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## **Acute Inpatient Prospective Payment System (IPPS)/Short Term Care Hospital (STCH) Review Findings Ask-the-Contractor Teleconference (ACT) Minutes/Transcription**

**April 7, 2009**

**Chairperson: Mary Sue Gardner, RN/BSN**

The Central Region, "Acute IPPS/Short Term Care Hospital (STCH) Review Findings" Ask-the-Contractor Teleconference (ACT) was called to order by Mary Sue Gardner, Medicare Outreach Nurse Analyst – Omaha Office, at 1:00 PM Central Time.

Mary Sue began the teleconference by introducing herself. She was joined by other Outreach Analysts and members of the Provider Education staff as well as nurses from the Medical Review Department.

This call was open to Legacy providers, those that were formerly serviced by us under Mutual of Omaha-Medicare, and to J5 providers, those that transitioned to WPS A/B MAC and were formerly serviced by another contractor.

The introductions were followed by a brief description of the purpose and objective of the call, including why WPS Part A is doing Acute IPPS reviews, discussion on the InterQual tool that WPS Part A uses in the review process, documentation guidelines that our providers need to follow when submitting claims for review, to ensure they submit the correct information, common findings/issues from our Medical Review department and the Comprehensive Error Rate Testing (CERT) review contractor, and how these findings affect the reimbursement of Acute IPPS claims.

This topic was selected due to Change Request 5849, which was effective August 1, 2008, informing Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (A/B MACs) to perform medical review for Acute IPPS hospital and Long Term Care Hospital (LTCH) claims to ensure CMS only pays for covered, correctly coded, and medically necessary services. The Quality Improvement Organizations (QIOs) will no longer be performing the majority of the utilization reviews for Acute IPPS and LTCH claims. Our Medical review department started reviewing Acute IPPS claims in fiscal year 2009. In working with the CERT contractor, we found that review findings were similar between WPS Part A and the CERT review contractor. In an effort to provide education to our providers, WPS Part A chose to host this Ask the Contractor Teleconference to discuss the review the findings and provide additional education about our review process of these claims.

The introductory discussion was followed by a review of a Power Point presentation that was provided to all registrants. WPS Part A also provided an additional handout that expanded upon the common findings of the reviews. This handout was discussed during the teleconference as well.

The final points discussed during this teleconference were how unfavorable review findings affect reimbursement of Acute IPPS claims.

At the conclusion of the presentation, the line was opened up for questions from the audience.



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### Audio Transcription

**Due to recording difficulties, the audio transcription including the question and answer segment of this call is not available. Since the audio is not available, the following is a transcription of the presenter's speaker notes from the call.**

"Hello everyone, and welcome to the WPS Part A Ask the Contractor Teleconference on Acute Inpatient Prospective Payment System, (IPPS) or otherwise known as Short Term Care Hospital (STCH) review findings.

My name is Mary Sue Gardner and I am a registered nurse on the provider outreach and education team. I am joined today by several other members of our Provider Outreach and Education Department, as well as our Medical Review Department, who will be assisting in the question and answer portion of today's call. In today's call we will be discussing Acute IPPS Hospital (Short Term Care Hospitals {STCH} reviews).

This call is open to our Legacy providers, meaning those providers that were formerly being serviced by us under our prior Mutual of Omaha-Medicare name, as well as our J5 providers, those that were previously being serviced by another contractor such as Wheatlands, Cahaba, BCBS of Nebraska, or Trispan.

Just as a reminder, today's call is being recorded by InterCall and all calls will be placed on silent hold under the open question and answer portion of the call.

I wanted to let you know that the intent of today's call is not to dispute the regulations regarding Acute IPPS reviews, but instead to inform you about WPS Part A's current review process of these claims, and to provide some background to our providers about what we have been findings upon review that may make a claim not considered for coverage.

So let's turn to today's presentation. I sent this presentation out in Microsoft Office Power Point. If you were not able to open the attachment, please stay on the line and listen to the presentation and notify me after the call, and I will make arrangements to get it to you in some other format.

In today's call, we are going to discuss why WPS Part A is doing Acute IPPS Hospital (STCH) reviews, and the InterQual tool that assists us in doing these reviews. We will also discuss our documentation guidelines to assist providers in ensuring they submit the correct information for review. Finally, we will discuss some of the common findings from our Medical Review department, which are similar to the findings of the Comprehensive Error Rate Testing (CERT) review contractor, and how these findings effect reimbursement of the acute IPPS (STCH) claims.

Change Request 5849, which was effective August 1, 2008 informed Fiscal Intermediaries (FI) and Medicare Administrative Contracts (MACs) to perform medical review for Acute IPPS hospitals and Long Term Care Hospital (LTCH) claims to ensure CMS only pays for covered, correctly coded, and medically necessary services.

This change request also informed providers and contractors that the Quality Improvement Organizations (QIOs) will no longer be performing the majority of the utilization reviews for acute inpatient prospective payment system hospital and long-term care hospital claims. The QIOs will retain their responsibility for performing expedited determinations, HINN reviews, quality



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reviews, provider-requested higher-weighted DRG/MS DRG reviews, and other functions outside the scope of FI and MAC medical review departments.

When reviewing acute IPPS (STCH) documentation, WPS must determine that the medical records indicate that inpatient hospital care was medically necessary, reasonable, and at the level of inpatient care appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and symptoms severe enough to warrant the need for inpatient care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

In determining the appropriateness of admissions, any pre-existing medical problem or extenuating circumstances are taken into consideration.

It is important to note, that inpatient care rather than outpatient care is required only if the beneficiaries medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.

When we determine that admission was appropriate, then we utilize the medical record to determine whether procedures and diagnosis were coded correctly. If we determine that admission may not have been appropriate, but the beneficiary's condition changed during the stay and inpatient care became medically necessary, we will make review determinations based on the first day in which care was determined to be medically necessary.

Part of our review of acute IPPS (STCH) claims, is also to perform a DRG/MS DRG validation review. The purpose of the DRG validation is to ensure that diagnosis, procedural information and the discharge status of the beneficiary as coded and reported, matches the attending physician's description and information contained within the medical record. If the principal diagnosis and secondary diagnosis or procedures affecting the DRG or MS DRG assignment of the claim are not reported properly, this may affect the DRG/MS DRG reimbursement. WPS is required to review and make corrections to any claim that we review and cannot validate the DRG/MS DRG reported.

WPS is also required to determine whether the length-of-stay for Prospective Payment System (PPS) cost outlier claims are appropriate and medically necessary. You should note where it is determined that a beneficiaries stay was unnecessarily long, and potentially represents fraud or abuse, WPS has the authority to refer these providers on to the Program Safeguard Contractor or Zoned Program Integrity Contractor (PSC/ZPIC).

### **What Tools Are Used To Assist With These Reviews?**

WPS Part A chose to use McKesson's InterQual screening tool.

As part of the requirement for review of acute IPPS (STCH) claims, CMS stated that the reviewer shall use a screening tool as part of their medical review process. CMS did not require that we use a specific criteria set. Please note, in all review cases, in addition to using screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.

### **What is InterQual?**

Most of you already know what InterQual is, are using this product or a similar product, but InterQual is a screening tool that uses evidence-based clinical decision support criteria to



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answer critical questions about the appropriateness of levels of care and resource use. During the last three decades, these criteria have helped define and legitimize the disciplines of utilization and care management, providing medical directors and other hospital, and health plan professionals support in making the type of objective, evidence-based decisions that define top-quality, efficient care, and leading to greater transparency and collaboration between payors and providers.

InterQual is a tool that helps to determine the appropriateness of a proposed medical intervention(s). It is an objective tool used to support clinical rational for decision making that uses Criteria components of; severity of illness (SI), intensity of service (IS) and discharge screening (DS) to assist in determining appropriate level of care criteria such as:

- Acute adult criteria
- Long-term acute criteria
- Behavioral health

InterQual is **NOT** intended to deny care, only to assist in the appropriate level of care that services should be rendered at and also assist with the appropriate timing of discharge. It is important to note that not meeting InterQual criteria, does not equate to denial of services. In these instances, our clinical reviewers take into account all documentation to determine if severity of illness and/or intensity of services exist outside the screening criteria.

#### **Why did WPS choose InterQual?**

Part of the requirements of Change Request 5849, state that contractors shall utilize a screening instrument as part of the complex review of each acute IPPS hospital review. CMS did not require the use of any specific criteria set.

WPS Part A choose InterQual as a screening tool because we found out that many of our providers were already using this tool, and it satisfied our internal needs as reviewers. Our decision to choose this tool is not intended to dismiss the use of other screening tools that facilities are already using, but instead it was chosen as a business decision to meet our internal needs.

It is important to note that the InterQual screening is just a tool, to assist in the determination of proper placement of the patient, length of stay in the acute inpatient setting and appropriate discharge criteria. The instrument is not intended to deny care. Clinical evidence of medically reasonable and necessary services, are the basis of the determination of the appropriateness of proposed medical interventions.

#### **How does the tool assist in the medical review process?**

WPS uses this screening tool in much the same way that providers use it. We however, use it as anonymous reviewers on a post-payment basis. In reviewing the documentation submitted by the provider, we use the screening tool to assist in determining if the patient's illness was severe enough to require the care at the proposed level. We also utilize the tool to determine if the services that were provided were at the appropriate level of care for continued stay, and if clinically stable, is the patient appropriate for an alternate level of care. Taking into account the clinical indicators, and stability of the patient, we can also utilize the screening tool to assist in appropriate discharge reviews. This is used to assist in determining the beneficiary's readiness for discharge or transfer.



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Again, it is important to note, that this is only a tool or instrument to assist in the review process. Our clinical reviewers take into account all documentation submitted for review, assess the documented clinical stability or instability of the patient, any medical interventions provided, the documented need to support intensity of services and the severity of illness, as well as use clinical medical knowledge that would support a reason for a beneficiary to require the services, even if they do not meet the screening criteria.

**Not meeting criteria does not necessarily equate to denial of services.**

One example of this is the patient with congestive heart failure (CHF), that presents to a facility with gastritis and vomiting. When we utilize the screening tool to determine the appropriateness of the admission, and continued stay, the beneficiary met the criteria for severity of illness, but did not meet for intensity of services because intravenous (IV) fluids were not running at 125 cc/hr. Using clinical knowledge, the reviewer determined that this beneficiary's stay was medically reasonable and necessary, because IV fluids at this high of a rate could cause a fluid volume overload for a beneficiary with CHF and have detrimental effects.

It is also important to note that as a provider using this tool, that you are paying careful attention to the notes section of the screening tool. We have found upon review that some facilities are checking criteria on the tool as being met, but when you read the actual requirements in the notes section for that criteria, that often the beneficiary did not meet the tool's criteria.

Now that we have talked about why we are doing the short-term care hospital reviews, and about the screening tool we use to assist us in the review, I want to spend some time talking about the documentation that is necessary to complete this review.

It is not enough for a provider to utilize a screening tool to determine appropriateness of admission, or continued care, if the documentation contained within the record does not support the services rendered.

Since we are doing our reviews on a post-payment, we have to rely on your medical record documentation to support the services you rendered were paid at the appropriate level. Lack of documentation, or missing documentation will only skew the review process, and may make your claim not considered for coverage.

Our Website (<http://www.wpsmedicare.com>) contains documentation guidelines to assist the provider in making sure they submit all documentation to support medically reasonable and necessary claims. We will discuss all of these guidelines, but you can also find them under the Medical Review section of our website.

These next several slides contain a guideline of the basic information that we request for medical review of acute IPPS (STCH) services. Please note: Our review is not limited to these pieces of documentation. Any documentation that you have that you believe supports the services as being medically reasonable and necessary, should be included if we request review of your records. These are guidelines to assist the provider in submitting the necessary information to support the services were provided as billed.

- **UB04**
- **Pre-admission/admission screening tools and any appropriate updates**
- **Acute care transfer records**
- **Documentation to support an interrupted stay**



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- **Diagnostic laboratory orders, indications and results**
- **Diagnostic/therapeutic radiology orders, indications and results**
- **Surgical intervention documentation**
- **Documentation to support any and all procedures ordered and/or performed**
- **Physician documentation**
  - **History and Physical**
  - **Physician progress notes**
  - **Physician consultation documentation**
  - **Physician orders**
  - **Discharge summaries**
- **Nursing documentation**
  - **Initial and daily assessment**
  - **Treatment record**
  - **Wound care documentation**
  - **Medication administration records, etc.**
- **Respiratory care documentation**
  - **Initial and daily assessments**
  - **Respiratory plans of care**
  - **Treatment goals**
  - **Units of treatment provided, etc.**
- **Physical Therapy, Occupational Therapy and Speech-Language Pathology**
  - **Initial and daily assessments**
  - **Plans of care**
  - **Treatment goals**
  - **Units of treatment provided, etc.**
- **Nutritional Therapy documentation**
  - **Initial assessments and updates**
  - **Plans of care**
  - **Patient goals etc.**
- **Case Management/ Medical Social Work**
  - **Admission screening tools**
  - **Discharge planning and coordination of team goals**
  - **Plans of care, etc.**

When diagnostic or therapeutic testing or procedures are ordered, we need to receive not only the order, but also the indications to support the order/procedure, as well as the results or findings.

Since Medicare is a physician directed program, it is important to have all the physician documentation as well. Pieces of the physician documentation include the history and physical (H&P), progress notes, orders, any consultation documentation, as well as discharge summaries to support stability for discharge.

Nursing documentation to be submitted is to include, but not limited to, initial and daily assessment, treatment records, wound care documentation, medication administration records, and plans of care.

Respiratory care documentation is to include, but not limited to, initial and daily assessments, respiratory plans of care, treatment goals, and units of treatment provided.



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When a beneficiary is receiving skilled therapy services such as Physical Therapy, Occupational Therapy, and/or Speech-Language Pathology the documentation is to include, but not limited to, the initial and daily assessments, plans of care, treatment goals, and units of treatment provided.

Other documentation that we ask you to submit, includes, but is not limited to, the information listed above under nutritional therapy documentation as well as case management or medical social workers documentation.

Now we will discuss some of the common issues that are being found on medical review of acute IPPS claims from WPS and the Comprehensive Error Rate Testing (CERT) review contractor. Eliminating these common findings will assist the provider in receiving the proper reimbursement for services provided.

Again, it cannot be stressed enough that not meeting criteria does not equate to denial of services. In all cases, in addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.

These common findings are based off comprehensive clinical reviews of documentation submitted.

Please refer to the handout on the last page, entitled "Common Findings" for a more comprehensive list of review findings and references for each of them. The common findings that I have listed on the handout, are worded the same as what the provider would see on an individual claim review from WPS Part A. You can see that we cite references for our providers back into the Medicare regulations to support why we found the services to not be considered for coverage. These issues are similar to the findings that the CERT review contractor is finding on acute IPPS claims as well.

The first common findings when reviewing STCH claims, is that the documentation does not support the care provided was medically reasonable and necessary for the entire length of stay. As a result of this, days were excluded from coverage. The indented bullet points are sub-categories of this more broad reason for denial, and explain a little more in depth the reason for this denial or disallowance of service days.

At the end of this presentation, we will briefly discuss how disallowance of days of service could affect your reimbursement.

The next common finding is that the documentation provided did not support the ICD-9-DM diagnosis code billed. The sub-bullets under this title provide more information as to how this may affect the payment assignment.

If diagnosis and procedures codes are found to be in error, the reviewer may add, delete or re-arrange the order of the codes. This could affect the DRG/MS-DRG payment rate. Our nurse reviewers will ensure, upon review, that the documentation provided supports the correct use of procedure and diagnosis codes, as well as correct DRG/MS-DRG assignment. Correction to the reported codes, or corrections to the order of the codes, could affect reimbursement of the claim.



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**Other common findings include:**

- Documentation that does not support patient met screening criteria requirements for admission for a short term acute care stay. We spoke earlier about how not meeting the screening tool criteria does not necessarily equate to denial of services, but if the supporting documentation does not support the need for the inpatient stay, outside of the screening tool components, services will not be considered for coverage.
- Documentation does not support services were provided as billed. Our expectation upon review of your claims is that the documentation is an accurate reflection of the reimbursement you are asking for, and directly supports the DRG/MS-DRG payment rate billed.
- Documentation supports the patient was being treated for a hospital acquired condition (HAC). The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payment for certain hospital-acquired conditions. CMS has titled the program, "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC & POA). For discharges occurring on or after October 1, 2008, IPPS hospitals will not receive additional payment for cases when one of the listed conditions is acquired during hospitalization (i.e., was not present on admission). The case would be paid as though the secondary diagnosis were not present. (CMS-1390-F)
- The following documentation was not received for review: Under this statement, the nurse reviewer would identify to the provider exactly what documentation was not received upon initial review. The presence of this documentation could have impacted why the claim was considered unfavorable, or not considered for coverage. (CMS Publication 100-8, Chapter 6)

Our nurse reviewers will also make educational notes on the individual claim reviews regarding issues found within the documentation that did not affect the decision. These statements are listed on WPS Part A's individual claim reviews as "Educational Notes," and do not necessarily denote reason for denial of services. They are generally listed as a finding that did not affect the payment of the claim reviewed.

- **Documentation supports additional procedure code(s).**
- **Documentation supports additional diagnosis code(s).**
- **Documentation supports the beneficiary was receiving the appropriate level of covered care for all hospital days, but the procedure performed was medically unnecessary.**
- **Documentation does not support the discharge status billed.**

Educational notes should not be discounted, and should be addressed by your facility. Just because they did not effect the reimbursement of your claim at this time, doesn't necessarily mean, if not corrected, that they may not effect reimbursement of a later claim.

Based on the common findings we just discussed, reimbursement of services could be affected in several different ways. Now let's take a few minutes to discuss some of the most common effects on your reimbursement of acute IPPS (STCH) claims that have been medically reviewed.

First, if diagnosis and procedures codes are found to be in error, the reviewer may add, delete or re-arrange the order of the codes. This could result in a change in the DRG/MS-DRG payment, if services are found to be reasonable and necessary.



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Next, if the documentation provided does not support the patient meets severity of illness or intensity of services, and supporting documentation doesn't support medical necessity that would outweigh this criteria, the claim could be denied in full.

Finally, if a review of the acute IPPS (STCH) claim is completed, and the decision has been made to disallow days, either because the beneficiary did not require inpatient level of care on admission, but it was determined that the condition changed during the stay and inpatient care became medically necessary, OR the documentation supported that the beneficiary became stable enough for discharge, and days were disallowed on the back end of the claim, the provider will be given a request for line item billing that they will need to respond to timely. Once the line item billing is received the claims processing department will determine the correct payment for the days deemed to be covered. This also could affect the amount of reimbursement you receive, as well as the timeliness of reimbursement.”

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This concluded the presentation portion of the teleconference. The lines were then opened to questions and answers. Due to the absence of the audio recording for this call, questions and answers are not available for posting.

At the conclusion of the question and answer portion of the call, the providers were encouraged to sign up for our e-News Sign Up located on our [Website](#), as well as directed to upcoming educational events that are listed on our Website that may be of interest to the providers.

The teleconference was ended at approximately 2:40 PM Central Time.

The references included in this presentation are for informational purposes only. The current Medicare regulations will prevail.

There were 251 participants on 95 lines for the teleconference.

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### Documentation Common Findings for Acute IPPS Reviews (STCH)

- Documentation does not support care provided was medically reasonable and necessary for the entire length of stay. Days were excluded. (CMS IOM Publication 100-8, Chapter 6)
  - Admission was for the purpose of performing a non-covered procedure. The beneficiary did not develop the need for inpatient level of care. (CMS IOM Publication 100-8, Chapter 6)
  - Documentation supports the beneficiary did not meet criteria for continued stay at a STCH level of care. (CMS IOM Publication 100-8, Chapter 6)
  - Documentation does not support the patient required level of care billed on date of admission, however at some point during the stay developed a condition appropriate for STCH level of care. (CMS IOM Publication 100-8, Chapter 6)
- Documentation does not support the billed ICD-9-CM code(s). (CMS IOM Publication 100-8, Chapter 6)
  - Documentation does not support the principal diagnosis ICD-9-CM code billed, which has an impact on the DRG assignment. (CMS IOM Publication 100-8, Chapter 6)
  - Principal diagnosis ICD-9-CM code billed is acceptable only when coded as a secondary diagnosis. (CMS IOM Publication 100-8, Chapter 3)
  - Documentation does not support billed DRG secondary diagnosis code(s) billed, which has an impact on the DRG assignment. (CMS IOM Publication 100-8, Chapter 6)
  - Documentation supports additional secondary diagnosis code(s), which impact the DRG assignment. (CMS IOM Publication 100-8, Chapter 6)
  - Documentation does not support billed procedure(s) was/were performed. (CMS IOM Publication 100-8, Chapter 6)
  - Documentation does not support the billed procedure(s) was/were reasonable and/or necessary. (CMS IOM Publication 100-8, Chapter 6)
  - Documentation supports additional procedure ICD-9-CM code(s), which impact the DRG assignment. (CMS IOM Publication 100-8, Chapter 6)
- Documentation does not support patient met screening criteria requirements for admission for a short-term acute care stay. (CMS IOM Publication 100-8, Chapter 6)
- Documentation does not support services were provided as billed. (CMS IOM Publication 100-1, Chapter 1, Section 20.3.1)
- Documentation supports the patient was being treated for a hospital acquired condition (HAC). (CMS-1390-F)
- The following documentation was not received for review: \_\_\_\_\_ . (CMS IOM Publication 100-8, Chapter 6)