Surveillance and Utilization Review Section (SURS)

Rachel Jones, SURS Section Chief
• 42 CFR Chapter IV, Subchapter C Part 456 Federal Regulations require each state to have a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments.

• OAC 5160-2-07.13 Utilization Review rule
• OAC 5160-1-27- Authorizes the review of provider records
• ORC 5164-57 – Recovery of Medicaid Overpayments
Hospital Utilization Review Contract

- Responsible for reviewing 1,500 hospital inpatient and outpatient claims per month for medical necessity, correct coding, and quality issues
- SURS handles all administrative appeals
- Prior authorizations / pre-certifications of certain inpatient procedures
- Focused Reviews
- Health Care Studies
- Technical Assistance
- Other functions as needed – disability determinations
Life Cycle of a Medicaid Retrospective Review:
A presentation to the Ohio Hospital Association

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March 8, 2016

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Permedion at a Glance

- **Permedion Clinical Expertise**
  - 1,000+ contracted medical review professionals
  - 90+ employee clinical professionals including nurses, clinical coders, and behavioral health professionals.

- **URAC Accreditation**
  - 99.9% Utilization Management
  - 99.83% Independent Review

- **QIO-Like**
  - States receive 75% FFP for contracting with QIO or QIO-like organization
  - Requires: Medicare board member, physician access, study capability, and physician involvement in every denial
Clinical Review Services

- Independent Medical Review / Independent Review Organization
- Audits
- Quality Assessment
- Utilization Management
Learning Objectives

✓ Define Utilization Management
✓ Understand the role of Utilization Management
✓ Describe the retrospective review process
   ✓ Records Requests
   ✓ Timelines
   ✓ Permedion Review and Response
✓ Documentation defects
✓ Appeals and Rebills to ODM
✓ Collaborate with the UM department to enhance and improve documentation
✓ Opportunities for Continuing Education
What is Utilization Management?
The “5 Rights”

The right care
In the right amount
At the right time
For the right patient
In the right setting
The “6th Right” of UM

The right payment
Utilization Management Components

- Prior Authorization / Pre-Certification
  - Providers submit for authorization of elective surgeries, admissions, outpatient diagnostics

- Concurrent Review
  - Length of stay review

- Retrospective Review
  - Targeted retrospective review program identifies issues related to:
    - No Documentation
    - No Admit Order for Inpatient
    - Medical Necessity
    - Readmit
    - Transfer
    - Compliance
    - DRG Reassign
    - Coding
    - Billing Error
    - Quality of care
Retrospective Review Process

- Sampling Methodology Approved by Client
- Sample Selected
- Medical Records Requested for On-site Review
- Record Made Available Within Time Frame?
  - Yes: Nurse Review
  - No: Issue Technical Denial
Pertinent Timelines

- Retrospective look-back window: 1 year
- Provider response to a record request: 30 days
Retrospective Review Process cont’d

1. Nurse Review
   - Can Nurse Approve?
     - No → Physician Review
     - Yes → Approval Recorded in System
       - Can Physician Approve?
         - Yes → Reports Updated and Compiled
         - No → Issue Denial Letter with Appeal Info, Update System
     - Issue Technical Denial
Pertinent Timelines

- Provider appeal after initial denial window: 60 days
- Provider to ODM Admin Appeal window: 30 days
Clinical Criteria

• Evidenced-based criteria sources
  – Milliman Care Guidelines
    – Inpatient/outpatient services
    – Recovery level of care services
  – Professional Society Guidelines, Policies and Position Statements
  – Current Peer Reviewed Published Medical Literature
Care Documentation

The Problem

• No Valid Admit Order or Unclear Care Level
• Untimely or Incomplete History and Physical
• Missing Operative Reports and Consents
• Untimely Discharge Summaries

If you didn’t write it down, it didn’t happen!
Documentation is Lacking

- 50-60% of H & P’s are incomplete
  - Lack Description of Medical, Family, Social and Surgical Histories and/or Review of Systems

- 20-30% Lack Signatures on Orders

- 50-60% Admit Orders Are Incomplete
  - Date, Time, Setting, Justification, Signature

- 50% of Records Coded Without Discharge Summaries Have Incorrect Diagnoses
Physician’s Role in Improving Acute Care Documentation

- Complete Admission Order
  - Date, Time, Setting, Diagnosis, Other
- Complete History and Physical
  - History and Review of Systems
- Complete Operative Reports and Consents
- Timely and complete Discharge Summaries (before billing occurs)
Record Review - Checklist

• Physician Level
  – Timely and complete History and Physical
  – Complete & Accurate Admission Order
  – Completion of Discharge Summary

• System Level
  – Conditions of Participation and Timely Submission of Records to the QIO
  – Consider the Explanation of Denials
Appeal Process

Appeals Review Process

Receive Requests for Appeal of Decision

Timely Receipt?

- Yes: Send case to Peer-matched Physician Review
- No: Send Notification to Provider

Decision Overturned?

- Yes: Send Approval Notification
- No: Send Notification of Continued Denial
Inappropriate Rebills

• In October of 2015, ODM instituted a process to prevent inappropriate rebill and reimbursement. 1 of 3 adjustment reason codes are assigned to claims based on denial category.

<table>
<thead>
<tr>
<th>Adjustment Reason Code</th>
<th>Adjustment Reason Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8008</td>
<td>Inpatient claim allowed to be re-billed as inpatient (same type of bill)</td>
</tr>
<tr>
<td>8009</td>
<td>Outpatient claim allowed to be re-billed as outpatient (same type of bill)</td>
</tr>
<tr>
<td>8010</td>
<td>Never allowed to re-bill claim, inpatient or outpatient (technical denials)</td>
</tr>
<tr>
<td>8012</td>
<td>Inpatient claim allowed to be re-billed as outpatient (resubmitted claim is type of bill 13X)</td>
</tr>
</tbody>
</table>

– The assignment of Adjustment Reason Code 8010 indicates that a provider is not permitted to rebill the associated claim.
Final Thoughts

• Improved Documentation
  – Better billing / reimbursement for the hospital and surgeon
  – Better patient care and follow-up

• Physician Participation / Leadership

• Ping the system (i.e. target the targets)

• Be sure to review your remits to determine next steps.
THANK YOU