

HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

Hospital appeals, receives about \$2 million in denials

System uses external physician advisor

Bon Secours St. Francis Health System received nearly \$2 million in denials and successfully appealed the vast majority of them during the few months the Greenville, SC, hospital was part of the Recovery Audit Contractor (RAC) demonstration project, says **James T. Jones**, PhD, RN, administrative director, case management and patient documentation for the Bon Secours St. Francis Health System.

South Carolina became part of the Recovery Audit Contractors demonstration project on July 1, 2007.

"We were part of the RAC demonstration for only a few months but we received 650 requests for medical records. Out of several million dollars of initial denials, the recovery rate under the appeals process has been an overwhelming success in that all but a small percentage of denials were overturned," says Jones.

The secret to success was the hospital's decision to contract with an outside physician advisor firm, which reviews patient records before the admission occurs when there is a question about medical necessity or patient status.

When the hospital administration asked Jones for his opinion on contracting with an outside physician advisor firm, he readily

agreed to contract one.

"I thought this was something that would work well because CMS requires the second-level review process under the Medicare Conditions of Participation. In my opinion, it's always best to have an escalated process where the physician who reviews the case has the authority to make a determination but is not an admitting physician and does not have a personal relationship with the physician whose orders he or she is reviewing," Jones says.

Under the arrangement, the hospital has its own dedicated team of physician experts who work with the case management staff and the medical staff. Jones has a monthly telephone conference with the firm to discuss how the referral process is going and any issues or concerns.

When case managers have any questions about a case meeting inpatient criteria, they call the physician advisor for a review while they are still on the telephone. In most cases, the case managers have the chart in front of them and can provide the information the physician advisor needs to make a determination.

If the case managers can't have the chart available when they make the call, they use a sheet that outlines all the information they need to gather in order for the physician advisor to make a medical necessity determination, Jones says.

"The staff understand that it is extremely important to check with the outside physician advisor firm if there is any sort of gray area. If

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the patient is clearly meeting inpatient criteria, they don't call. But they do call in situations where lab values may be abnormal or the patient is on a slow IV fluid drip and may be more appropriate for observation services," he says.

The case managers ask for review of about 30% to 40% of Medicare patients.

"These calls are so important because only the second-level physician reviewer has the authority to override the criteria and say that, based on other comorbid conditions, that may place the patient at higher risk the patient meets admission criteria," he says.

"The case manager documents in the medical record that the case was reviewed by the physician advisor and the patient did or did not meet medical necessity," he says.

The physician advisor firm then e-mails a determination letter in an encrypted secure zip file that only four people can access. That includes Jones, his administrative assistant, the lead case manager, and an RN case manager on the surgical unit.

"We make the letters accessible to four of us to make sure that someone is on site when the letters arrive and can get them printed and sent to the medical records department in a timely manner," Jones says.

The medical records department scans the letter into the electronic medical record.

"Once we receive the letter of determination from the physician advisor firm, it is available in the electronic medical record within two hours," Jones adds.

The hospital retains the letters of determination from the firm as part of the permanent patient record.

"Now if there is ever any question from an auditor or if the case ever goes to court, we have it in the record that we have a process in place and that we followed it," he says.

Before signing the contract with the outside physician advisor firm, Jones presented the idea to the hospital's medical executive committee and utilization management committee and got their buy-in.

"We conducted extensive education with the physicians in meetings and one on one in the hallways. We told them that what we were doing would not only help the hospital, but would help them to document the correct severity and status that will affect their MEDPAR data," he adds.

Physicians accept admissions reviews

Physician acceptance to having their admissions reviewed by an outside firm was a challenge at first, but it's improved now that physicians face the same level of risk as the hospital and are subject to having their professional fees recovered if the hospital receives a Medicare denial, Jones says.

"During the demonstration project, it was difficult to get most of the medical staff to buy into what a RAC denial means, but now, I have physicians calling me to ask how they can comply," he says.

When the process started, the physician advisor firm's trainer met with Jones and the case management staff to describe how the process would work.

During the educational sessions, Jones emphasized the importance of making the telephone call to the physician advisor company and ensuring that their letters of determination are included in the patient chart.

"We're not looking for them to agree with us. The whole secret to compliance is to get it right the first time," he says.

The actual referrals are about 70% above the projected referrals, Jones reports.

"This tells me that all the education and coaching is paying off. Now the case managers understand the importance of making referrals to the physician firm when there is a question of medical necessity," he says.

Jones receives regular monthly reports on compliance issues, which he uses to educate his case management staff.

"We have conducted extensive education with the staff on the use of Condition Code 44. If Medicare determines that a hospital invokes Condition Code 44 frequently, it opens the hospital up to more scrutiny. Our Condition Code 44 rate is extremely low, due to the education the staff have received from the physician advisor firm," he says.

The hospital uses the outside physician advisor firm for about 70% of its payer mix. It's used primarily for Medicare and Medicaid cases since commercial insurance reimbursement is primarily driven by the contract, Jones says.

"We treat any self-pay or uninsured patients the same as we do Medicare patients. We have to manage them well

because we don't want to add to the cost to the self-pay patients or to the hospital," he says.

The hospital had been using the new system to determine admission status for nearly a year when it became part of the RAC audits.

"We had the process down very well by then and were very successful with compliance and the RAC process," he says.

St. Francis appealed all of its denials with the help of the outside physician advisor firm.

When the records requested by the RAC included a letter from the physician advisor company explaining medical necessity and the medical reasoning for making that determination, the denials were automatically overturned at the first appeal level.

"That told me that our process was working very well to lower our exposure to the RAC denials," he says.

The appeals process can take up to two and a half years to recover any money that Medicare takes back if the hospital has to appeal through the entire five levels of appeal, Jones points out.

Of the 38 cases that St. Francis appealed to the administrative law judge level of appeal, 99.8% of denials were overturned in favor of the hospital.

Jones already was knowledgeable about the demonstration project after moving to Greenville from Florida, one of the initial states in the RAC demonstration project.

"The hospitals here weren't as familiar with the RAC process. I was able to educate our staff about what the RACs mean and the kind of processes we must define and follow," he says.

Jones recommended that the hospital's RAC steering committee have senior administrators as part of the team so the committee could make decisions immediately and go forward with them.

"The RAC team needs to be widespread and high-powered. At St. Francis, the chief medical officer and the chief financial officers are members of the RAC team and strong supporters of the process," he says.

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