



THE RIGHT CARE FOR EVERY PATIENT EVERY TIME

Case Review Connection

The Medicare Quality Improvement Organization for Florida

9th Statement of Work

As part of the QIO program, FMQAI is preparing for its 9th Statement of Work (SOW) contract cycle (August 2008 - July 2011) with the Centers for Medicare & Medicaid Services (CMS). Under the 9th SOW, the QIOs will focus on four main themes: Beneficiary Protection, Patient Pathways (Care Transitions), Patient Safety, and Prevention. In addition, the QIOs will be required to help Medicare promote three over arching themes: adopt value-driven healthcare, support the adoption and use of health information technology, and reduce health disparities in their communities. As part of the 9th SOW, QIOs will be required to offer help to specific nursing homes and hospitals that that have not recently performed well on important quality measures. If you are interested in reading more about the 9th SOW, you can do so by going to www.cms.gov and typing 9th SOW in the search field.

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Hospital Discharge Appeals

Preadmission/Admission HINNs

Regulations found at 42 CFR Part 476.71 require QIOs to review the medical necessity of hospital discharges and **admissions**, in addition to other requirements specified in that section of the regulation. The utilization review committee or the hospital may issue a preadmission/admission HINN should they believe the service to be provided is not reasonable and necessary, could safely be provided in another setting or the care is custodial in nature. New templates for the HINN notices can be found and downloaded from the CMS website:

www.cms.gov/BNI. Once at the website click on FFS HINN under BNI (left side of the screen) and then click on HINN (zip) under DOWNLOADS. The QIO contact information to insert in the letter is as follows: FMQAI, 1-800-844-0795

Please note that these appeals are only processed during regular QIO business hours Monday through Friday.

Hospital Discharge Appeals (cont.)

HINN 12 - Noncovered Continued Stay

There are two instances where the HINN 12 notice is applicable.

The beneficiary has requested a timely Expedited Determination review:

- The QIO agrees with the discharge
- The hospital may issue a HINN 12 for charges incurred after 12 noon the day after the verbal determination is made/shared, provided the beneficiary chooses to remain in the hospital

The beneficiary has received the Important Message follow up notice and does not request an Expedited Determination review by midnight of the day of discharge:

- The provider may issue a HINN 12 for charges incurred as of midnight the day of discharge if the beneficiary continues to remain in the hospital.

The HINN 12 notice is found at www.cms.gov/BNI. Click on FFS HINNs under BNI. Click on HINN Forms under Downloads on the page. You will find the notice and instructions for the notice.



Alternative Dispute Resolution (ADR)

Although the main focus of conversations about Medicare's Alternative Dispute Resolution Program tends to be the mediation option, external ADR is also a crucial and productive aspect of the program. What is external alternative dispute resolution? External ADR resolves beneficiary concerns by utilizing the provider's own quality management processes such as a Patient Debriefing Committee, a Patient Relations Committee, Case Management or Risk Management. In order for a beneficiary to be deemed appropriate to participate in the external ADR process, one or more of the following criteria must apply.

- The provider has its own quality improvement process that is able to satisfy the same expectations/goals as mediation.
- There is a case management issue that can be facilitated or resolved by FMQAI staff.
- The concern can be resolved through advocacy for the beneficiary.
- The beneficiary is will and able to proactively and independently resolve concern with appropriate referral by FMQAI.

ADR (cont.)

FMQAI serves as either the conciliator or facilitator in the external process. When acting as conciliator, FMQAI serves the role of the beneficiary's tour guide to his/her own healthcare. FMQAI assists the beneficiary or family member in personally pursuing resolution of concerns with the provider by explaining processes, clarifying appropriate procedures and providing contacts. Often, conciliation is a matter of simply demystifying the system so that the beneficiary can take the reins. When acting as facilitator in the external ADR process, FMQAI serves as intermediary between beneficiary and provider to assist in resolution of concerns. As facilitator, FMQAI takes the reins in navigating the beneficiary through the system and advocating for needs to be resolved. This often can be as simple as informing the QIO liaison at a hospital of a patient's needs/concerns. The use of facilitation is especially helpful when a beneficiary has difficulty communicating his/her needs personally or has some extenuating circumstance that renders him/her unable to personally pursue the resolution of the concerns.

With prompt use of conciliation or facilitation, many concerns can be resolved quickly and easily before a situation becomes a formal complaint, however such preemptive work is not necessarily recognized in the broad spectrum of conflict resolution. This is especially true with repeat callers. As with any customer service provider, health care has its "frequent flyers" that present again and again with minor problems that they are unable to resolve on their own. External ADR is a fantastic solution for such "frequent flyers" as we can identify their needs and serve both as advocates and guides along their health care path. Although this "case management" of sorts is not the specific purpose of the QIO, it is a form of alternative dispute resolution that is highly effective for preventing larger healthcare problems. For example, one particular "frequent flyer" at FMQAI is an elderly man caring for his wife who is unable to read and has some difficulty communicating his wife's needs to her providers. By developing a relationship with this gentleman and making a few calls to connect him with the appropriate people, his concerns have been easily resolved and, thus, external ADR via facilitation is demonstrated as a successful strategy.

External ADR may also come into play when a provider is somewhat apprehensive about the mediation option and would like to proceed with their processes. In this case, FMQAI becomes a matchmaker of sorts by facilitating the communication between beneficiary and provider in order to bring both to a better understanding of the concern, the provider's resolution process, and the goals of the process. Providers may choose this option in order to gain a greater sense of control over the process, however, this option is only feasible for certain, highly competent beneficiaries who are focused solely on the actual care provided and not any other ancillary issues. The removal of the mediator from the process can pose potential problems as it allows the door to be opened for "he said, she said" without direct focus on the goals of the process. A mediator is always beneficial in preventing such issues and providing an accurate, objective perspective on the agreements made during the meeting. Yet, in the right situation, external ADR can prove quite satisfactory for both parties due to its informality and simplicity.

In many situations, external ADR is the best route toward resolving beneficiary concerns and improving the overall quality of health care provided. External ADR plays an active role in FMQAI's efforts to improve the quality of healthcare. For more information regarding the QIO's, FMQAI is introducing a new course entitled ***"Medicare Alternative Dispute Resolution Program: A New Way to Answer Beneficiary Concerns About Health Care"***. You can access this CEU at <http://www.fmqai.com/Professional-Providers/Case-Review/Continuing-Education/>. This course is approved for 1.0 continuing education contact hour by the Florida Board of Nursing, CE Broker #50-747 and the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling, Board Provider BAP #925, Exp. 3/2009 and CE Broker #50-747.

Coding Corner

Clinical Documentation Improvement Programs

The goal of any clinical documentation improvement program is to have physician documentation in the medical record that accurately reflects the acuity of the patient's condition. Sounds simple right? Not exactly. Physician documentation is the basis on which the reimbursement and ultimately the hospital's CMI (Case Mix Index) is determined.

The best plan is to have the medical record examined concurrently in order to spot opportunities to improve documentation. Coders who code the record concurrently or RN's that have been trained in the use of Coding Guidelines and MS-DRG's are typically responsible for reviewing the record and querying the physician for clarification of the documentation. Physicians must also be educated on documentation requirements and how what they document impacts the bottom line and quality indicators for the hospital.

Example 1

The physician documents that a 72 year old female is admitted with "urosepsis", hypotension, leukocytosis, positive blood and urine cultures for E-coli and dyspnea. The patient expires after 2 days. Without a documentation improvement program or retrospective query, the medical record will be coded as follows:

599.0 - UTI
458.9 - Hypotension
786.09 - Dyspnea

DRG 690 CMS wt. 0.8000

Example 2

This example refers to the same patient as above. This time a documentation specialist has concurrently queried the physician for clarification of the diagnosis of "urosepsis." After explaining to the physician that "urosepsis" is a nonspecific term that will be coded as a UTI per coding guidelines, the physician documents E-coli Sepsis secondary to the UTI. Also while performing the concurrent review of the medical record, it is noted that the physician has documented dyspnea and that the patient's blood gases were severely deranged. A query is placed on the record noting the blood gas derangement and dyspnea. The physician is asked what diagnosis, if any, that this represented for this patient. The physician then documents in the progress notes as a result of that query that the patient was admitted with acute respiratory failure. As a result of the concurrent query process, the same patient as above will be coded as follows:

038.42 - Septicemia due to E-Coli
995.92 - Severe Sepsis
518.81 - Acute Respiratory Failure
599.0 - UTI

DRG 871 CMS wt. 1.7484

Coding Corner (cont.)

By querying concurrently:

1. The documentation in the record has been positively impacted.
2. An educational opportunity was provided for the physician that documented “urosepsis.”
3. The DRG more accurately reflects how acutely ill the patient was on admission.
4. The increased turn around time on being able to get the record coded and billed without having to hold it up for a query that might or might not be answered is eliminated.

It should be noted that facility “buy in” to the documentation improvement program is vital to its success. With the support and cooperation of those in leadership roles within the facility to encourage physician education and compliance with the program, good results can be achieved.

HPMP Updates

Transition of HPMP Out of the QIO Program

Effective August 1, 2008 with the beginning of the 9th Statement of Work, Quality Improvement Organizations (QIOs) will no longer be responsible for implementing the Hospital Payment Monitoring Program (HPMP).

The purpose of HPMP was to measure monitor and reduce the incidence of improper fee-for-service inpatient acute care Medicare payments. QIOs will no longer be responsible for these functions and funding for QIO assistance related to these responsibilities will cease. These responsibilities are being transferred to other entities. Hospitals should be aware that support and education provided by QIOs related to payment error reduction will no longer be available. Hospitals may wish to contact the following organizations for questions previously directed to QIOs related to compliance or payment error reduction activities:

- Compliance-related questions: Health Care Compliance Association
- Billing questions: Fiscal Intermediary or Medicare Administrative Contractor

FMQAI asks that all Florida Hospitals continue to monitor one and two day admissions. Recovery Audit Contractos (RACs) will conduct Medicare audits for inappropriate payments. In the recently completed three-year RAC demonstration project, 84% of overpayments were attributed to inpatient hospitals and 40% of overpayments were due to medically unnecessary services. RACs view chest pain admissions as one of the top DRGs for unnecessary admissions. FMQAI believes continued monthly self-auditing of your utilization process is a beneficial step toward decreasing unnecessary admissions and payment errors.

After evaluation of case review and HPMP data in the 8th Statement of Work, FMQAI would like to share the following information:

PTCA, PCI and AICD Pacemaker Billing

As technology has progressed and the need for prolonged care after these procedures has become less, FMQAI recommends that these elective procedures be billed as outpatient.

Inpatient Only List

Please remember that Medicare pays by the Federal Register Addendum E Inpatient only list that can be found at:

http://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS1392FC_Addendum_E.zip

For more information regarding the transition of HPMP, please see Memo dated June 9, 2008 that was e-mailed to each hospital.



Contacts

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