

# FMQAI Services

## Utilization Management Services

- Utilization Review
- Case Management Education
- Physician Advisor Development
- CMAP Implementation
- Independent Validation

## Coding Services

- DRG Validation
- “Present on Admission”
- MS DRG
- Physician Queries

## Compliance Design

- RAC Preparation
- Analytical Review
- Quality Improvement Process Implementation
- Core Measures Improvement Plan
- Hospital Administration Overview
- Quality of Care Review



*Information for Healthcare Improvement*

### Contact Information:

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ISO 9001:2000 Certified



## Case Management Assignment Protocol

Overpayments for Medicare fee-for-service claims reported by the federal government in 2007 totaled \$9.8 billion, with \$4.3 billion attributed to overpayment of inpatient claims.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) uses education, special studies, fraud investigation, and medical record review by Medicare claims processing contractors to protect and recoup Medicare assets. With the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress added another effort to protect Medicare funds: Recovery Audit Contractors (RACs).

<sup>1</sup>Centers for Medicare & Medicaid Services. Improper Medicare Fee-for-Service Payments Report. November 2007.



## Challenges for Hospitals

Admission denials represent almost 50% of the total errors for inpatient Medicare claims,<sup>2</sup> making medical necessity and unnecessary admissions lucrative targets for recovery of Medicare funds from hospitals. In fact, most of the overpayments from the three-year RAC pilot project were collected from inpatient hospitals, with about a third coming from claims not meeting Medicare medical necessity criteria.<sup>3</sup>

Of particular concern to hospitals are short stay ( $\leq$  two days) admissions claims for symptom codes rather than diagnosis codes and admissions through emergency departments. These are likely to be denied, thus putting hospitals at risk for repayment of Medicare funds. For fiscal year 2006, hospitals owed approximately \$2.9 billion for inpatient admission denials.<sup>2</sup>

<sup>2</sup>Centers for Medicare & Medicaid Services. National Payment Error Data. FY 2006.

<sup>3</sup>Centers for Medicare & Medicaid Services. CMS RAC Status Document. FY 2007.



Information for Healthcare Improvement

## FMQAI's Solution

FMQAI has helped hospitals reduce unnecessary Medicare admissions with the Case Management Assignment Protocol (CMAP) since 2003. Hospital staffs use the protocol to assign patients to the correct billing category – inpatient vs. observation.

CMAP addresses high denial areas such as symptom DRGs, emergency department admissions, and short stays. Hospitals with a strong commitment to using the protocol have been shown to reduce inappropriate inpatient admissions by 91%.

FMQAI's national experience includes:

- Hands-on implementation in 30 acute care hospitals
- Technical assistance to more than 115 hospitals
- Training of six Medicare Quality Improvement Organizations and their selected hospitals
- Multiple private contracts

FMQAI's experience in reducing unnecessary admissions has been published in peer-reviewed journals.<sup>4,5</sup>

<sup>4</sup>A case management protocol. Reducing unnecessary Medicare admissions in Florida. *Lippincott's Case Management*. 2005 Mar-Apr;10(2):72-80.

<sup>5</sup>Reducing unnecessary Medicare hospital admissions for chest pain in Arizona and Florida. *Professional Case Management*. 2008;13:74-84.