

Recovery Audit Contractor Medical Necessity Readiness

One Health System's Journey

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ABSTRACT

Purpose: To develop a sustainable approach to Recovery Audit Contractor medical necessity readiness that mitigates the regulatory and financial risks of the organization.

Primary Practice Setting: Acute care hospitals.

Conclusions: Utilizing the model for improvement and plan-do-study-act methodology, this health system designed and implemented a medical necessity case management program. We focused on 3 areas for improvement: medical necessity review accuracy, review timeliness, and physician adviser participation for secondary reviews. Over several months, we improved accuracy and timeliness of our medical necessity reviews while also generating additional inpatient revenue for the health system. We successfully enhanced regulatory compliance and reduced our financial risks associated with Recovery Audit Contractor medical necessity audits.

Implications for Case Management Practice: A successful medical necessity case management program can not only enhance regulatory compliance and reduce the amount of payments recouped by Medicare, but also generate additional inpatient revenue for your organization. With health care reform and accountable care organizations on the horizon, hospitals must find ways to protect and enhance revenue in order to carry out their missions. This is one way for case managers to help in that cause, to advocate for the care of their patients, and to bring value to the organization.

Key words: *medical necessity, model for improvement, PDSA, RAC, recovery audit contractor*

Hospitals are under the regulatory microscope like never before. With the implementation of recovery audit contractors (RACs), Medicare administrative contractors, Medicare integrity contractors, zone program integrity contractors, and so forth, not to mention accountable care organizations on the horizon, hospitals must provide the highest-quality care while also reducing costs and utilization. And all of this must be done while protecting revenue made from care already provided. This article will describe how Indiana University (IU) Health, formerly Clarian Health Partners, utilized the model for improvement and plan-do-study-act (PDSA) methodology to develop a program that mitigates our regulatory and financial risks associated with RAC medical necessity audits while also generating new inpatient revenue.

Indiana University Health is an academic, multihospital statewide health network in Indiana closely affiliated with the Indiana University School of Medicine, the second largest medical school in the country. In 2009, more than 1000 residents and fellows received training in IU Health hospitals. The system has 2889 staffed beds with 21,883 full-time employees. There were more

than 115,000 inpatient admissions, more than 1.8 million outpatient visits, and 2600 research studies in 2009. Gross patient revenue was \$7.3 billion.

BACKGROUND

In section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress directed the Department of Health and Human Services to conduct a 3-year demonstration program using RACs to detect and correct improper payments in the Medicare Fee for Service program. The demonstration program was designed to determine whether the use of RACs would be a cost-effective means of adding resources to ensure correct payments are

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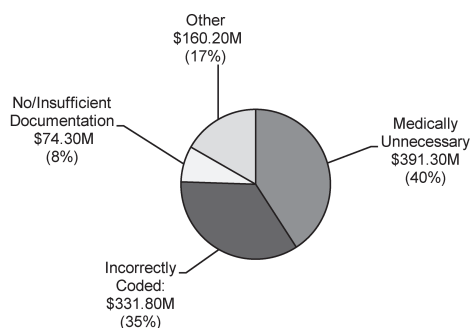


FIGURE 1

Overpayments collected by error type (net of appeals): cumulative through 27 March, 2008, claim recovery audit contractors only.

being made to providers and suppliers and, therefore, protect the Medicare Trust Fund. The demonstration operated in New York, Massachusetts, Florida, South Carolina, and California and ended on March 27, 2008.

The demonstration project proved successful with nearly \$1 billion in overpayments identified. Figure 1 shows how these overpayments were categorized, the majority of which were services the RACs deemed medically unnecessary. Not only did hospitals and other providers lose revenue for care they had already provided, they found themselves spending money to appeal the RACs' findings and protect their payments. Even with the appeals activity, however, the demonstration was successful and Congress mandated that RACs go nationwide, permanently, by 2010. For more details, see *The Medicare Recovery Audit Contractor (RAC) Program* (Content Management System, 2008).

In 2008, IU Health created a multidisciplinary RAC team including representatives from our revenue cycle services, (health information management, coding, billing, and denial management) as well as the legal, corporate compliance, patient access, and case management (CM) departments. Our first task was to assess baseline performance in coding and medical necessity. Our findings were less than stellar. For the purposes of this article, we will focus on medical necessity compliance.

Our CM department reviewed Medicare 1-day inpatient stays to determine whether we applied medical necessity criteria correctly, whether the patient's encounter type in the electronic medical record (EMR) was correct, and whether there was a valid status order on the chart. Our findings indicated a 24% to 55% error rate across the five hospitals that make up IU Health Central Region: Methodist, University, Riley Children's Hospital, IU Health West Hospital, and IU Health North Hospital. Given our

Medicare patient volume and average reimbursement per case, we estimated that this error rate could result in \$27 million dollars at risk for our facilities. We found that our errors were due to the following:

- Case management staffing that was available only from 8 a.m. to 5 p.m. Monday to Friday; insufficient to address admission status, which is a 24/7 issue.
- Medical necessity assessments were typically done the day after admission and were often delayed well past the first 24 hr of admission. They sometimes did not occur until after the patient was discharged.
- Inconsistent application of medical necessity criteria resulting in incorrect status assignment.
- Inconsistent physician adviser (PA) participation in secondary medical necessity reviews.

With permanent RAC implementation just around the corner, we had to find a way to improve our medical necessity compliance and we had to do it quickly.

METHOD

We utilized the Model for Improvement to address our less than stellar medical necessity compliance. For more information on the model itself, see *How to Improve* (Institute of Healthcare, 2000) The model required us to ask three questions:

1. What are we trying to accomplish?
2. What changes can we make that will result in an improvement?
3. How will we know that a change is an improvement?

What are we trying to accomplish? Our aim was to mitigate our financial and regulatory risks associated with RAC medical necessity audits.

What changes can we make that will result in an improvement? We focused our efforts in three areas: (1) improving timeliness of medical necessity assessments, (2) improving compliance with our medical necessity criteria, and (3) utilizing PAs to ensure that our assessments were as complete and accurate as possible.

We wanted to complete our medical necessity assessments as close to the time of admission as possible, so we determined that 95% of first medical necessity assessments should be completed within 24 hr of admission.

We added a new level of CM by placing specially trained nurses at all points of entry to the hospitals. Medical necessity (MN) case managers were hired to work from 10 a.m. to 10:30 p.m. daily, including weekends and holidays. They focused on patients admitted through the emergency department, postanesthesia care unit, cardiac catheterization laboratory, as well as transfer patients and direct admissions. On the basis of our Medicare patient volumes, admission sources, and time estimated to conduct the medical necessity reviews, we proposed that we would need 50 new MN case managers across all five hospitals, plus a manager to implement and oversee the program. This was a daunting prospect, particularly since our program development took place during the third and fourth quarters of 2008—just as we were entering the economic downturn. Our hospitals were pulling the purse strings pretty tight.

We expanded our medical necessity criteria licensure to include the online version of the criteria and embedded this in our electronic CM documentation system. Department policy and procedures were created noting the expectation for use and frequency of review. This forced the CMs to apply the criteria more consistently across the board. All staff were reeducated in the medical necessity review process and expected to complete interrelater reliability testing at or above 90% accuracy to ensure compliance. Those not passing at 90% were provided additional education and retested to assure all were performing at the expected level. We also trained more certified medical necessity educators to have onsite to support staff.

Lastly, we needed to ensure medical necessity compliance by adding PAs to the process. Since only one of our hospitals has a full-time PA, we proposed that we contract the services of an external PA group. These physicians conduct secondary medical necessity reviews when patients do not meet inpatient criteria on first review done by the CM. They utilize medical decision making and risk stratification to determine the most appropriate admission status and provide a letter of medical necessity for the patient's medical record. The contracted PAs are official members of our hospitals' utilization review committees and review all potential condition code 44 cases to ensure compliance. Medicare regulations require that in order to change a patient's admission status from inpatient to observation, the case must be reviewed by a physician member of the hospital's UR committee and the attending physician must agree with the status change. By embedding our PA group physicians in our UR committees, we are able to meet this requirement. In addition, this PA group will help us appeal our RAC denials when they occur, an added level of protection.

We wanted to be sure we completed all Medicare reviews prior to discharge since we cannot correct a status order postdischarge in this population. Therefore, the goal for this metric was set at 100%.

How will we know that our changes result in improvements? We defined our metrics at program implementation. We wanted to complete our medical necessity assessments as close to the time of admission as possible; so we determined that 95% of first medical necessity assessments should be completed within 24 hr of admission. Secondly, we wanted to be sure we completed all Medicare reviews prior to discharge since we cannot correct a status order postdischarge in this population. Therefore, the goal for this metric was set at 100%. Third, we wanted to improve our accuracy in using medical necessity criteria. We expect that at least 95% of the time, we apply medical necessity criteria correctly, we have a valid status order on the chart, and the patient's encounter type in the EMR is correct and matches the criteria and physician's status order.

PROGRAM COSTS AND RETURN ON INVESTMENT

So, how were we going to pay for all of this: 50 full-time employees, a new manager, electronic medical necessity criteria, and an external PA group? Remember, we were embarking on this journey just as the economy was tanking. Funds were nonexistent for new programs. We knew that we had to make a compelling case for our system-wide senior executives in order to get their buy-in and approval.

Of course, our primary concern was bringing our medical necessity program into compliance with federal billing regulations. But how were we going to accomplish this without increasing costs or, at the very least, remaining budget neutral? After all, we estimated program costs to be about \$10 million as depicted in Table 1.

TABLE 1
Estimated Program Costs

Wages and Benefits for 50 FTEs Plus a Manager	\$5.5M
Online medical necessity criteria	\$158K
Contracted physician adviser group	\$4.3M
Total Cost	\$10M

TABLE 2
Estimated Return of Investment (ROI)

Estimated Revenue From Observation	
Conversions to Inpatient Status	\$27M
Estimated cost	\$10 million
Estimated net ROI	\$17 million

After an initial assessment, the PA group estimated that they could convert 50% to 60% of our Medicare observation patients to inpatient status. Given our average Medicare reimbursement per case and patient volumes, we estimated that this could result in an additional \$26.7 million in inpatient revenue for the five hospitals that make up the IU Health central region. We used this revenue potential to justify the new program. In fact, as Table 2 shows, we estimated that we could actually create additional revenue with our proposed process and senior executives agreed.

PLAN-DO-STUDY-ACT METHODOLOGY

During implementation, we utilized the PDSA cycle to improve various aspects of the program. For example, we found that after streamlining workflows and combining processes, we only needed 29 full-time employees, a significant reduction from our initial estimate of 50 and a dramatic cost saving. In addition, we did not hire a new manager for the program. The existing CM managers handled program development, implementation, and ongoing oversight.

We used the PDSA cycle to address first year turnover as well. This was a new program with a lot of unknowns. We were still developing the program even after we hired the case managers to run it. Process specifics were still to be defined and we all became colearners. New staff were not only orienting to a new job in a new health system, they were also helping to develop a new program. This resulted in high stress for some, who became frustrated and left. In addition, some CMs decided that they needed

We had to strike a delicate balance between assigning the most appropriate status while not creating more denials from our commercial/managed care payers. This was tricky since they often use different medical necessity criteria than we do.

TABLE 3
2009 Actual Return of Investment (ROI)

Indiana University Health Methodist Hospital	\$4.2 Million
Indiana University Health University Hospital	\$1.7 million
Riley Hospital for Children	\$0.08 million
Indiana University Health West Hospital	\$2.3 million
Indiana University Health North Hospital	\$1.4 million
Gross ROI	\$9.68 million
Minus program costs	\$2.5 million
2009 actual ROI	\$7.18 million

more direct patient contact and still others needed more “black and white” directions. They also left the program within the first year. After identifying the reasons for staff turnover, the following improvements were implemented:

- We explicitly defined the roles and responsibilities, expanding guidelines as new information became available.
- We applied lessons learned as soon as possible and shared information across the IU Health central region.
- We developed workflows and decision trees that were specific to procedure and payer type since we applied the MN process to all patients, not just Medicare.
- We had to strike a delicate balance between assigning the most appropriate status while not creating more denials from our commercial/managed care payers. This was tricky since they often use different medical necessity criteria than we do.
- Managers held weekly face-to-face meetings with new CMs to gauge understanding and program compliance.
- We conducted ongoing self-audits and provided feedback to the case managers.
- As the position evolved, we improved our candidate selection to better match the job requirements. We now conduct peer reviews to gauge personality fit before extending a job offer.

TABLE 4
2010 Actual Return of Investment (ROI) Through October

Indiana University Health Methodist Hospital	\$2.0 Million
Indiana University Health University Hospital	\$0.9 million
Riley Hospital for Children	\$0.04 million
Indiana University Health West Hospital	\$2.2 million
Indiana University Health North Hospital	\$1.1 million
Gross ROI	\$6.16 million
Minus program costs	\$2.5 million
2010 actual ROI through October	\$3.66 million

Medicare 1-Day Stay Audits - Compliance*

*Criteria appropriately applied, valid status order, encounter type matches status order, physician advisor status determination letter on the chart
Goal = 95%

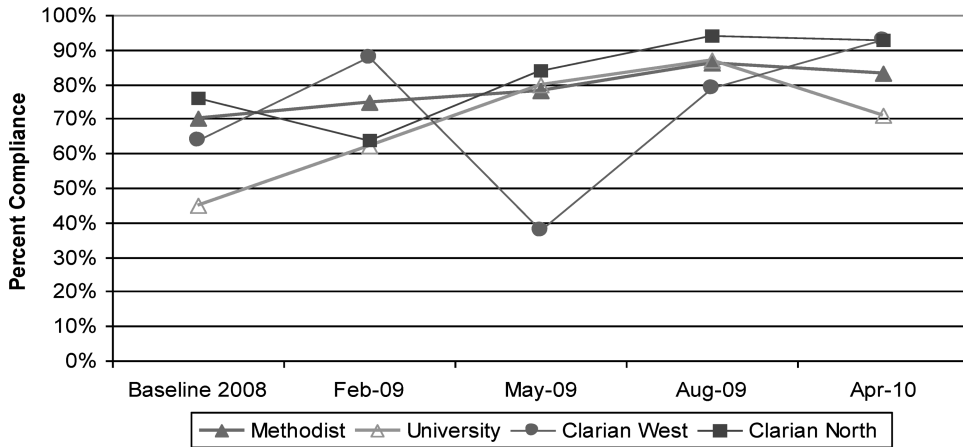


FIGURE 2

Medicare 1-day stay audit results.

- We implemented 30- and 90-day meetings with new staff to provide better support.
- And currently, we are conducting team-building activities to better unite the inpatient case managers and MN case managers.

We now have a stable workforce and can focus further PDSA efforts on improving program outcomes moving forward.

OUTCOMES

Our financial outcomes are on track to achieve initial return on investment (ROI) estimates within the first three years of operation as you can see in Tables 3 and 4. From program inception through

October 2010, our total ROI is \$10.84 million and growing. Senior leadership is satisfied with the results and shares the financial outcomes with the finance committee of our board of directors on a quarterly basis. Our outcomes are also shared monthly with executive and clinical leaders at each facility.

Two of our hospitals achieved 93% review accuracy compliance as shown in Figure 2. The others have improved as well and we all strive to reach our 95% accuracy goal. We continue looking for ways to improve and apply the PDSA methodology where needed. Our compliance with timeliness measures is directly impacted by staffing variances as you can see in Figures 3 and 4.

Q2 2009 thru Q3 2010
Goal = 95%

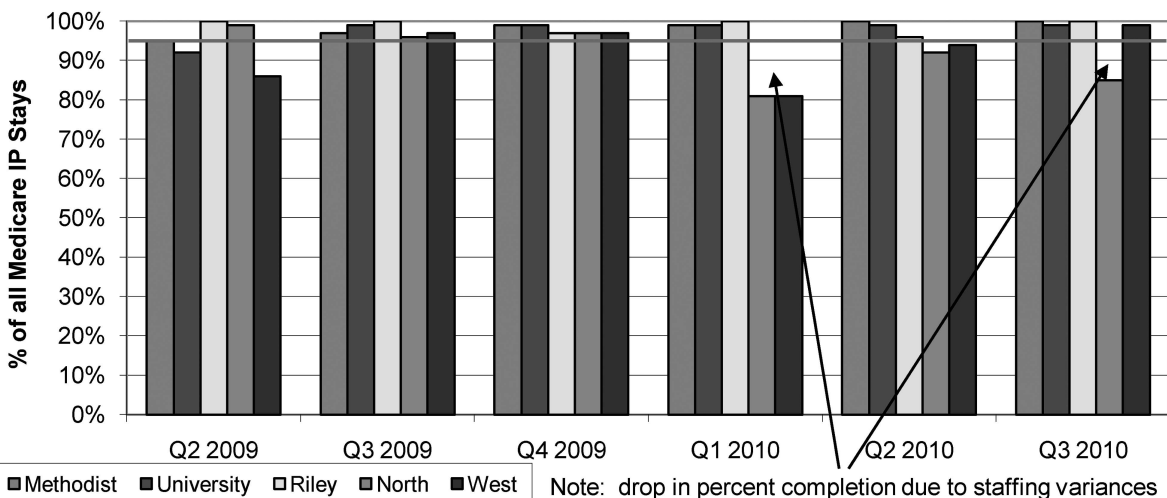


FIGURE 3

Percent of status reviews done within 24 hr of admission.

Q2 2009 thru Q3 2010
Goal = 100%

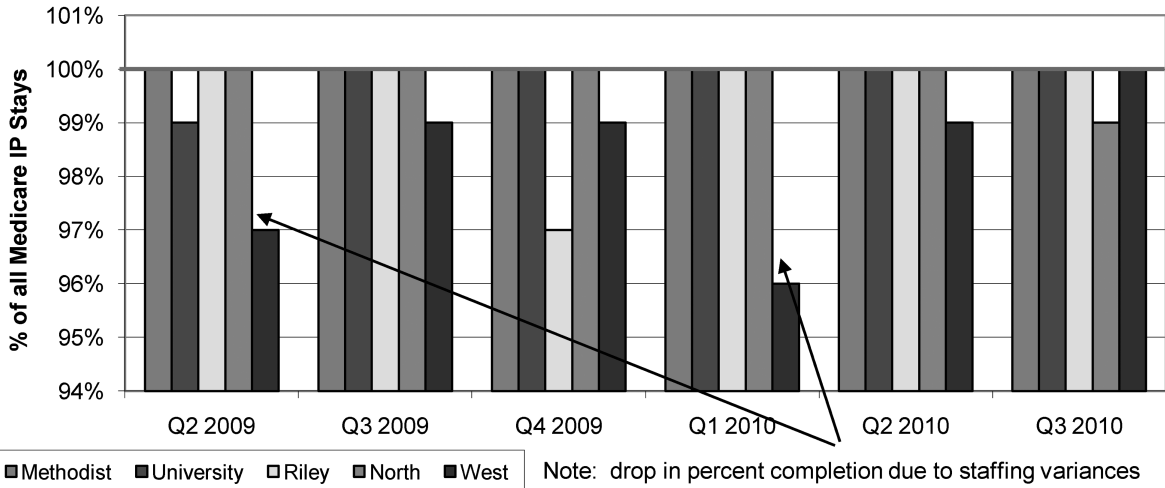


FIGURE 4
 Percent of status reviews done prior to discharge.

We anticipate consistently achieving our goals now that our workforce is stable and we have developed better coverage plans when staff is unexpectedly unable to work.

An added benefit of our medical necessity program is that we now have CMs available 7 days per week to meet discharge planning needs for patients in the emergency department, catheterization laboratory, and postanesthesia care unit, which we did not have before. We have improved customer service and have prevented inappropriate admissions, particularly from the ED.

Although we have improved our medical necessity review accuracy and timeliness, our RAC outcomes are still unknown. As of the writing of this article, we have received medical record requests from our region's RAC, but have not yet received determination or demand letters. We are confident though that our medical necessity program has not only improved our regulatory compliance but will also protect and

enhance inpatient revenue for the IU Health System now and in the future.

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