

Inpatient Prospective Payment System Hospital and Long Term Care Hospital Review and Measurement Fact Sheet

Background

This fact sheet describes a change that is being made by the Centers for Medicare & Medicaid Services, with regard to the review of acute inpatient prospective payment (IPPS) hospitals and long term care hospitals (LTCHs). Medicare Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs) will now conduct medical review to prevent improper payment of inpatient hospital claims. Medical review is the process performed by Medicare contractors to ensure that billed items or services are covered and are reasonable and necessary as specified under section 1862(a)(1)(A) of the Act. In addition, the Comprehensive Error Rate Testing (CERT) contractor will now conduct medical review to measure inpatient hospital payment error rates.

Previously, in addition to their focus on quality issues, the Quality Improvement Organizations (QIOs)' responsibilities included the following for acute IPPS hospitals and LTCHs:

- The Hospital Payment Monitoring Program (HPMP), which was performed on a post payment basis and consisted of 2 parts:
 - 1) Utilization review of randomly selected claims for payment purposes, and
 - 2) Measurement of the accuracy of Medicare Fee-for-Service (FFS) payments to acute IPPS hospitals and LTCHs (that is, the “error rate”)
- Performance of provider-requested higher-weighted diagnosis related group (DRG) reviews;
- Review of Emergency Medical Treatment Active Labor Act (EMTALA) cases; and
- Performance of Expedited Determinations.

QIOs are no longer responsible for the functions previously included in the HPMP. They will retain responsibility for quality oversight in all Medicare FFS settings, provider-requested higher-weighted DRG reviews, EMTALA reviews, provider education on quality of care issues, and expedited determinations.

Rationale

CMS is making this change as part of its commitment to improving the efficiency and quality of health care delivered to Medicare beneficiaries. The transition of responsibility for measuring and preventing improper payments to inpatient hospitals from the QIOs to the FIs, MACs, and the CERT contractors will allow the QIOs to concentrate on improving patient quality of care and maintaining quality improvement and provider assistance efforts. This transition also aligns the oversight of acute IPPS hospital and LTCH claims with that of all other Medicare FFS provider types.

Timing

The transition is occurring in two phases:

- The CERT contractor began reviewing claims for the purpose of measuring error rates for acute IPPS hospital and LTCH claims on April 1, 2008.
- We anticipate FIs and MACs will begin reviewing acute IPPS hospital and LTCH claims, for the purpose of determining the appropriate payment due and preventing or reducing improper payments, this summer.

Hospitals will start receiving medical record requests from the CERT contractor in May, and FIs and MACs will begin requesting medical records later this summer.

Responsibilities

- The activities related to acute IPPS hospital and LTCH review that will now be performed by a different review entity are: FIs and MACs will perform medical review of acute IPPS hospitals and LTCH claims, on either a prepayment or post-payment basis, to ensure that they are for covered, correctly coded and reasonable and necessary services and will conduct claim adjustments, as appropriate, on claims which are not.
- FIs and MACs will conduct provider feedback, through their medical review departments, based on findings from medical review of acute IPPS hospital and LTCH claims. They will also continue to conduct provider education, through their provider outreach and education department, on issues related to submitting inpatient claims correctly as part of their goal to reduce the error rate.
- The CERT contractor will perform reviews on a post-payment basis, in order to determine the degree to which Medicare FIs and MACs are paying acute IPPS hospitals and LTCHs claims appropriately, in accordance with coverage, coding, and medical necessity guidelines.

These utilization reviews, provider education, and error rate measurements will be conducted in a manner consistent with that used by FIs, MACs, and the CERT contractor in the review and error rate measurement for all other Medicare fee-for-service (FFS) claims.

The activities related to acute IPPS hospital and LTCH claims review which will continue to be performed by the QIOs are:

- Quality of Care Reviews due to beneficiary complaints, complaints other than from beneficiaries, and quality of care reviews for cases referred by CMS or CMS designated entities (e.g. FIs, Carriers, MACs, SSAs, OIG).
- Utilization reviews for Hospital requested higher-weighted DRGs;
- Utilization reviews referred by CMS or CMS designated entities (e.g. FIs, Carriers, MACs, SSAs, OIG.) for cases involving issues such as transfers and readmissions;
- Review of Emergency Medical Treatment Active Labor Act (EMTALA) cases;
- Expedited determinations; and
- Provider education on quality of care issues, and other issues under their purview (e.g. hospital-requested higher weighted DRG review, etc.).

Claim Review Process

The coverage and payment guidelines used by the FIs, MACs and CERT contractor will be the same as used in the past by the QIOs, though some claim selection and review procedures will be different.

Notification and Record Submission:

The hospital will know when a claim has been selected for review in slightly different ways, depending on the review entity. For purposes of measuring the error rate, the CERT Contractor will notify providers that claims have been selected for CERT review via letter or telephone contact.

- The medical record request letter will be mailed or faxed according to the hospital's preference.
- Hospitals may submit medical records via mail or fax.

For prepay review, the FIs and MACs will suspend claims for review and the FIs and MACs will then send out a request for supporting documentation. Providers may use the claim inquiry screen in the Direct Data Entry (DDE) system and verify the status of the claim. They may view the narrative for the reason

code that is applied to a suspended claim. The narrative will provide the reason for the suspension. Hospitals submit hardcopy medical records via mail.

For post pay review, the claim is already paid. An FI or MAC performing post pay review will send a request for medical records to the provider. The FIs or MACs will review the claim and make any adjustment necessary to the claim based on the review. Hospitals submit hardcopy medical records via mail.

Screening and Review:

Most QIOs used a commercial screening tool as a first-level indicator of the appropriateness of the services billed, though they were not required to use a particular tool. FIs, MACs and the CERT contractor are also required to use screening criteria in the review of acute IPPS hospital and LTCH claims, though, as was true for the QIOs, CMS is not mandating the use of a particular tool.

In addition to use of a screening tool, FIs, MACs, and the CERT contractor will apply coverage, coding, and medical necessity guidelines, utilizing clinical judgment in making payment determinations on each claim, as the QIOs did.

Reviewers:

Qualified clinicians, such as nurses and therapists, will perform the reviews, consulting with physicians or other specialists as needed. As is the case with all other Medicare claim types reviewed by FIs, MACs, and the CERT contractor, there is no CMS requirement that physicians be used to review each acute IPPS hospital and LTCH claim on which an adjustment may be made.

Comparison Chart

Because of varying statutory requirements, there are some differences in the claim review processes used by various review entities. The following table provides a comparison of the processes used by the QIOs, CERT contractor, FIs, and MACs.

Table 1: Side-by-Side Contractor Activity Comparison

Issue	QIOs (HPMP)	CERT	FIs/MACs
Review selection	Random	Random	Targeted to claims with suspected improper payments. Initially, there may be some random review.
When the claim is selected for review	Post payment: 3 months after discharge	Post payment: Medical record request letter sent 35 days after payment	Prepayment: Shortly after the claim is submitted or Post payment: Up to 4 years after payment
Credentials of reviewers	Qualified clinicians	Qualified clinicians	Qualified clinicians

Issue	QIOs (HPMP)	CERT	FIs/MACs
Level of physician involvement in review process	Review all claims where non-physician reviewer identifies a problem with the claim	As needed for complex cases	As needed for complex cases
Use of coding experts	Mandatory	Mandatory	Mandatory
Distribution of Program for Evaluating Payment Patterns Electronic Report (PEPPER Report) This is a report containing hospital specific data for fourteen Diagnosis Related Groups (DRG) and discharges that have been identified as high risk for payment errors for every hospital in a QIOs state.	Mandatory	N/A	Undetermined
Use of web-based application that allows providers to customize address & contact information	No	Yes	Future web based application would allow providers to see and update their practice location.
Reimbursement for photocopying medical records	Yes	No	No
Where to file initial appeal	QIO	FI or MAC	FI or MAC