

# ***Levels of Care for Cardiac Device Implant Cases: A Case Management Perspective***

Prepared by The Center for Case Management

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## ***Introduction***

### ***Overview and purpose of this document***

The assignment of the most appropriate, effective, and compliant level of care for a patient receiving an implantable cardiac device is a concern for many hospitals today. The regulations and parameters surrounding these questions are complex and often confusing.

This document explores the issue of **level of care**, including related topics such as clinical indicators, denials, and strategies for developing appropriate and compliant procedures in this difficult arena. It should be noted that the terminology related to this topic varies from reference to reference; admission status, level of care, and in some sources, site of care, are often used interchangeably. This document will refer to level of care in its discussion. The paper will also use **InterQual®** as the primary reference set for the discussion regarding criteria for implantable cardiac devices.

The term “**implantable cardiac device**” may be generally interpreted to include a range of devices such as pacemakers, implantable cardioverter defibrillators (ICDs), and cardiac resynchronization therapy (CRT) devices such as CRT-P and CRT-D.

These issues have been carefully researched using the most robust resources available at the time of publication. Even so, questions will still arise about correct level of care assignment for individual patients within organizations. As with most topics in today's health care environment, these and other decisions must be made within the context of the patient's condition as well as guidance the organization receives from Compliance Officers, Risk Managers, legal counsel, and others.

## ***Executive Summary***

Proper designation of level of care is essential for a number of reasons. These reasons include (but are not limited to): (1) need to accurately reflect the patient's condition, including severity and comorbidities; (2) compliance with existing regulations and parameters from government agencies such as the Centers for Medicare and Medicaid Services (CMS, "Medicare") and others; and, (3) appropriate reimbursement for each patient's care.

There are a number of factors to be considered in making the decision regarding level of care determinations for patients presenting for implantation of a cardiac device.

- **The primary factor in determining level of care is the individual patient's presenting health status.** Complete documentation of the individual patient's presenting health status includes the description of the current health needs of the patient, including the severity of signs and symptoms, underlying clinical condition, comorbid conditions, and the type and severity of the interventions to be provided.
- The patient's past medical history, particularly as it influences the current reason for admission.
- **Determination of the appropriateness and level of the admission as reflected in clinical criteria (InterQual®, Milliman®, or MCAP™).** When criteria are applied correctly and consistently, they provide strong support for the decision and ultimately in defending that decision (i.e., appealing a denial, if needed).
- The nature or type of the admission; more specifically, whether the admission is elective, urgent, or emergent.
  - In considering this factor, **a distinction must be made between *scheduled* and *elective*.** A scheduled admission can be *urgent*; the mere fact that it is being scheduled does not eliminate the urgent need for the procedure or the potentially life-threatening nature of the patient's underlying physical condition.
- **Physician documentation of the patient's condition is a critical component of determining the appropriate status designation.** That documentation should include detailed information regarding the nature of the underlying pathology and/or comorbidities, as well as the risks of and the need for treatment. A clinical documentation improvement program is an important consideration to support

physicians in providing the most accurate and comprehensive documentation. That will, in turn, provide a foundation for the most appropriate severity assignment and the most appropriate and compliant reimbursement.

Other factors may be influenced by external parameters and internal decisions:

- Specific payer requirements may be detailed in contracts negotiated with the hospital. It is imperative that the contract language be carefully established with the payer, with input from the provider's clinicians and Case Management staff. It is equally imperative that hospital staff interacting with the patient, the payer, and the clinicians regarding level of care designations have thorough, operational knowledge of each contract's parameters and requirements.
- Medicare requirements are often different than those of commercial payers. Staff interacting with the patient, payer, and the clinicians regarding level of care designations should have thorough, operational knowledge of Medicare's parameters and requirements.
- Hospital by-laws and admissions policies will influence the decision regarding admission status. An example of this relates to "Inpatient Only Lists" that Medicare and other payers may use to specifically designate certain procedures as appropriate only in the inpatient setting.
- Level of care is a risk area for compliance and reimbursement for organizations. The underlying principles of compliance include appropriate care for the patient's clinical condition and appropriate billing for the stay. This includes identification of the appropriate level of care, most commonly based on application of criteria to a patient's condition at the beginning of and regularly during the stay to ensure that the patient is at the appropriate level of care throughout the stay. Level of care is based on a physician's order for the level of care. **There are two important considerations: (1) The organization may be at risk if the level of care is not appropriate based on the criteria used; and, (2) if the level of care is not appropriate and the organization bills and receives reimbursement for the improper level, it is at risk for fraud.** Additional information regarding compliance considerations may be found in Appendix C.

## ***Clinical Criteria Sets***

### **What are clinical criteria sets and how did they get established?**

At the inception of Medicare, its architect, Wilbur Mills, stated “The government does not desire or intend to be involved in supervision or control over the practice of medicine or in the manner in which medical services are provided.” Nonetheless, a great deal of direct and indirect oversight rapidly came into use. The original Medicare regulations of 1974 made it a requirement that hospital days reimbursed by the program should be validated in some way. This led to an attempt to build criteria to prove “medical necessity” of care components. The AMA and Joint Commission attempted to collaborate in creating such a system, but their work was based on diagnosis codes. Since the actual code for a patient’s illness often is not known at the time of admission to a facility, the system proved impossible to use for concurrent reviews; therefore it could not reduce inappropriate or unnecessary hospital days. It also failed to take into consideration the services to be rendered, so a patient could have an inpatient stay declared valid based solely on an impressive diagnosis while receiving or requiring very little in the way of nursing services.

**Today, Medicare, most insurers, state governments, and other payers require validation of services using a review system.** The term *Clinical Criteria* actually refers to two distinct forms of clinical indicators in common use; differing substantially in design and manner of use. The most widely used products described as *clinical criteria* are the InterQual Criteria ([www.InterQual.com](http://www.InterQual.com)), a product of McKesson Corporation, and the MCAP Clinical Review Criteria, ([www.oakgroup.com](http://www.oakgroup.com)) produced by The Oak Group. Another product in wide use, Milliman Care Guidelines, ([www.careguidelines.com](http://www.careguidelines.com)) produced by Milliman Inc, is often referred to as “criteria,” although they are not identified as such by the company. Each is meant to be used to perform Utilization Review, a process mandated by many payers including Medicare, in which evidence is obtained by the reviewer to validate a patient’s level of care, hence its reimbursement. The three products have somewhat differing methods of development and maintenance, determined to some degree by the orientation and design for use of the product. A more complete description of these three criteria sets, including how they are developed, is provided in Appendix A.

Medicare utilizes Quality Improvement Organizations (QIOs) to monitor the medical necessity of hospital services. However, since Medicare does not have a specific requirement regarding which criteria set a hospital uses, individual QIOs may adopt the use of a specific set. For example, the Illinois QIO uses the Milliman Care Guideline product while the Massachusetts QIO employs InterQual Level of Care criteria. In addition, each commercial payer selects a criteria set (InterQual, Milliman, or MCAP) for use in its utilization review process. Given that hospitals will provide care to beneficiaries of government and commercial payers who use differing criteria sets, the hospital must identify the set the organization will use based on internal and external circumstances. It is important that Case Managers and others be skilled in effectively translating the patient's condition to payer representatives, including translating the findings from a focused review across criteria sets.

It is important to note that InterQual provides the following disclaimer regarding the intent of their Criteria:

***“The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities or particular situations or provide the sole basis for definitive decisions. The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided to a patient.”<sup>1</sup>***

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<sup>1</sup> McKesson; 2006 InterQual Level of Care – Acute Adult Criteria, page i

## ***Clinical Criteria Related to Implantable Cardiac Devices***

Clinical criteria for cases involving implantable cardiac devices are located within the InterQual “Care Planning” product suite, specifically in the InterQual Adult procedures section. InterQual criteria address implantable cardiac devices in two ways. The **I**ntensity of Service, **S**everity of Illness, and **D**ischarge Screens (ISD) Level of Care criteria associate procedures with inpatient or outpatient *settings* in a manner similar to the Medicare Inpatient Only List, but are independent of Medicare’s determinations. These ISD criteria indicate the likely level of care for a patient undergoing placement of an implantable cardiac device; the level of care that most patients undergoing cardiac device implantation would require. In this context, the level of care would depend on whether or not the patient’s clinical condition, therapeutic intervention(s), and associated required services for appropriate diagnosis, treatment, and recovery necessitate a particular care setting; the procedure itself is a contributor to these but is only one driver of several.

The designation for cardiac device implantation in the InterQual Level of Care criteria has not changed in the last several years. InterQual’s ISD lists cardiac device implantation as an outpatient procedure, with Observation Status as the level of care. It is important to recognize that not all payers have the same criteria for, or recognize the concept of, “Observation Status” as a level of care in the same manner as Medicare.

**However, the patient’s clinical condition or unusual needs for nursing services may modify the setting designation on an individual patient basis.** This is an important consideration because, as noted earlier, the individual patient’s presenting condition and underlying health issues are important drivers in designating the appropriate level of care. The patient’s clinical condition and the underlying reason for which the cardiac device is being implanted (e.g., the treatment of potentially life threatening conditions) may well suggest a deeper assessment of the patient’s presenting situation and consideration of an inpatient level of care designation. As always, this decision should be based on individual patient circumstances and must be supported by appropriate documentation.

## ***Admission Types: Elective, Urgent, and Emergent***

Elective, Urgent, and Emergent represent three types of admissions. It is important to understand the differences between these categories to identify an appropriate level of care designation. These terms should be documented in the body of the patient record for use during discussions about the appropriateness of the level of care determination with payers.

It is important for hospitals to have definitions of elective, urgent, and emergent admissions. The definitions should be agreed upon by the organization, the medical staff, and the payers. Ideally, those definitions should be included in the payer contracts. Identification of an admission as elective, urgent or emergent should be based on application of the previously agreed-upon definitions and the physician's assessment of the patient's condition at the time of presentation. The type of admission should be clearly documented in the admission summary.

To provide a comparative basis for hospitals, we have provided a template for definitions of elective, urgent, and emergent admission types. As noted earlier, the final definitions should be adopted by the formal physician and hospital leadership structure before they are put into use. After the final definition language is developed, appropriate staff (including physicians, nurse reviewers, and Admitting Department staff) will require formal orientation to the definitions.

- (1) **Elective** describes an admission for which the patient's condition is not life-threatening, disabling or requiring immediate attention. The services have no time urgency and could be optional. This permits adequate time to schedule the admission and to identify the level of care designation. These admissions usually require prior approval by non-Medicare payers.
- (2) **Urgent** is used to define an admission for which the patient's condition is not *currently* life-threatening but requires care and treatment in the near future to prevent serious deterioration of physical or mental health. Generally, the patient is admitted to the first available, appropriate bed. **The fact that an admission is scheduled does not preclude it from being urgent in nature.** The designation as Urgent is related to the underlying physical issue and its potential for being life

threatening. This is an important distinction in the case of admissions for cardiac device implantation. **Although cardiac device implant patients may be scheduled for their procedure, the nature and risk of their underlying disease and required therapeutic procedure might prompt the hospital to develop a procedure to scrutinize the presentation of these patients to determine whether, in fact, the admission is urgent.** These admissions may require prior approval by non-Medicare payers, or timely notification soon thereafter.

- (3) **Emergent** is defined as an admission when a patient needs immediate medical intervention related to a severe, life threatening or potentially disabling medical condition or injury. The Elective and Urgent admission categories are the most easily confused. The primary difference is that in the Urgent admission there is an *identified condition* that requires immediate attention to prevent serious deterioration of the patient's health.

Correct identification of the type of admission (elective, urgent, or emergent) required by an individual patient is important for a number of reasons. InterQual identifies ICD or pacemaker insertion as appropriate for *inpatient* status if the procedure is deemed urgent or emergent, or if it is performed using a thoracotomy approach. Correct designation of admission type also supports the clinical team in approaching the patient with the appropriate sense of urgency, allowing resources and services to be delivered in a timely way. Identification of the correct admission type will also support correct level of care designation which will, in turn, support obtaining appropriate reimbursement for patients based on their actual clinical needs.

## ***Levels of Care: Inpatient, Outpatient, Same Day Surgery/Outpatient Surgery, Observation***

### *Levels of Care*

**Levels of care are the basis for determining the amount of payment a hospital will receive for patient care.** Hospitals must establish a consistent process for assigning levels of care, operationalized by knowledgeable staff, with little variability in application to individual cases to insure compliance with applicable regulations and rules by government and commercial payers.

**Level of care determination is based on a specific set of criteria in which patients must meet both Intensity of Service and Severity of Illness definitions.** Available level designations include: Inpatient, Outpatient, Same Day Surgery/Outpatient Surgery, and Same Day Surgery/Outpatient Surgery with Observation. Both Observation and Same Day Surgery/Outpatient Surgery are considered to be Outpatient status and are billed as such. These procedures may be referred to as either Same Day Surgery or Outpatient Surgery. Not all payers recognize all of these designations. Organizations must consult their payers to determine the most appropriate designation to use.

### **Inpatient**

A patient is considered to be in an inpatient status when formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed; even if it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.<sup>2</sup>

Inpatient status is designated after a determination of “medical necessity”. Medical necessity is, in turn, further assessed by comparing the patient's symptoms and treatment with a predefined set of criteria (InterQual, Milliman, or MCAP) to identify if the patient's stay should be managed in an acute care setting. Once medical necessity is determined, ongoing review of the patient's condition throughout the hospitalization is

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<sup>2</sup> Medicare Benefit Policy Manual, Chapter 1: Inpatient Hospital Services Covered Under Part A, page 6-7

needed to assess whether the patient requires continued care in an acute care setting or whether the patient can be moved to a different level of care.

Hospital by-laws and admissions policies will influence the decision regarding level of care. An example of this relates to the Centers for Medicare and Medicaid Services (CMS) Inpatient Only List. Medicare has an Inpatient Only List that is updated and published annually as part of the Proposed and Final Rules for the Outpatient Prospective Payment System. This list should be reviewed by the hospital's physicians to identify whether there are additional procedures that they believe should be added to the Hospital's own Inpatient Only List based on their experience and/or findings in the literature. Because Medicare will only pay for *inpatient status* for the procedure codes on the CMS Inpatient Only List, this entire set of procedure codes should be included in every hospital's Inpatient Only List.

Many commercial payers also have Inpatient Only Lists that are part of their negotiated contracts. These lists should also be reviewed by the hospital and physicians to determine whether the list is clinically appropriate and complete. If there are procedures that are on a payer's Inpatient Only List that should be challenged and/or that are not on the List that the hospital and physicians believe should be, then this should be discussed with the payer, based on supporting clinical evidence.

**An important consideration is that procedures that are not on the Inpatient Only List may still be admitted and billed as inpatient.** The inpatient designation would be based on the patient's *individual* health status and condition.

Because of the continuing confusion in most hospitals regarding appropriate level of care designation, it is valuable to have Case Managers positioned at all points of entry. These Case Managers are experts in level of care designation and provide real time consultation and/or confirmation regarding the most appropriate designation based on the patient's presentation and external regulations. They can deflect issues by insuring that the correct status is assigned from the beginning of the admission.

**Outpatient** designation is generally used for patients who require a lab test, x-ray, or other outpatient test. Medicare also includes Observation and minor surgical procedures in its definition of outpatient services.

**Same Day Surgery/Outpatient Surgery** references a surgical procedure that is performed the day the patient comes to the facility and goes home without staying overnight in an inpatient bed. It is important to note that the designation of Same Day Surgery or Outpatient Surgery refers to procedures performed in a hospital and not in an Ambulatory Surgery Center (ASC). Again, Medicare has specific requirements for Same Day Surgery/Outpatient Surgery that may differ from those of commercial payers and/or state regulated Medicaid. For Medicare, the requirements for Same Day Surgery/Outpatient Surgery include:

- The surgery is performed the same calendar day as the outpatient registration.
- The recovery period is expected to be 4 to 6 hours.<sup>3</sup>
- The patient is discharged as an Outpatient.

Medicare uses specific categories called Ambulatory Payment Classifications (APCs) that designate the payment for Same Day Surgery/Outpatient Surgery level of care and other outpatient procedures.

Each hospital should have a process to identify whether procedures will be paid at the Same Day Surgery/Outpatient Surgery level of care. However, when it is determined that a patient needs extended care after a same day surgical procedure and it is anticipated that the patient will go home the next day; the physician should order *Observation after Same Day Surgery/Outpatient Surgery*. The order should include the reason for Observation and documentation in the medical record should reflect that the treatment the patient received justified the stay in Observation. An important consideration is that **Medicare requires that Observation must not be scheduled or pre-determined but must follow a post-operative assessment in order to verify the need for an extended stay.**

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<sup>3</sup> Medicare Claims Processing (PUB. 100-04), Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPSS) 290 - Outpatient Observation Services (Prior to Rev. 1445; Effective: 01/01/08; Issued: 02/08/08)

**Observation Status** is described in Medicare guidelines as a “well defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”<sup>4</sup> In essence, **Medicare considers Observation status as a designation into which a physician admits a patient for a specific period of time to provide an opportunity to determine if the patient will require further monitoring and/or treatment in an inpatient setting.** CMS further defines Observation services as “those services furnished by a hospital on the hospital’s premises, including the use of a bed and at least periodic monitoring by a hospital’s nursing or other staff which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for possible admission to the hospital as an inpatient.”<sup>5</sup> Observation status events are billed as *outpatient* and the term Outpatient Observation is often used. As noted earlier, **Outpatient Observation status cannot be determined pre-operatively or pre-procedure.**

CMS further indicates that, “Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually less than 24 hours”.

Inpatient and Outpatient Observation status designates different levels of payment, even though the care provided is likely to be the same. Another important factor is patient location. The Medicare Claims Processing Manual notes that "Patients admitted to outpatient observation may be treated in a variety of bed arrangements such as a freestanding clinical decision unit, an observation bed that is part of the emergency department and under the emergency department's control, or in virtual observation (in

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<sup>4</sup> CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 787, December 16, 2005, Change request 4259

<sup>5</sup> Medicare Benefit Policy Manual Chapter 6, Section 70.4

any acute care bed, but billed as outpatient observation), with all of them being billed in the same way."<sup>6</sup>

The criteria for Observation Status in the Medicare regulations are as follows:

- The patient does not meet inpatient criteria.
- Stabilization and discharge is expected within 24 to 48 hours.
- The treatment is needed for more than 8 hours.
- The clinical diagnosis is unclear and can be determined in less than 24 hours.

To reinforce, within Medicare regulations, Observation Status is an *outpatient* level of care and has very specific requirements. The physician's order must indicate Observation in an order, such as "Place in Outpatient Observation." In addition, observation services must be reasonable and necessary. If the care is custodial in nature, such as for patient or family convenience, it will not be covered and the patient may be responsible for additional costs. Observation status cannot be provided in a critical care area. In most situations, no surgical procedures are done during the observation period.

Medicare mandates that the beneficiary must be in the care of a physician during the period of Observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.<sup>7</sup>

#### *Non-Medicare Payer Designation of Observation Status*

Individual commercial payers and state-regulated Medicaid have their own specific guidelines for Observation designation that should be thoroughly reviewed by relevant hospital staff and applied as appropriate. Observation status as described by InterQual for most *commercial payers* is limited to a maximum of 48 hours. If a patient meets only Observation status criteria and the physician has no plans for discharge after 48 hours, a

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<sup>6</sup> Medicare Claims Processing Manual, January, 2006; Chapter 4

<sup>7</sup> Medicare Claims Processing (PUB. 100-04) Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPSS) 290 - Outpatient Observation Services (Prior to Rev. 1445; Effective: 01/01/08; Issued: 02/08/08)

peer clinical reviewer (PCR) referral is required. A patient meeting only Observation criteria must be billed as outpatient.

**A change in patient status from Observation to Inpatient is based upon meeting identified criteria rather than a time based rule.** Patients in Observation status should be continually reassessed based on criteria for appropriate discharge or transition to inpatient status. When the review indicates that a different level of care is indicated, the appropriate physician order should be obtained. There may also be a need to contact commercial payers to communicate the change in status.

#### *Example of regional differences*

Interpretation of the Medicare regulations related to level of care and associated billing is managed at the regional level. Therefore it is crucial that hospitals communicate with and work closely with the Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC)), and QIO for their area. How these organizations interpret the regulations can have a significant impact on their application to hospital claims. Florida provides an example of this in a release dated June 1, 2006 titled "PTCA, PCI, and ICD Pacemaker Billing".

*"FMQAI, the Medicare Quality Improvement Organization (QIO) for Florida, by law reviews medical services provided to Medicare beneficiaries in the state of Florida to determine if the services meet medically acceptable standards of care, are medically necessary and are delivered in the most appropriate setting. Under the Hospital Payment Monitoring Program, FMQAI monitors hospital admissions and coding patterns by conducting hospital profiling and trending of identified activities. Recently FMQAI conducted a review regarding the overall admission status for a PTCA and PCI procedures and ICD pacemaker insertion. Based on the CMS administrative data reports, PTCAs and PCIs are the top DRGs billed for one-day stays in Florida with a 60 percent rate. After review of the Federal Register and consultation with both Florida fiscal intermediaries and other QIOs, there seems to be variation in billing status. As of July 1, 2006, FMQAI will no longer be uniformly allowing these procedures to be billed as inpatient services via an override process. Cases will be reviewed individually and evaluated as to whether inpatient or outpatient billing is appropriate. The medical record must contain information that documents the need for an inpatient level of care. Those cases that appear to be routine, expected discharges within 24 hours and which do not substantiate Severity of Illness (SI) and Intensity of Service (IS) criteria will be considered for inpatient billing denial."<sup>8</sup>*

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<sup>8</sup> FMQAI, [www.fmqai.com](http://www.fmqai.com)

This ruling by the Florida QIO further emphasizes the need for consistent, accurate, and criteria based reviews of each patient to identify and/or confirm the appropriate level of care. If challenged, the hospital should be prepared to substantiate the level of care for every patient based on physician documentation and a criteria-based review.

## ***Changes in Level of Care - Condition Code 44***

Condition Code 44 was created by Medicare to address its previous regulation that prohibited changing a level of care designation from an inpatient level of care to Outpatient, even if the change was to a more appropriate level of care.<sup>9</sup>

Condition Code 44 is used for inpatient cases being changed to outpatient status, including observation. It is considered when a physician orders inpatient services but there is a determination, through internal review before the claim is initially submitted, that the services did not meet inpatient criteria. Medicare's parameters for Condition Code 44 require that:

- The change in status from inpatient to outpatient is made prior to the patient's discharge, while the beneficiary is still a patient of the hospital.
- The hospital has not submitted a claim to Medicare for the inpatient admission.
- A physician concurs with the Utilization Review committee's decision.
- The physician's concurrence is documented in the patient's medical record.

If these conditions are met, Condition Code 44 can be used to bill for Outpatient services, including Observation care.<sup>10</sup>

The Finance Department or Business Office must use Condition Code 44 correctly in order to avoid inappropriate or incorrect billing. Policies must be developed and implemented, and Case Managers must be educated about them to ensure that all criteria are met for appropriate use of Condition Code 44.

### ***Type of Admission and Level of Care for Implanted Cardiac Devices***

Cardiac device implant patients with commercial payer plans should be placed in the level of care designated by the contract negotiated with the hospital and/or pre-authorized by the plan. However, if the criteria-based review of the patient indicates another level is more appropriate for their clinical condition, the payer should be notified for reconsideration of level of care status.

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<sup>9</sup> CMS Manual System Pub. 100-04 Medicare Claims Processing, ch. 1

<sup>10</sup> MLN Matters Number SE0622: Clarification of Medicare Payment Policy when Inpatient Admission is Determined Not to Be Medically Necessary, Including Use of Condition Code 44: Inpatient Admission Changed to Outpatient, March 2006

**Medicare does not provide specific instructions regarding the designation of level of care related to cardiac device implant cases.** The process for determining the appropriate level of care for Medicare patients receiving these devices is the same as for other procedures.

- Medicare elective admissions, if not urgent, should be Same Day Surgery/Outpatient Surgery. Outpatient Observation would not be the appropriate level of care since it cannot be designated in advance of a scheduled admission. Again, *scheduled admissions are not always elective*. Given the underlying life-threatening nature of the reason for which implantable cardiac devices are needed, the patient should be assessed to determine whether the admission would be considered urgent. Exceptions to assigning elective Medicare cardiac device implant patients to Same Day Surgery/Outpatient Surgery that might create a need for an inpatient admission could include the patient's clinical condition, underlying health issues, and/or comorbid conditions. These patient-specific issues must be documented by the physician in the patient record.
- Elective patients who are registered for outpatient Electrophysiology studies and become patients who urgently need a cardiac device implanted are then admitted as inpatients. The documentation of the change in status should be reflected in the medical record.
- Urgent and emergent cardiac device implant cases should be considered for admission as inpatients based upon their medical necessity as determined by the physician's assessment.

## ***Management of Patient Flow and Level of Care***

Patient flow is extremely important to health care organizations for a number of reasons, including capacity, quality, and finances. Scheduling processes allow the anticipation of bed availability on a daily basis. When patients are scheduled for a Same Day Surgery (SDS)/Outpatient Surgery procedure, they can be managed in an SDS unit pre- and post-operatively. If patients must be monitored overnight, placed in Observation status, or admitted as an inpatient after a scheduled Same Day Surgery, a bed must be available for the patients. For facilities operating at or above capacity, this becomes a daily struggle to ensure sufficient beds for all patients requiring one. Many facilities place Observation patients in locations throughout the organization with no dedicated Observation unit. Patients with ICDs or other cardiac devices require telemetry monitoring post-procedure necessitating the availability of a telemetry bed. All of these issues can lead to problems in bed management.

Criteria are guidelines for Case Managers and physicians as they identify the appropriate level of care for each patient based on the severity of presenting symptoms, past history, comorbidities, laboratory values, and the treatment plan. It is important for physicians to have an understanding of criteria when ordering level of care for a patient *and/or* to have an expert available for guidance as admission orders are written.

Case Managers evaluate whether the patient is placed in the appropriate level of care based on criteria. If documentation supporting the physician's order for level of care is not identified, the first step is to ask the physician for any available and legitimate additional clinical information.

# **Payment**

## **Inpatient**

Medicare pays for inpatient stays based on Medicare Severity Diagnosis Related Groups (MS-DRGs). (Note: The use of the acronym DRG will be assumed to refer to the MS-DRG system that went into effect October 1, 2007). The hospital will receive payment for one DRG per admission. The reimbursement for each DRG depends on the hospital-specific “base rate” and the “relative weight” of the DRG. A hospital’s base rate is determined by a number of factors, including the cost of living for the area in which the organization is located. Each DRG will have a CMS-determined “relative weight” based upon the average hospital resource consumption associated with the treatment of the types of cases assigned to the DRG. The DRG relative weight is multiplied by the hospital’s base rate to determine the reimbursement for that DRG. For example, Hospital X would receive a payment of \$25,206 for a Medicare inpatient case assigned to MS-DRG 227 (**ICD w/o Cardiac Cath w/o MCC**) if Hospital X has a base rate of \$5,000 and the relative weight for MS-DRG 227 is 5.0411).

Other payers may reimburse for services based on a DRG (case rate), per diem (daily rate), discounted fee for service, or a capitated rate. The commercial payer rate for DRG reimbursement depends on the contract negotiated by the organization and is often very different than the Medicare payment rate. It is important for all involved in determining level of care and billing to know the related requirements negotiated with commercial payers as well as state specific rules.

## **Outpatient**

Medicare Outpatient procedures are paid based on Ambulatory Payment Classifications (APCs). APCs are similar to DRGs in that payment is determined prospectively. However, a hospital may be paid for more than one APC per visit depending, in part, on the number and types of services provided.

Outpatient procedures for other payers are paid based on the contract rate and terms negotiated with the payer by the hospital. Some hospitals and payers have negotiated

contracts that specify payment based on a pre-determined percentage of hospital charges. For example, if a hospital negotiates a contract in which it will be paid 50% of charges for an outpatient stay, it will be reimbursed \$12,500 for a case that has \$25,000 in billed charges.

#### *Pre-Admission Processes*

Most commercial payers (and some state Medicaid programs) require pre-certification procedures be completed by the hospital or physician's office before the insurer approves and, ultimately pays for, the inpatient stay or outpatient procedure. Although traditional Medicare does not require pre-certification for any services, some Medicare managed care plans may have different rules.

Pre-certification is a crucial front end procedure that requires careful attention to detail and compliance with the requirements of each individual payer as the requirements for pre-certification may vary by plan. Case Managers, Admitting staff, and others need to understand the hospital's reimbursement structure for clarity about the appropriate level of care based on criteria based assessment within the context of payer requirements. It is important to have a specific process between physicians, their office staff, and the hospital to ensure timely coordination of information regarding the patient's clinical condition and insurance status.

During the pre-admission or admission process, **it is important that patients be informed about how the hospital services will be paid and any anticipated financial responsibility they will have as a result of the hospitalization.** Individual commercial contracts specify levels of co-payment and/or co-insurance, sometimes based on the level of care to which the patient is admitted. Although many individuals have heard these terms, they often don't become real until a thorough explanation of the financial impact is provided to them based on their specific situations.

#### *Comorbidities, Documentation, and Reimbursement*

**Complete documentation by physicians and others has always been essential for the provision of effective and accurate care.** However, there are other outcomes of complete documentation to be considered, including reimbursement and calculation of severity rates. This is particularly true now because Medicare began to use Medicare

Severity DRGs (or MS-DRGs) as of October 1, 2007. Medicare has also begun publishing severity-adjusted hospital mortality rates at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov).

It is important that physicians and others receive focused education regarding complete documentation. The documentation of *one* existing comorbidity and/or complication can make a significant difference in both reimbursement and expected mortality rates. For example, the case of a patient admitted with diagnoses of paroxysmal ventricular tachycardia, cardiomyopathy, and non-specific congestive heart failure who undergoes insertion of an ICD during the hospitalization would be assigned to MS-DRG 227 which has a weight of 5.0411. If this same patient was assessed and documented to have acute (or acute on chronic) systolic/diastolic (or a combination of systolic and diastolic) congestive heart failure, the addition of one such major comorbidity or complication (MCC) would result in the case being grouped into MS-DRG 226 which has a weight of 5.9123, adding approximately \$4,700 to the hospital reimbursement.

## ***Clinical Documentation Improvement Programs***

Within the new MS-DRG system it is even more essential that comorbidities and complications be clearly and comprehensively documented. The revised system creates three levels of DRGs: with a major complication or comorbidity (MCC), with a complication or comorbidity (CC), or without complication or comorbidity (w/o CC/MCC). There are also shifts in what is considered a comorbid condition and some chronic diseases that were previously identified as comorbidities must now be documented as an acute exacerbation to be categorized as a CC or MCC. A key point to remember is that these MCCs or CCs are secondary diagnosis codes, not the principal diagnosis code. The complete list of CCs and MCCs can be obtained in Tables I and J of the FY2008 IPPS Final Rule at <http://www.cms.hhs.gov/AcuteInpatientPPS> (Acute Inpatient - Files for Download). In addition, the entire IPPS Final Rule can be downloaded at: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>.

In a clinical documentation improvement program, Clinical Documentation Specialists (usually Registered Nurses), concurrently review physician documentation. They assess the presence and *wording* of documentation related to the principal diagnosis and other comorbid conditions. In addition, they review other data (such as laboratory results) to identify whether there may be other secondary comorbidities that are present but have not been documented or not documented completely. From the example just highlighted, it is clear that documenting only congestive heart failure is not sufficient – the specific type of heart failure is also critical to substantiate a different DRG with higher severity and higher reimbursement.

## ***Denials and Denial Management***

There are issues that are likely to lead to denial of payment for cardiac implantable devices. One is inappropriate level of care determination for the patient prospectively or concurrently based on the urgency of the patient's need and/or clinical condition. Another issue is lack of or inadequate documentation regarding the appropriate indication for the implantation of cardiac devices. Both of these issues are most effectively handled concurrently so that level of care and indications are documented in such a way to avoid receiving a denial. Denials can be avoided when physicians know and document the appropriate level of care for patients presenting with conditions or diagnoses common to the physician's practice, have access to a knowledgeable resource regarding level of care designation (such as a Case Manager), and know and document the indications for implantable cardiac devices. They can also be avoided through consistent attention by Case Management and other staff to required processes (such as pre-certification) for all patients and their payers, including the accurate use of criteria.

### *Denials: Definition, Categories, and Responses*

When reviewing the bill and/or patient chart, the payer assesses whether the stay was medically necessary and/or whether the patient could have been managed at another level of care. A denial occurs when the payer determines that the organization should not receive the full payment for the services rendered. Denials can cause delays in reimbursement or a failure to be paid at all. Denials can be total (e.g., payment for the entire hospitalization is denied) or partial (such as denial for one or more days within the hospitalization). There are also situations in which the reimbursement is calculated by the payer on a lower level of care than billed by the hospital. For example, a hospital may bill the stay as an inpatient but the payer, upon reviewing the admission, may reimburse at an Outpatient or Observation rate.

A denial letter is sent to the Utilization Review/Case Management department or to the Finance Department or Business Office by the payer. Each non-Medicare payer contract outlines the process for responding to the denial, such as the type of response required, how long the organization has to appeal and, subsequently, how long the

payer has to respond. Payment will be withheld by the insurer until the denial is resolved.

**Prevention of denials is the best approach to managing denials.** Prevention and management of denials requires consistent attention and precision on the part of the hospital staff. This is usually a significant role for Case Managers as they typically have the knowledge of the application of clinical criteria as well as the payer's process for issuing and addressing denied coverage, including conditions under which coverage may be decided. Each payer contract specifies those parameters and **both the payer and the provider must follow those negotiated rules.**

### **Types of Denials**

Denials can be viewed from different perspectives. From the perspective of timing, denials may be concurrent (e.g., issued while the patient is still in the hospital) or retrospective (e.g., issued after the patient has been discharged). Case Managers are usually the first members of the hospital staff who have knowledge that a concurrent denial will be issued. The expected denial is frequently based upon lack of documentation of medical necessity as identified through the use of criteria or via communication from the payer. This requires prompt and knowledgeable intervention by the Case Manager with the goal of preventing the denial when possible.

Denials may also be categorized as clinical or administrative. Clinical denials are related to lack of medical necessity. A key indicator of this is when patients do not meet criteria for their current level of care. Administrative denials are related to incorrect patient information and/or failure to follow the payer's requirements regarding notification, verification, or pre-certification. They may also be related to incorrect processing of patient bills.

Through contracts negotiated with hospitals, commercial insurers require that certain levels of care be pre-certified before the scheduled patient is admitted to an acute care hospital. This process helps identify whether the scheduled patient has a health plan benefit for the stay or procedure and if it is medically necessary for the admission to occur or the procedure to be done. This can be complex because the rules regarding needs for pre-certification are different for each different insurer. Another complexity is

that the hospital can not independently pre-certify the scheduled patient because the insurer usually requires clinical information from the physician who examined the patient to verify that the patient needs the stay. If a payer requires pre-certification by the physician for a hospital admission and the patient is admitted without pre-certification, the insurer is likely to issue a denial. It is important that hospital Admitting/Access staff be knowledgeable about what needs to be pre-certified and what does not. It is critical that the Admitting/Access department review each scheduled admission to verify that pre-certification is complete before the patient comes to the hospital in order to prevent a denial. Hospitals should implement a coordinated process that includes their physician practices to ensure timely flow of all information necessary to complete the pre-certification process.

For most commercial insurers, the process and requirements change if a patient is admitted urgently or emergently. In these situations, there are time frames within which the hospital must notify the insurer about the patient's admission to the hospital. These time frames are contractual and should be known by the staff reviewing benefits and completing the pre-certification process. If this is not done within the required time frame, a denial will be issued.

Once the insurer is aware that the patient is in the hospital, some payers may require that clinical information is called to a designated contact point for further review. This is done to ensure that the patient meets coverage and/or clinical criteria for continued stay within an acute care facility at the level of care that was ordered. If the clinical information is not provided or there is not enough information provided, a concurrent denial may be issued while the patient is still in the hospital. If this happens, the Utilization Review nurse can obtain additional information from the physician and then provide that information to the payer in an attempt to overturn the denial. If the insurer does not agree that the additional information provided by the hospital substantiates the need for an inpatient stay, the physician caring for the patient (or in some cases the Case Management Physician Advisor) may be asked to discuss the case with the insurer's medical director. The payer may still determine that medical necessity has not been met and a final denial is issued. A letter describing the denial and the reason for the denial is issued to the hospital and the patient. If the denial is issued concurrently the patient needs to be informed that the payer will not pay for the stay.

### ***Managing Denials***

Organizations should be alert to issues that are likely to lead to a denial being issued, particularly in the situation of implantable cardiac devices, as prevention is a more effective strategy than appealing a denial. Those issues include:

1. The patient does not meet the coverage criteria for the device implant procedure
2. Length of stay is determined to be not medically necessary based on clinical criteria
3. Delay of service, such as when the procedure cannot be scheduled or performed in a timely manner.

To minimize the risk of denials, physician documentation should clearly outline the services the patient is receiving and/or about to receive. It should also provide detailed clinical information supporting the need for initial and/or continued acute care, (i.e. telemetry/monitoring for cardiac or respiratory events). As the risk for denials is present when patients do not meet inpatient level of care criteria, discipline is needed by the Case Management staff to review patients vis-à-vis criteria on a frequent basis. When physician documentation no longer supports the patient at an inpatient level of care criteria, a discussion with the physician by the Case Manager to request additional clinical information or to explore progression to another level of care is warranted. If this discussion does not result in clarification (and subsequent documentation) of the patient's clinical picture, referral to the Case Management Physician Advisor may be needed.

Managing denials relies on knowledgeable staff and advocacy for both the patient and the hospital. When clinical denials are received, either concurrently or retrospectively, one of the first steps is to identify the basis for the denial as specified by the payer. The second step is to review the patient's specific situation based on the application of criteria. Consultation with the patient's physician may be a part of this step. Based on the result of that review, hospital staff (often the Case Managers) make a decision regarding how to proceed.

For a concurrent denial, if it is determined that the patient unquestionably meets criteria for the assigned level of care, communication with the payer is called for in which the rationale is clearly and definitively outlined. If this does not deter the impending,

concurrent denial, the patient's physician (or the Case Manager's Physician Advisor) is asked to communicate with the payer's Physician Advisor. If the Case Manager identifies that the patient is *not* meeting the appropriate level of care criteria and a concurrent denial is looming, communication with the patient's physician and development of a plan to transition the patient to the next level of care is in order. If the patient's physician disagrees with the assessment regarding level of care and with the need to discharge or transition the patient, the Case Management Physician Advisor is again called in as a resource for a second level review.

When retrospective clinical denials are received, the first two steps of the process are similar. The payer's stated reason for the denial as outlined in the letter is noted and the patient's chart is reviewed within the context of that reason. Clinical criteria are also used to reassess the appropriateness of the designated level of care and medical necessity. If the review confirms that the patient was at the appropriate level of care and that the care was medically necessary, a letter of appeal is written. In many situations, the patient's physician (or the Case Management Physician Advisor) may be asked to provide information about the patient's clinical situation in support of the appeal.

Appealing denials is a process that requires strategic development and careful implementation. It is recommended that a designated staff member be identified to manage clinical denials. If such an individual is not available, the Case Manager should review the case and make a recommendation about whether the denial should be appealed. If the hospital agrees with the payer's determination that a procedure should have been billed as an outpatient, specific payer instructions need to be followed to resubmit the claim. For example, Medicare requires that the claim be resubmitted as a specific bill type that will result in reduced payment. For some commercial payers, it may be possible to negotiate for a different level of care payment (such as Same Day Surgery). If the hospital disagrees with the denial, the physician should communicate with the insurer's medical director; physician to physician dialogue often clarifies the patient's situation and a reversal of the denial occurs. There may be a need to write a letter describing the clinical symptoms and treatments related to the patient's clinical condition that necessitated the level of care in question. If the reason for the challenged level of care is outside the criteria set in use, this should articulated by the physician in a letter of response. For example, if the hospital's cardiologists have identified an

organization wide standard of care that is outside the recognized criteria set and the patient meets this description as stated in the organization's standard, this should be articulated in the denial letter. The letter should include a copy of that standard and/or the hospital's Inpatient Only List, if applicable, in addition to any supporting literature or research findings.

**The best method for addressing actual or potential retrospective or concurrent denials is to provide adequate clinical information documenting the patient's severity of illness and the intensity of the services provided.** Comprehensive and authoritative knowledge about the health conditions as well as the treatment protocols is another strong foundation for preventing and managing denials. Each organization should review professional organization guidelines, such as the American College of Cardiology (ACC), for guidance when developing documentation and other tools for the patient population receiving implantable cardiac devices. These guidelines may provide a strong clinical rationale for defending level of care designations. Any clinical or quality issues that are identified in the course of providing care should be reviewed at the appropriate medical staff committee level to address patterns and practice issues to further enhance quality of care and decrease the potential for denials.

Data management is part of the denial management process within all hospitals. Denial data should be aggregated and analyzed by case type (DRG), physician, and payer to determine whether there are consistent trends and patterns. If patterns or trends *are* identified, a strategic action plan can be developed, implemented and evaluated.

To prevent technical denials, precision and thoroughness in patient registration and billing is required. This includes developing and implementing appropriate processes for benefits checking and pre-certification as well as notification. Likewise, timely mailing of medical records, billing and calling clinical reviews will decrease the amount of administrative denials.

**Particularly in the case of ICDs, the patient's condition upon admission, the underlying problem, and any other factors such as comorbidities or age are factors to consider when appealing or avoiding denials.** Knowledge of the American College of Cardiology/American Heart Association (ACC/AHA) guidelines will

assist the physicians and others to provide appropriate documentation and a strong clinical rationale related to the indication for ICDs and other cardiac devices. And, as in other diagnoses and procedures, the correct and consistent use of criteria by Case Managers will provide strong documentation of medical necessity for inpatient, outpatient, and observation care. As noted earlier, clarification of the definitions of elective, urgent, and emergent admissions will support clarification of level of care designation internally and externally. As previously mentioned, it will be useful to have those discussions with payers as part of contract negotiations.

## ***The PEPPER Report***

The PEPPER report is a tool that Medicare developed for and distributes to organizations to assess their own performance and compare it to others within their state. PEPPER stands for **P**rogram for **E**valuating **P**ayment **P**atterns **E**lectronic **R**eport. This report assesses compliance regarding coding and effectiveness of utilization review for Medicare patients. It also reflects the patterns of payments made to each hospital compared to those made to other hospitals in the state. The report does not specify if the organization has effective and/or compliant coding and utilization practices but indicates high risk areas that should be reviewed for utilization and coding practice compliance.

PEPPER is developed under contract with the Centers for Medicare & Medicaid Services (CMS) by the Hospital Payment Monitoring Program (HPMP) Quality Improvement Organization Support Center (QIOSC), which is the Texas Medical Foundation (TMF) Health Quality Institute. TMF provides all Quality Improvement Organizations (QIOs) with hospital-specific data for long-term, acute-care inpatient prospective payment system (PPS) hospitals within their states quarterly. The overall goal of HPMP is to reduce the Medicare payment error rate within each state as well as nationally. The PEPPER report contains hospital-specific Medicare claims data statistics for target areas that have been identified by the Centers for Medicare & Medicaid Services (CMS) as being at high risk for payment errors. These target areas include one-day stays, hospital readmissions and several DRGs that have historically been associated with payment errors.

The PEPPER report is available on a quarterly basis to most organizations through the QIO. Notification is sent to identified recipients within each hospital; those recipients must then download the report.

The report includes quarterly data that is a cumulative running average over the year. The year is the same as the CMS fiscal year and so the first quarter is October through December. The report contains hospital data compared to state data regarding the

following categories (new MS-DRGs are referenced where possible):

- One day stays excluding transfers
- One day stays with transfers
- DRG 127 CHF one day stays (MS-DRGs 291, 292, 293)
- DRG 143 Chest Pain one day stays (MS-DRG 313)
- DRG 182 and 183 GI one day stays (MS-DRGs 391, 392)
- DRG 296 and 297 Nutritional disorders one day stays (MS-DRGs 640, 641)
- DRG 014 intracranial hemorrhage (MS-DRGs 64, 65, 66)
- DRG 079 complex pneumonia (MS-DRGs 177, 178, 179)
- DRGs 239 pathological fractures (MS-DRGs 542, 543, 544)
- DRG 243 back pain (MS-DRGs 551, 552)
- DRG 253 fracture/sprain/strain (MS-DRGs 562, 563)
- DRG 416 septicemia
- DRG 475 respiratory diagnosis with ventilator
- Seven day readmit to same facility or elsewhere
- Same day readmit elsewhere
- Same day readmit same facility
- Three day stay transfer to SNF
- Complication and Comorbidity pairs
  - This could indicate possible coding or billing errors related to over coding due to unsubstantiated complications and/or comorbidities.

These areas are selected by CMS for a number of reasons including the following.

- These DRGS are target areas because of the number of payment errors identified
- Many were DRGs with admission denials with a LOS of one day
- 079, 416, 475 were selected because of high dollars in error for DRG changes
- 014, 127, 243, 182/183, 296/297 had high admission denials and DRG changes (MS-DRGs 64, 65, 66; 291, 292, 293; 551, 552; 391, 392; 640, 641)
- Readmissions associated with payment errors due to billing errors and premature discharges, incomplete care or inappropriate readmission

The goal for organizations is to be below the 75<sup>th</sup> percentile or above the 10<sup>th</sup> percentile, depending on the section being reviewed. An organization that is above the 75<sup>th</sup> percentile or below the 10<sup>th</sup> percentile compared to its state is considered an outlier. Organizations should review each area in detail in which they fall within the outlier range to assess compliance with coding practices and or utilization review practices. If there is a need for improvement, an action plan and follow up should be documented. If an internal assessment is completed and verifies that there are no areas for improvement, that should be documented as such and reviewed with the Utilization Review, Medical Records/Health Information Management (HIM) and Compliance committees. Examples of issues identified in the PEPPER reports from a variety of hospitals and potential strategies to address those issues are provided in Appendix D.

**One section of the report identifies the top 20 DRGs with one day stays. This is of particular interest to hospitals that provide care to Medicare patients with ICD implantation.** For one day stays, the state's median is the benchmark; in other words, the goal is to be below the state's median. **ICD implantation is often one of the organization's top 20 DRGs for one day stays.** This is related to the usual length of stay for this case type. In analyzing the top 20 DRG list, if the organization's overall one day stay rates are high compared to the state, the hospital should consider if there is an issue with the appropriate use of Observation. If only one or two DRGs have a high rate of one day stays, the problem might be isolated to those DRGs. Regardless whether any DRG one day rates are high, a review of those one day stays should be done to assure compliance with utilization review practices. Should an issue be identified, an action plan should be developed and implemented to reverse the trend.

Each quarter, immediately after the PEPPER report becomes available, identified members of the hospital staff should analyze the contents to identify areas in which the hospital is above the 75<sup>th</sup> percentile or below the 10<sup>th</sup> percentile. As noted, it may also be necessary to review charts for some or all of the acknowledged areas of concern. Once the reviews and analysis are complete, they should be documented and shared with the Utilization Review and Compliance committees with an action plan if one is needed.

## ***Education***

A hospital's best strategy for consistently designating the correct, compliant and most financially appropriate level of care is a highly knowledgeable and empowered staff. This requires initial and ongoing education of all staff that influence the level of care designation in any way. The stakeholders that should be part of this process include: physicians and their office staff, Case Managers, Utilization Review nurses, Admitting and Registration staff, staff at all points of entry into the hospital (such as the Emergency Department and Peri-operative units), coders, and Hospital Information Management (HIM) staff. In addition, members of the Finance Department, Business Office, Managed Care Contracting, and Compliance should also understand the economic dimensions to these care processes and decisions so that billing and contracting processes remain compliant and aligned with organizational values.

Specific content and the depth of information provided will depend, in part, on the area in which the staff member works.

It is imperative that *all* new staff, including physicians, to these areas be given a thorough orientation to level of care related processes and regulations. As education sessions are completed, the level of staff knowledge should be evaluated to insure they have the appropriate and necessary level of knowledge. **Staff knowledge is the single most important factor in correct designation of level of care.** In addition, staff must be updated as new regulations or negotiated parameters come into effect. New information should be reviewed verbally and also provided in writing. Many of these regulations are complex and difficult to absorb in one sitting. Department leaders, in particular, must have a deep and operational knowledge of the relevant parameters to be a resource to staff.

An outline of education topics related to implantable cardiac devices and their appropriate level of care is provided in Appendix E.

## ***Additional Resources***

It is important for hospitals to maintain knowledge about current changes in Medicare regulations regarding payment. There are many resources available for this. The *Federal Register*<sup>11</sup> is the repository for all Medicare regulations, and CMS regularly communicates proposed and final changes through it. The Medicare website<sup>12</sup> is also an excellent resource to monitor for announcements of policy changes, program transmittals, etc. Medicare has a number of “list serves” with free subscription services that distribute proposed and final Medicare changes. It is recommended that at least one individual within each hospital receive these changes and review them. The changes should also be shared with all individuals in the hospital who interface with Medicare related processes. Similarly, most non-Medicare payers provide websites with access to their clinical and administrative policies. A selected list of additional resources is provided in Appendix F.

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<sup>11</sup> <http://www.gpoaccess.gov/fr/index.html>

<sup>12</sup> <http://www.cms.hhs.gov/home/medicare.asp>

## ***Key Strategies for Hospitals***

Everyone benefits when the appropriate level of care is provided in the most cost effective setting. Hospitals and physicians must work together in a collaborative manner to ensure that the processes and procedures are in place to define, deliver, measure, and communicate this quality outcome.

This section provides a list of strategies that are designed to support effective and compliant management of level of care. As the list is reviewed within the organization, existing processes should be identified along with the need to reassess their effectiveness. Strategies that have not yet been implemented within the organization should be assessed for potential usefulness and those identified as useful should be listed in priority order. This process provides guidance in establishing priorities as strategies are developed.

- ❑ Identify at least one individual within the organization to regularly review updates to CMS/Medicare regulations through subscriptions to list serves and/or reading the Federal Register. As planned or impending changes are identified, related individuals within the organization should be notified and appropriate strategies to manage the changes should be developed.
- ❑ Support physicians in providing comprehensive and thorough documentation of patient conditions, including comorbidities.
  - Provide education to the physicians about the specific needs for documentation.
  - Implement a Clinical Documentation Improvement program. If one already exists, assess its effectiveness and update it as needed. This is particularly important with the advent of MS-DRGs.
  - Work with physician office staff to create a smooth flow of information and processes related to pre-registration, registration, and authorization.
- ❑ Use clinical criteria robustly. Ensure that the Case Managers and related staff have updated information about criteria sets and periodic changes they

undergo. Review their use of clinical criteria in daily practice to assess how effectively criteria are used by staff.

- ❑ Negotiate payer contracts with careful attention to Case Management/Utilization Management related processes such as level of care notification and denials.
- ❑ Create (or update as needed) a policy and procedure regarding Outpatient Observation status and its management for the hospital. Simultaneously create (or update as needed) a policy and procedure regarding Condition Code 44. Ensure that all related staff are knowledgeable about the policies and procedures. An educated staff is the strongest approach to compliant and effective management of level of care.
- ❑ Create an Inpatient Only List specific to the hospital's patient populations and needs. Forward the resulting List through the usual channels of approval within the hospital and physician leadership structures.
  - Ensure that staff involved in any aspect of admissions and/or level of care determination are thoroughly oriented to the list.
- ❑ Establish hospital based definitions of elective, urgent, and emergent admissions. Forward the resulting definitions through the usual channels of approval within the hospital and physician leadership structures.
  - Ensure that staff involved in any aspect of admissions and/or level of care determination are thoroughly oriented to the list.
- ❑ Implement an Emergency Department and Access Case Management role and program. This facilitates identification of the appropriate admission type (inpatient, Outpatient Observation or Same Day Surgery/Outpatient Surgery) at the beginning of the patient's interaction with the organization.
- ❑ Establish and/or update (as needed) a Clinical Documentation Improvement program.
- ❑ Establish a robust Revenue Cycle Committee and engage that committee in the most effective and compliant management of processes such as admission types and Condition Code 44. A Revenue Cycle Committee also helps establish close collaboration between key departments such as Finance, Case Management, Coding, and Access.

- ❑ Create (or update as needed) a tight denial management program that responds to denials in a timely way and creates a data base that supports analysis of patterns and trends.
- ❑ Analyze the hospital's PEPPER report as it is issued and create a strategic response to identified outliers.

# ***Appendix***

## **A. Clinical Indicators/Criteria**

There are three major criteria sets available for use in the process of validating services: InterQual, Milliman, and MCAP. **Medicare does not have a specific requirement regarding which criteria set a hospital uses.**

### **InterQual**

The InterQual products date from 1976 and gained rapid acceptance. They identify illness by body system and symptoms rather than codes, and their documentation was appealing to users.

The **InterQual Criteria** are based on the concept that patient circumstances define needs, known as *indications*, for various deliverable components of healthcare, including hospital beds in the range of levels of care, durable medical equipment, surgical and radiological procedures, and specialty care referrals. The level of care criteria (known as “ISD”, an acronym for Intensity of Service, Severity of Illness, and Discharge Screens) is the flagship product. The InterQual system uses a list of patient variables to delineate one axis, “Severity of Illness”. Physician requests for nursing and other services or treatments define the second axis, “Intensity of Service.” A patient match to both axes supports assignment to a “level of care”, from intensive to rehabilitation and outpatient. The lists used for these criteria matches follow no uniform pattern; rather, they represent the product developer’s best effort at creating mutually exclusive condition statements so as to allow the necessary level of detail to distinguish among the levels of care. If the patient matches in both axes, the decision is supported and the review completed.

The InterQual product is described as a clinical decision support tool intended to be used as screening criteria to support first level utilization review. They are designed to be used by nurses performing utilization review, and contain a great deal of explanatory material to aid the user in understanding the pathological processes and services associated with a specific patient situation. This feature is designed to facilitate the review process, which often involves judgments unfamiliar to the reviewer, and to promote inter-rater reliability, which has obvious importance in the user acceptance of

the product. Users gradually memorize considerable portions of the product contents for commonly-reviewed decisions, leading to substantial speed in the reviewing process.

**A key component of the InterQual system is that decisions that cannot be completed by the reviewer are designated to be referred to the physician advisor for the reviewer's organization, who may determine that the case is outside the criteria, incompletely documented or exceptional in some other way. The physician advisor is intended by the product's designers to have the final say, thereby insulating the product's producers and first line reviewers from any decision to deny a service to a patient.**

InterQual criteria are continually reviewed and updated, with new editions of every product released annually. Criteria development begins with the Product Specialist group in the company office (primarily nurses, some physicians and other specialized practitioners such as a Physical Therapist, many holding advanced degrees and Case Management certification) which is responsible for drafting and coordinating the review process. These product specialists create new criteria and change existing ones based on customer queries, physician comments, and published medical literature, primarily reviews and guidelines from reliable sources. Newly drafted criteria are reviewed by relevant members of a national panel composed of approximately 700 medical experts and 100 other clinical staff representing various professional disciplines.

The InterQual products are designed to permit review of 80% of all coverage decisions. The remaining decisions are associated with uncommon or less common services and circumstances and are not covered. In those situations, the user is expected to work with the local medical advisor to create a policy. The clinical content of InterQual criteria is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and/or primary care physicians. Each annual release of the criteria reflects a thorough review of new medical literature, society guidelines, current practice standards, and incorporation of consultant and user feedback.

The development of 2008 criteria provides an example of the review and revision processes. Development of the 2008 criteria began with an extensive review of domestic and international medical literature, a review of existing guidelines and content

from related McKesson products. A draft set of criteria and all material deemed relevant was assembled into packets which were sent out to approximately 20 experts in the respective fields. They were asked to review the literature and apply critical thinking. Essentially they are tasked to reject anything deemed not validated by existing evidence. All of the individual critiques were returned to the McKesson development team, who collated the commentary and refined the new criteria to reflect the consensus of the experts and, to the extent possible, consistent with the nature of the product, to indicate areas of controversy. The draft criteria were then refined with new language and formatted. The second draft was then distributed to another panel of specialists for their review and comment. This cycle continues until a solid consensus is determined. Once the criteria are released, the company requests feedback based on the experience of clients using them. Criteria-based decisions frequently called into question or overturned on review are given particular notice for revision in subsequent releases. Content which is deemed controversial and cannot be resolved by the panels may be retained but only with related notes for product users -- reviewers -- to use as guides.

InterQual developers are intentionally conservative and do not rush to make changes until convinced that they are clinically justifiable. Quite often there are innovations in medical technology, surgical procedures or pharmaceutical agents that are not incorporated into InterQual criteria until they are thoroughly explored and accepted by the medical community.

InterQual also has a criteria set called ISP (Indications for Surgical Procedures) which defines the patient characteristics (physiological derangement, morbidity, outcome of initial therapeutic interventions) that indicate a “medically necessary” status for a procedure. These criteria do not deal with settings except by reference to the ISD listings. They change as surgeries prove to be more or less safe and effective and as experience accumulates validating wider use of procedures initially reserved only for the most compromised.

In the 2006 criteria released in May of that year, clinical revisions involved a third of the 100 top procedures contained in the two volume set. The only change made in 2006 to the Cardiology Criteria was for Implantable Cardioverter Defibrillator (ICD) Insertion. That change was to add a new indication justifying insertion. The specific criterion was

“Non-ischemic cardiomyopathy greater than 9 months”, which requires documentation that a patient suffered from non-ischemic cardiomyopathy for a period exceeding nine months in length. The clinical rationale appended in support of the addition was “Studies have shown ICD placement reduces the risk of sudden death in patients with severe non-ischemic cardiomyopathy.”

## **Milliman**

The core component of the *Milliman Care Guidelines* is an actuarial analysis of utilization intensity for standard hospital and outpatient service codes and DRG classifications. Raw data is obtained from various sources deemed reliable, primarily cooperating commercial insurers and Medicare. A statistical distribution is developed for each code after reviewing the raw data and editing out extraordinary outlier points. These distributions of cost, length of stay, and other variables are then projected into “Guidelines” considered appropriate to an “optimally-managed” patient population.

In Milliman Care Guidelines, the concept of “optimal management” is supported by clinical statements defining it. The statements offer schedules or pathways for clinical care of patients falling into the respective categories, and are prepared by clinicians in various contracted arrangements. These clinicians are not necessarily involved in the preparation or interpretation of the statistical tables that are the core product; their work is supportive and intended to define the “optimally managed” standard. The Milliman product is thus not primarily focused on individual patients or reviews validating the components of their care.

## **MCAP**

MCAP began as the effort of several Boston hospitals to create a home-grown system to comply with the Medicare utilization review requirement. The product became a separate commercial entity in the 1980’s. In contrast to other products, MCAP’s developers use an explicit process of development based in peer-reviewed medical literature, making this product and process appear to be somewhat more academic in style.

Oak Group’s *MCAP Clinical Review Criteria* are similar in many ways to the InterQual criteria. They match patient and service variables to lists of benchmarks to identify

accepted decisions, and refer non-accepted decisions for medical advisor determination. A key difference between MCAP and InterQual is that MCAP attempts to use as criteria patient characteristics that are routinely stated or measured. InterQual may require review of physician findings and other investigations to satisfy “severity of illness” criteria. This is appealing to some users, (particularly in academic environments, where physicians are highly accessible) but insufficiently specific for others.

Each of the three criteria products is licensed to users and, as noted, maintained by the vendors. All are offered in software form and can be used across a network. Some offer continuous updates. Interestingly, the InterQual criteria, the most widely used of the products, has been produced in book form since its introduction, and many skilled users prefer carrying the books (now small in size and spiral bound) from location to location rather than using the product on a network terminal.

### ***What evidence is used to develop the criteria?***

The processes of creating or updating clinical criteria are very similar for the patient review-oriented products such as MCAP and InterQual. Customers (primarily licensed health plans and hospitals) request coverage for new clinical situations, procedures, settings, or services not currently encompassed in the products. Product managers decide, often after consultation with contracted clinical specialists, whether there is sufficient experience and evidence regarding the new item to make it possible to draft criteria to cover it. The existence of several publications in peer-reviewed journals or policy statements from authoritative specialty groups provides assurance that the new practice can be reliably covered.

### ***Has something changed recently?***

**In the 2007 InterQual criteria just released there are two revisions affecting implantable devices within the cardiology criteria.** The first is a change of language for clarity of first level reviewer interpretation. The 2006 indication, “MI by HX” or Myocardial Infarction (heart attack) by history was changed to read “ischemic cardiomyopathy.” ICD placement remains appropriate in patients with ischemic cardiomyopathy as a result of a previous confirmed Myocardial Infarction.

The second change involves Percutaneous Coronary Interventions (PCI). For all indications, the setting has been changed so that, regardless of the clinical reason for PCI intervention, the setting must also be addressed. The new rule is: When PCI is done on an elective basis, the Outpatient setting is deemed safe and appropriate. When the procedure is performed urgently, the Inpatient setting is appropriate.

Draft clinical criteria are generally based on guidelines, criteria, benchmarks, and other descriptions or definitions of care provided to an individual or group and may use a variety of data: clinical research, statistical analyses of cost, length of stay, clinical outcomes, opinions of consensus groups, and so on. Medical specialty colleges, healthcare payers, federal agencies, and other organizations involved in the financing of healthcare expenditures have in recent years become more active in writing guidelines for their own operations or clientele.

Initial writing of indicators is a great deal simpler than maintenance. A snapshot of accepted knowledge about a clinical decision can begin with any authoritative and current source. Maintenance of indicators is quite another matter. It is an intensive process requiring constant review of medical research literature, which can be quite demanding even for narrowly-defined areas of interest. The National Library of Medicine offers excellent search capabilities through MEDLINE but evaluation of the findings in publications requires critical reading and familiarity with the design of investigations and the pitfalls of analytic methods.

Guidelines prepared by medical professional groups such as the American College of Cardiology may represent the most rigorous attempts to express current evidence-based medical knowledge validated by well-designed studies. Several sources for evidence-rated evaluations are also available and represent high-level critical reading of the medical literature. The best known of these are the Cochrane Library and the publication Clinical Evidence (British Medical Journal publications). The U.S. Agency for Healthcare Research and Quality (AHRQ, formerly Agency for Health Care Policy and Research, or AHCPH) published a number of reviews of common health conditions in the 1990's, but policy changes led to the agency abandoning the originating of reviews. At present, its role is contracting with various research organizations for reviews.

Since not all practices in medicine have been carefully evaluated, other methods, such as consensus groups, authoritative statements by experts, or anecdotes about experience may be the only available way of proposing indicators for some, especially newly emerging, practices and therapies.

Groups that favor one practice over another may also publish guidelines, often simply indicating when their practice, drug, treatment, or specialty activity is “indicated”, i.e. when, in their opinion, their favored approach may possibly be helpful. Thus, there is a range of clinical indicators available to anyone seeking to create a framework for applying indicators to determine the fit of services to patients.

## ***B. Inpatient Only Lists***

Medicare developed an Inpatient Only List as part of the implementation of the Outpatient Prospective Payment (OPPS) system. This was in response to the concern that certain procedures, by the nature of the procedure itself, were not appropriate for outpatient care, particularly for the senior population that Medicare finances.

A list of procedures which are payable only as inpatient is published on an annual basis as part of the Proposed and Final Rules for the Outpatient Prospective Payment System (OPPS). The current list took effect on January 1, 2008. Updates are occasionally made between releases. Medicare will not pay for care provided to patients who are admitted as Outpatients for procedures or conditions that are on the Inpatient Only List.<sup>13</sup>

While the CMS and InterQual Inpatient Only Lists are largely the same, there are conditions/procedures that CMS will reimburse only when it is performed on an inpatient basis, while InterQual views the procedure as appropriate in an outpatient setting. As well, some payers have their own lists which may or may not be a component of their contracts with providers. Understandably, physicians and others are confused by these inconsistent reimbursement arrangements. InterQual encourages them to *focus on the medical necessity of the procedure* and seek guidance from their Case Managers to clarify the appropriate level of care. The Case Managers should review the individual case using criteria and provide a recommendation regarding the designation.

**Cardiac device implantation is not on the CMS or the InterQual Inpatient Only Lists. However, that exclusion does not rule out admitting patients to inpatient status when their presenting condition and the underlying reason for the procedure is treatment for a life threatening condition.** An initial review, using criteria, will provide a foundation for identifying the appropriate level of care: Outpatient or Inpatient. The Health Care Finance Administration (HCFA, the predecessor to CMS) provided clarification of this in the 1998 proposed rules for OPPS.

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<sup>13</sup> Medicare Benefit Policy Manual, *chapter 6, rev 42, 12/16/05*

“We acknowledge that we have classified in outpatient APC groups some procedures that may seem closely related to procedures that we are excluding from the OPSS on the basis of their status as inpatient procedures. *We expect that when the former are performed in the outpatient setting they will be only the simplest, least intense cases. The fact that a service is included in an APC group under the hospital OPSS should not be construed to mean that the procedures may only be performed in an outpatient setting. In every case, we expect the hospital to assess the risk to the individual patient and to act in that patient’s best interest.*”<sup>14</sup>

Further clarification was provided by CMS in a response to providers.

“Assignment of an APC payment to a service or procedure does not mean that Medicare covers the service or procedure or that it may only be payable when furnished in an outpatient setting. In the November 1, 2002 Final Rule (for CY 2003) as well as the April 7, 2002 and November 20, 2001 final rules, we (CMS) explained in detail our rationale for the “inpatient only list.” Assignment of an APC payment to a service or procedure does not prohibit hospitals from providing these services on an inpatient basis when it is reasonable and necessary to admit the patient based on the patient’s medical conditions. *Physician documentation should clearly state the reason for admission as an inpatient rather than an outpatient.*

And, regardless of how a procedure is classified for purposes of payment, *we expect, as we stated in our proposed rule, that **in every case the surgeon and the hospital will assess the risk of the procedure or service to the individual patient, taking site of service into account, and will act in the patient’s best interests.***

If the patient’s medical condition or the complexity of the surgical procedure results in the reasonable expectation that the patient will require more than 24 hours of inpatient care post-operatively, the surgeon’s rationale for inpatient care must be documented in the medical record.”<sup>15</sup>

### **Developing a hospital-specific Inpatient Only list**

InterQual provides a list of procedures entitled “Guideline for Surgery and Procedures in the Inpatient Setting” to assist clients. Hospitals that have not developed their own inpatient procedure list or that need guidance in developing one may adopt the InterQual list. InterQual states that their list is intended only as a *guide* and strongly recommends

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<sup>14</sup> Federal Register Page 47571 September 8, 1998 (Volume 63, Number 173)

<sup>15</sup> Hale, D. (2006). *Observation Status: A Guide to Compliant Site of Service Designations*. Marblehead, MA: HCPro, Inc., page 29.

that it be reviewed and approved by the medical staff at an organizational level before it is adopted as hospital policy.

InterQual indicates that the organization, through medical staff review, can identify and document what the standard practice for admissions should be. The process of medical staff review should include a meeting or other vehicle in which physicians come to consensus on the characteristics of patients that determine inpatient versus outpatient stay based on criteria. When documented in a medical staff review format, it becomes support for the local standard of care and can be used for level of care determination. Documentation of the inclusion of a condition or patient characteristics in the hospital's inpatient only list and the related literature review are strong supports for effective denials management and appeal.

Once the hospital's Inpatient Only List is formally adopted, Case Managers and Utilization Review nurses, and Admitting Department staff need a complete understanding of the list and its use as one of the considerations for assigning level of care.

If a hospital receives a denial related to a procedure that it has placed on its Inpatient Only List, the response to that denial will be based on both the documented Inpatient Only List (with associated literature and research support) *and* the results of the criteria based review that demonstrates the appropriateness of the patient's designated level of care. The severity of the patient's condition as well as mitigating characteristics such as comorbidities and age are significant drivers in determining level of care.

## **C. Compliance Considerations**

### *Processes to Improve Compliance*

Each organization should develop processes to ensure compliance in level of care designations. The purposes of developing organizational processes, policies, and procedures for appropriate assignment of level of care include:

- Merging best practice with known regulations and requirements imposed by government and payers.
- Increasing consistency of practice among staff.
- Compliant and appropriate billing, minimizing the organization's exposure to denial of reimbursement by payers.
- Minimizing or eliminating the organization's risk for compliance violations and/or fraud.

A number of proactive processes can be used to improve compliance. Such processes can also assure compliance with level of care determination and billing. Three major processes include development of an admission process to identify appropriate level of care, Case Management oversight in all access points, and development of a Revenue Cycle Committee to review compliance issues.

### Admission Process

A clear admission process is needed within each hospital to identify patients being admitted and to evaluate the appropriate level of care for the stay based on the knowledge of Medicare and relevant commercial payer rules as well as the patient's condition. Development of the process must include input from a number of departments, including finance, patient registration, Emergency Department, and Case Management. Representatives from physicians' offices are also important participants. Depending on the organization, process development could also include a centralized scheduling area.

It is imperative that staff involved in scheduling know the requirements outlined in commercial contracts and the Medicare rules for level of care. When a patient is scheduled for admission, a review of the level of care, the procedure and the payer

should occur to determine the appropriate level of care designation and the need for pre-certification. Benefits must be checked to confirm that the correct payer is on record. If a change is needed in any of these areas, it should be managed before a scheduled patient is admitted for a procedure. Equally important is the evaluation and verification of consistency between the scheduled level of care and actual order written by the physician when the patient presents for admission. If there is a discrepancy or a clarification is needed, it is crucial that the physician and the physician's office be informed and engaged in the process to insure consistent billing for the event.

#### Case Manager Oversight at Each Access Point

Case Management should be part of the admission process to perform utilization review functions whether the admission is scheduled, urgent or emergent. This requires that the Emergency Department and patient registration offices have access to a Case Manager. The Case Manager must understand the rules for the commercial payers and Medicare and operationally translate them for each patient situation. The Case Manager must also understand and be skilled in applying criteria and effectively communicating the patient's situation to payers. Using that knowledge and skills, the Case Managers can verify that the patient is at the right level of care at the point of service. They can also review all patients to ensure that the level of care is appropriate for quality of care and compliance purposes.

An Emergency Department Case Manager can be an invaluable resource to organizations seeking assignment of an appropriate level of care on admission. Emergency Department Case Managers must have deep knowledge of the requirements related to level of care and be available to provide consultation to physicians and others regarding individual patients. These Case Managers can provide additional services, including identifying alternate care venues for patients, addressing the needs of patients experiencing high numbers of readmissions, and supporting staffing in implementing best practice in a number of clinical areas.

### Revenue Cycle Committee

Revenue Cycle Committees are important participants in the development and oversight of and communication about issues related to level of care. This committee performs a number of vital functions within an organization, including:

- Developing and/or approving protocols within the context of the clinical condition of the patient, payer requirements, and the needs and risks of the organization.
- Defining outcomes for level of care related processes and sharing them with the utilization review and compliance committees.
- Evaluating the effectiveness of level of care and other procedures within the organization and implementing corrective strategies.
- Communicating changes in level of care requirements to all staff related to those processes.
- Reviewing issues of clinical and reimbursement management, facilitating input from clinicians.
- Supporting the alignment of the clinical management of patients and reimbursement.
- Reviewing denial information and implementing corrective strategies.

## ***D. Sample PEPPER Report Findings with Potential Strategies***

- The rate of one day stays for the top 20 DRGs for this organization is 18.5% while the state average is 17.3%. The hospital's one day stay rate is slightly high, indicating there may be an opportunity to improve the use of Outpatient Observation status. A review of a sample of the one day stay patients will identify if there is a problem with the appropriate use of one day stays versus Outpatient Observation status.
- Complication or comorbidity (CC) capture rate: 54%. This capture rate is low and may indicate that there is an opportunity for improvement in physician documentation. A review of the patient records in these charts would identify if there is an opportunity for improved complication and comorbidity capture rate. A clinical documentation improvement program would likely support an improved rate.
- The percent of patients that fall into DRG 416 as opposed to DRG 320 or 321 has been above the 75<sup>th</sup> percentile for the last 4 years. A review of these charts should be done to ensure the patients were coded correctly.
- Transfers to SNF (skilled nursing facility) with a 3 day stay have been above the 75<sup>th</sup> percentile for the last 3 years. This is included in the PEPPER report because Medicare wants to insure that each of these patients met inpatient criteria for all 3 days. If the patient does not have a qualifying hospital stay, the SNF stay will not be paid by Medicare. There should be a review of a sample of these charts to assess the appropriateness of each day of the inpatient stay. The policy requiring *qualifying* 3 day stays in advance of a transfer to a SNF should be reviewed with Case Managers and Social Workers to insure they understand the definition of a qualifying stay for transfer to SNF.
- The rate of 7 day readmissions is above the 75<sup>th</sup> percentile in the current year. This may be an indication of inadequate discharge planning. It may also indicate that patients are being discharged before they are ready. A review of a sample of these charts is needed to assess whether the patients met InterQual discharge criteria and to assess the adequacy of discharge planning.

## ***E. Suggested Topics for Educating Staff Regarding Level of Care Designation***

- Level of care designations
  - Definition and implications
  - Relation to reimbursement, compliance, and financial complications for the patient/family
  - The definitions of elective, urgent and emergent in use by the hospital
- Types of health care reimbursement
  - Case based (DRG), fee for service (including discounted fee for service)
- Medicare
  - Regulations regarding level of care
  - Requirements for utilization review
  - Hospital-Issued Notice of Non-Coverage (HINN) and Condition Code 44
  - The Inpatient Only List
  - Requirements regarding the issuance of and appeal of denials
- Medicaid
  - Regulations regarding level of care
  - Requirements for utilization review
  - Requirements for pre-certification, verification, and notification
  - Requirements regarding level of care designation
  - Requirements regarding the issuance of and appeal of denials
- Commercial insurance payers. It is useful to create a grid that highlights the contractual requirements of each payer for staff reference. Categories of the grid may include:
  - Requirements for pre-certification, verification, and notification
  - Requirements regarding level of care designation
  - Requirements regarding the issuance of and appeal of denials
- Criteria
  - The concept and identification of medical necessity
  - The criteria set used by the hospital (InterQual, MCAP, or Milliman). This should include a review of what the criteria look like and how they are used.

- Individuals engaged in the review process must have a thorough orientation to the criteria and be coached until they are using them correctly.
- Obtaining and verifying correct patient information
- Denials
  - Strategies for preventing denials – technical/administrative as well as clinical
  - The process for managing denials established by the hospital and their roles in it
- Implanted Cardiac Devices
  - What are pacemakers, ICDs, and cardiac resynchronization devices and why they are used?
  - What are the clinical characteristics of patients likely to receive such a device?
  - Considerations when designating level of care for cardiac device implant procedures

## **F. Additional Resources**

### **Print**

- Hale, D. (2006). *Observation Status: A Guide to Compliant Site of Service Designations*. Marblehead, MA: HCPro, Inc.
- Walsh, K., & Zander, K. (2007). *Emergency Department Case Management: Strategies for Creating and Sustaining a Successful Program*. Marblehead, MA: HCPro, Inc.

### **Web Based**

- ACC/AHA/HRS 2008 Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities. American College of Cardiology Foundation; 2008. <http://content.onlinejacc.org/cgi/content/full/j.jacc.2008.02.032>
- ACC/AHA/ESC 2006 Guidelines for Management of Patients with Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death. American College of Cardiology Foundation; 2006. <http://content.onlinejacc.org/cgi/content/full/48/5/e247>
- ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult. American College of Cardiology Foundation; 2005. <http://www.acc.org/qualityandscience/clinical/guidelines/failure/update/index.pdf>
- Ambulatory Payment Classifications (APCs):
  - 69 *Federal Register*, No 219 (November 15, 2004) (65681-67015) provides information about Ambulatory Payment Classifications (APCs). <http://www.archives.gov/federal-register/index.html>
- Automatic Implantable Cardioverter Defibrillator (AICD) Project Baseline Report. A Special Study for the Hospital Payment Monitoring Program Assessment of Appropriateness of AICD Insertions in New York State [http://projects.ipro.org/shared/admin\\_memos/hpmp/200406-Baseline-Report.pdf](http://projects.ipro.org/shared/admin_memos/hpmp/200406-Baseline-Report.pdf)

- Centers for Medicare and Medicaid Services: [www.cms.hhs.gov](http://www.cms.hhs.gov)
- Condition 44:
  - CMS Manual System, Publication 100-04 Medicare Claims Processing. Transmittal 299. Date: September 10, 2004. *Use of Condition 44 , “Inpatient Admission Changed to Outpatient”*
- Coverage
  - Centers for Medicare and Medicaid Services. 2005 National Coverage Decision (NCD) for Implantable Automatic Defibrillators, Medicare Coverage Database: [http://www.cms.hhs.gov/mcd/viewncd.asp?ncd\\_id=20.4&ncd\\_version=3&basket=ncd%3A20%2E4%3A3%3AImplantable+Automatic+Defibrillators](http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=20.4&ncd_version=3&basket=ncd%3A20%2E4%3A3%3AImplantable+Automatic+Defibrillators)
  - Sample commercial payer coverage policy: 2006 Blue Cross of Idaho Coverage Policy for Automatic Implantable Cardioverter Defibrillator (AICD) [http://www.bcidaho.com/providers/medical\\_policies/sur/mp\\_70144.asp](http://www.bcidaho.com/providers/medical_policies/sur/mp_70144.asp)
- *Federal Register*: <http://www.archives.gov/federal-register/index.html>
- InterQual - [www.McKesson.com](http://www.McKesson.com) : McKesson is the parent company for InterQual. Use the search function on their website to locate the specific InterQual information you need.
- Medicare Conditions of Participation [http://www.access.gpo.gov/nara/cfr/waisidx\\_04/42cfr482\\_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr482_04.html)
- Medicare Listserv: [http://www.cms.hhs.gov/InfoExchange/03\\_listserv.asp](http://www.cms.hhs.gov/InfoExchange/03_listserv.asp)
- Medtronic Cardiac Rhythm Disease Management reimbursement website: [www.medtronic.com/crdmreimbursement](http://www.medtronic.com/crdmreimbursement)
- Milliman Care Guidelines - [www.careguidelines.com](http://www.careguidelines.com)
- Oak Group - [www.oakgroup.com](http://www.oakgroup.com) : The website for MCAP criteria.

- Observation:
  - Medicare Claims Processing (PUB. 100-04) Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPSS) Section 290 - Outpatient Observation Services (Prior to Rev. 1445; Effective: 01/01/08; Issued: 02/08/08) <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>
  - Medicare Benefit Policy Manual, Ch. 6, Hospital Services Covered Under Part B - <http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf>
  - January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Observation <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4259.pdf>
  
- QIOs by State: The QIO for each state will provide guidance about the coverage for specific diagnosis and or surgical procedures. The QIO has an internal hospital contact in each health care organization that receives Medicare reimbursement information. That internal contact can act as a conduit to the appropriate staff at the QIO to ask questions about denials and coverage of specific procedures. <http://www.medqic.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&name=QIO%20Listings>
  
- Urgent Care: [http://www.empireblue.com/provider/noapplication/f4/s2/t0/pw\\_ad067869.pdf](http://www.empireblue.com/provider/noapplication/f4/s2/t0/pw_ad067869.pdf)