
MEDICARE COMPLIANCE

Prevent Inappropriate Admissions By Strengthening UR Committees

With all the pressure they face to reduce medically unnecessary admissions, hospitals need strong utilization review (UR) committees — especially since there have been few consequences for physicians whose admission decisions conflict with strict Medicare regulation and guidance (though that is starting to change).

An effective UR process, powered by highly trained case managers and physician advisers, is a great way to help prevent inappropriate inpatient admissions, according to Atlanta attorney Mitch Mitchelson, who represented the first hospital to settle a false claims lawsuit for alleged medically unnecessary inpatient admissions, and physician Robert Corrato, M.D., CEO of Executive Health Resources in Newtown Square, Pa., who served as a medical-necessity expert in the case.

Increased Scrutiny on Admission Necessity

Admission necessity has probably never faced more oversight — from recovery audit contractors, Medicare quality improvement organizations and program safeguard contractors (which are morphing into zone program integrity contractors). With advances in medicine and technology, more procedures can be performed on an outpatient basis, putting pressure on hospitals to establish inpatient medical necessity.

“The increased scrutiny we’re seeing today is an important part of preserving the integrity of the Medicare trust fund and is not going to end any time soon,” Corrato says. “But if [hospitals] follow the regulatory mandate that Medicare has provided through the appropriate constitution of a UR plan and meet the baseline regulatory requirements of a UR committee, [they] should not be fearful of increasing regulatory scrutiny.”

There’s a lot to know about UR committees and what Medicare expects of them, Corrato and Mitchelson say. UR committees are a requirement of Medicare’s Conditions of Participation. According to 42 CFR 482.30, “The hospital must have in effect a utilization review 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 Medi-caid programs.”

The plan will be carried out by a UR committee that “addresses the utilization of services furnished

by the hospital and its medical staff to Medicare and Medicaid patients,” Corrato says.

The committee must evaluate medical necessity with respect to (1) admissions to their institution (i.e., Medicare claims status review); (2) the duration of care (i.e., continued-stay review); and (3) professional services rendered, such as drugs and biologicals (i.e., outliers in length of stay or outliers in cost or utilization).

“Review of admissions may be performed before, at or after hospital admission,” according to the regulation. Of course, that’s not exactly relevant anymore given the opportunity that hospitals have to shift inappropriate admissions to outpatient status using condition code 44, as long as the treating physician and the UR committee concur — and that decision is made before the patient is discharged, Corrato notes.

He says the UR committee should be composed of medical staff leadership (e.g., chief medical officer, department chairs) and physician advisers who are “intimately involved and knowledgeable regarding day-to-day UR issues, medical standards of care and the evolving federal regulations and guidance specific to your hospital”; administrative leadership (e.g., CFO); case management; health information management; business office leadership; patient financial services; and others as needed.

The admission decision ultimately belongs to physicians, who consider factors like the severity of the patient’s signs and symptoms and the medical predictability of something adverse happening to the patient. But the UR committee and case managers monitor physician decision making to help ensure compliance with accepted admission-screening criteria (e.g., InterQual), federal regulations and guidance regarding medical necessity, and other physicians’ opinions and standards of care.

“Until recently, treating physicians remained unaffected when a hospital did not comply with the Medicare inpatient medical-necessity regulations, and it was the hospital that suffered strong penalties. However, we are now on the threshold of a significant change in the world of Medicare, where hospitals and their treating physicians will both be held accountable and possibly experience economic and other sanctions

for not remaining compliant with Medicare's regulations," claims Corrato. "This change will make it even more important for hospitals to build strong UR plans and committees."

Physician Advisers as Peer Reviewers

While UR committees provide oversight and resolve conflicts over admission necessity, "daily accountability is best established through the collaboration of treating physicians, case managers and physician advisers," Corrato says.

Following the admission of a patient, case managers provide the first level of review, using admission screening criteria to determine whether Medicare would consider an inpatient admission medically necessary, according to the patient's severity of illness and intensity of services.

Often, case managers and physicians are on the same page, and admission decisions go smoothly. However, many times an admitted patient may not meet the criteria for inpatient status, according to the guidelines the case manager is reviewing. At this point in the admission-review process, case managers should contact the physician to discuss the patient's status. The physician may have additional information or be aware of the patient's medical history or other factors that are not yet, or not thoroughly, noted in the patient's chart.

At this point in the process, an effective line of communication between the case manager and physician is critical to the assurance of thorough charting, which can help ensure appropriate patient status. The communication between the case manager and physician often does not clarify the medical-necessity status or, for whatever reason, does not occur. In such common situations, a physician adviser can step in to provide an additional review of the case and assist in reaching a correct and compliant admission medical-necessity status determination.

Physician advisers are often written into UR plans so that a treating physician's peer can discuss a potentially medically unnecessary admission with a medical-staff physician, says Mitchelson, who is with the law firm Alston & Bird LLP. When this step can't take place, the case is often referred to the entire UR committee, he says.

"Physician advisers should always be reaching out to treating physicians to discuss inpatient medical necessity and to ensure they properly document all of the contributing factors of their treatment decisions which support medical necessity," Corrato says.

Resolving Disagreements

If there's disagreement between the physician adviser and the treating physician regarding admission medical necessity, the case should be referred to the UR committee, where a second physician member of that committee will make a final admission medical-necessity determination. That's one of the reasons why the regulations call for at least two physician members on the committee, Corrato says.

Since case managers perform the first level of admission medical-necessity screening, it is imperative that they are highly trained and skilled, Mitchelson says. This is now a mantra at Saint Joseph's Hospital in Atlanta, which arrived at an amount of \$26 million to settle false claims allegations of medically unnecessary inpatient admissions last year (*RMC 1/7/08, p. 1*).

Saint Joseph was accused of billing Medicare for thousands of zero-day, one-day, two-day and three-day stays that weren't covered because, under Medicare's guidelines, the patients needed only outpatient care (e.g., observation). None of the problems the investigation turned up was intentional, Mitchelson says, and Saint Joseph's quickly made substantial modifications to strengthen its admission-review process, including validated first-level case management and second-level physician adviser admission medical-necessity review. By demonstrating this commitment to improving the admission-review process, the two parties were able to come to a settlement.

The corporate integrity agreement (CIA) imposed on the hospital by OIG as part of the false claims settlement included a case management protocol. The protocol allows medical staff to permit admission decision making by case managers, subject to physician veto. That raises the stakes for highly qualified case managers. The CIA also sets forth requirements for case manager training and certification.

"You want to make sure they are educated and have some kind of inter-relator reliability to ensure they are following criteria on a daily basis," Mitchelson contends.

Assessing UR Effectiveness

Hospitals should regularly assess the performance of their UR committees. Corrato says this can be done in various ways. "You must be somewhat of an operational process sleuth," he says. "For example, take an in-depth look to determine whether case managers are completing first-level medical-necessity reviews in a timely fashion and on all appropriate admission cases.

Also ensure that case managers' and physician advisers' determinations are validated over time and will stand up to regulatory muster. Regarding the efficiency of care after the decision to admit an inpatient has occurred, ensure that discharge planners are involved very early on in the patient stay, thus avoiding delays in disposition from the inpatient setting for reasons that are not related to medical necessity. Discharge planning should begin upon admission," he maintains.

In one UR case that Corrato consulted on, stroke and transient ischemic attack (TIA) patients had longer lengths of stay than their peers in the region (indicating that they might not be being discharged in a timely manner).

It turned out that many treating physicians wouldn't release these patients until they had a pre-

discharge confirmatory MRI to determine the location and extent of the stroke as part of the process to define future postdischarge care. The inpatient and outpatient sides of the hospital shared one MRI, resulting in delays in obtaining nonemergent inpatient MRIs in a timely fashion. The solution was simple: Earmark inpatient time slots on the MRI schedule (which, if not used, could be quickly filled with an outpatient), and, if necessary, keep the MRI open later to accommodate stroke and TIA patients. "This subsequently prevented a delay in the discharge of stroke patients through the fulfillment of the regulatory mandate of the UR committee to evaluate the duration of stays," Corrato says.

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