRG 981	Extensive OR procedure unrelated to principal diagnosis with MCC
MS-DRG 982	Extensive OR procedure unrelated to principal diagnosis with CC
MS-DRG 983	Extensive OR procedure unrelated to principal diagnosis without CC/MCC
MS-DRG 987	Nonextensive OR procedure unrelated to principal diagnosis with MCC
MS-DRG 988	Nonextensive OR procedure unrelated to principal diagnosis with CC
MS-DRG 989	Nonextensive OR procedure unrelated to principal diagnosis without CC/MCC

1. Sound medical guidelines can not only assist physicians in their identifications of clinical situations to support higher-weighted complication/comorbidity MS-DRGs, but also in their clear documentations of these episodes in order to help hospital staff accurately code the records for reimbursement.

Offensive and defensive steps

The new set of government entities and their scopes of work require that hospitals assume a preemptive approach to managing risk. This includes assessing data and operations to identify inefficiencies and areas of vulnerability, and then creating a strategy for improving care and documentation.

CMS requires that care follow current medical literature, without identifying specific guidelines. Whatever guidelines a hospital follows, it should include facilitating documentation and quality of care directly related to indications for admission, inpatient stay until transfer, and complications and comorbidities within the clinical record.

Specifically, at the point of admission, guidelines should facilitate identifying the principal condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care and all secondary conditions that coexisted at the time of admission, that developed subsequently, or that affect the treatment received and/or the length of stay.

The clinical documentation should identify all significant procedures that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training. And all documentation should make clear the time of the onset of the condition and must be in the medical record prior to billing.

The full range of hospital claims are coming under scrutiny, from three colonoscopies provided to the same beneficiary on the same date of service to physical therapy provided in an inpatient setting when the therapy could have been safely and effectively provided in an outpatient setting.

Audit targets include inpatient admissions for procedures that are eligible for outpatient surgery (e.g., laparoscopy or cholecystectomy), one-day stays that would qualify as observation for conditions such as chest pain, back pain, heart failure, and gastroenteritis, and inpatient rehabilitation for joint replacement patients that are deemed not medically necessary for the inpatient setting by Medicare ruling 85-2 and the Medicare Benefit Policy Manual Section 110.

Complicated Medicare severity diagnosis-related groups (MS-DRGs) are expected to be an area of focus. See the adjacent list of MS-DRGs that will likely come under scrutiny.

Once guidelines and documentation processes are determined, the next steps are a thorough and ongoing education of the general staff and a standardized method for prompting providers and caregivers about diagnostic and treatment options and appropriate documentation. Hospitals also should determine a managed approach to denials and appeals defenses.

Those hospitals that have or will implement independently developed evidence-based practice guidelines and documentation processes will be better prepared to provide high-quality care with regard to patient safety, assure that care is delivered in an efficient manner, and have the information available to defend their medical decisions and claims in the ongoing war on waste.

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