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Understanding CY 2016 OPPS FAQs

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The Centers for Medicare & Medicaid Services' (CMS) release of the 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule solidified updates to the "Two-Midnight" rule regarding inpatient admissions, leaving hospitals to evaluate the impact this will have on their compliance programs moving forward. With a renewed emphasis on physician judgment and medical necessity – not hospital level of care – providers must demonstrate a legitimate, defensible, and consistent Utilization Review process to determine and support an appropriate admission.

Executive Health Resources has reviewed the 2016 OPPS final rule and provides you with the questions you may have – and the answers you need – to ensure your hospital withstands auditor scrutiny given the changes CMS made to address the persistently large improper payment rates in short-stay claims and provide guidance on the implications of what these regulatory changes could have on your medical necessity admission review program.

Key Points to Consider

- **Renewed emphasis on provider judgment and medical necessity**
  - inpatient hospital care rather than hospital level of care
- **Renewed enforcement by Quality Improvement Organizations (QIOs)**
  - Extensive referral possibilities
- **Recovery Auditors (RAs) for additional payment audits**
- **DOJ/OIG/ZPIC – continued requirement to address cases of suspected fraud**
- **QIO auditing begins on October 1, 2015**
  - Recovery Auditors may resume performing patient status reviews for claims with dates of admission of January 1, 2016 or later, and only after referral by the QIO

Who is the QIO?

The Quality Improvement Organization (QIO) is poised to become a major player in the medical review arena. In the 2016 Outpatient Prospective Payment System (OPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) announced that it is changing its existing medical review strategy and plan to have the QIO, and not the Medicare Administrative Contractors (MACs), conduct reviews of short inpatient stays.

So, who are the QIOs and what do they do? The QIOs work under the direction of CMS to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries. The QIO program comes in two flavors: medical case review and quality improvement. The Beneficiary and Family Centered Care QIOs (BFCC-QIOs) perform medical case review, and Quality Innovation Network QIOs (QIN-QIOs) perform quality improvement activities and provide technical assistance. Medical reviews of short inpatient stays will be performed by the BFCC-QIOs. The two BFCC-QIO contractors are Livanta and KePRO.

Under the new medical review process for short inpatient hospital stays, QIOs will review a sample of post-payment claims to determine the appropriateness of the admission using criteria as specified in the proposed rule. Denials will be referred to the MACs for payment adjustment and the process by which providers appeal denied claims will remain unchanged. QIOs will be responsible for educating hospitals about claims denied under the 2-midnight policy and collaborating with hospitals to develop a quality improvement framework to improve organization processes and/or systems. (*80 FR 39353*)

Of all the changes to the medical review strategy, the one likely to garner the most attention is the QIO referral of hospitals to the recovery auditors. The referral process was outlined in the proposed rule as follows:

> "Under the QIO short-stay inpatient review process, those hospitals that are found to exhibit a pattern of practices, including, but not limited to: Having high denial rates and consistently failing to adhere to the 2-midnight rule (including having frequent inpatient hospital admissions for stays that do not span one midnight), or failing to improve their performance after QIO educational intervention, will be referred to the recovery auditors for further payment audit." (*80 FR 39353*)

Since many of the terms in the preceding paragraph are undefined (i.e., what is a high denial rate? What does it mean to consistently fail to adhere to the 2-midnight rule? What improvement is expected after educational intervention?), it will be interesting to see how the QIOs wield this broad referral authority.

What will the QIO review?

Beginning on October 1, 2015, the QIOs assumed responsibility for reviewing post-payment claims and making a determination of the medical appropriateness of the admission for short inpatient hospital stays. These reviews were previously conducted by the Medicare Administrative Contractors (MACs). From October 1, 2015 through December 31, 2015, post-payment claim reviews for short-stay inpatient hospital stays conducted by the QIOs will be based on Medicare's current payment policies and can include claims with dates of admission prior to October 1, 2015. Beginning on January 1, 2016, QIOs will conduct patient status reviews in accordance with CY2016 OPPS, and will refer hospitals to the Recovery Auditors if they are found to be non-compliant with any policy changes finalized in the OPPS rule.

Note: QIO referrals to the RAs will not begin until January 1, 2016.

When will the QIO reviews begin?

The QIO transition of Probe & Educate activities began October 1, 2015. Round 3 medical reviews for the Probe & Educate program, performed by the Medicare Administrative Contractors (MACs), terminated as of September 30, 2015, although there may be carryover of educational activities and other things as they wrap up their involvement with Probe and Educate.

During the educational portion of the new Probe & Educate process under the QIOs, hospitals will be provided the opportunity to submit additional documentation to support their claim. QIOs will be pulling the following number of charts per hospital per year: For large hospitals 50 claims and for small hospitals about 20 claims.

QIOs will have 30 days to review a case and make a determination from the date they receive the requested medical records. QIOs will receive monthly reports from CMS which will provide them with eligible claims to review from the previous 90 days.

What's changed with the Two-Midnight rule?

For greater than 2-midnight stays:

As stated in 2016 OPPS final rule summary:

> "We are not proposing any changes for hospital stays that are expected to be greater than 2 midnights; that is, if the physician expects the patient to require hospital care that spans at least 2 midnights and admits the patient based on that expectation, the services are generally appropriate for Medicare Part A payment." (*80 FR 39351*)

For less than 2-midnight stays:

The change in 2016 OPPS final rule states that CMS will now:

> "...allow for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights." (*80 FR 39350 XV .B*)

For payment purposes, the following factors, among others, would be relevant to determining whether an inpatient admission where the patient stay is expected to be less than 2 midnights is nonetheless appropriate for Part A payment:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient; and
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more). (*80 FR 39350-39351*)

Will appeals go to the MAC or QIO?

The current appeals process remains unchanged by the modifications outlined in the 2016 OPPS final rule. The final rule states, "Providers' appeals of denied claims will be addressed under the provisions of section 1869 of the Act." The first level of appeal, known as the "Redetermination," will continue to be processed by the MAC.

QIOs will refer claim denials for short inpatient hospital stays to the MACs for payment adjustments.

QIOs will educate hospitals about claims denied under the 2-Midnight policy and collaborate with hospitals to develop a quality improvement framework to improve organizational processes and/or systems.

Will QIOs have limits on the number of reviews they can request?

The 2016 OPPS final rule did not identify limits on the number of claims the QIO will review under the new medical review short-stay inpatient review process. In the final rule, CMS only stated that, "By October 1, 2015, QIOs will review a sample of post-payment claims and make a determination of the medical appropriateness of the admission as an inpatient."

The sample size will be 10 claims biannually for small hospitals and 25 claims biannually for large hospitals. ("FAQs: Two-Midnight Short-Stay Reviews," Two-Midnight Short-Stay Reviews Kick-off Webinar, www.keproqio.com/twomidnight/pdfs/TwoMidnightShortStayReviews_FAQ_October%202015_508.pdf. Published October 2015.)

What will be the focus of the MACs?

CMS has instructed the MACs that, absent evidence of systematic gaming or abuse, they are not to review claims spanning 2 or more midnights after admission for a determination of whether the inpatient hospital admission and patient status was appropriate (*Questions and Answers Relating to Patient Status Reviews 3/12/14*)

CMS will direct MACs not to focus their medical review efforts on stays spanning at least 2 midnights after admission absent of evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. However, MACs may review these claims as part of routine monitoring activity or as part of other targeted reviews. (*Selecting Hospital Claims for Patient Status Reviews: Admissions on or after October 1, 2013; last updated 2/24/14*)

Who can determine inpatient status?

For inpatient hospital services covered under Part A, "The decision to admit a patient is a complex medical judgement which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting." "Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital." (*Medicare Benefit Policy Manual, Chapter 1, §10*)

What are the standards and regulations regarding physician decisions of medical necessity?

"Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association." By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine." (*HCFA Ruling 95-1*)

What is the status of the Recovery Auditors (RAs)?

Beginning in January 2016, RAs may conduct reviews for inpatient status reviews only for those providers that have been referred by the QIO as exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to: having high denial rates and consistently failing to adhere to the 2-Midnight rule (including repeatedly submitting inappropriate inpatient claims for stays that do not span one midnight), or failing to improve their performance after QIO educational intervention. RAs may continue to conduct reviews of short stay inpatient claims for other reasons, including CMS-approved claim reviews unrelated to patient status (e.g., coding reviews, reviews to determine the medical necessity of the procedure provided, etc.).

Under the QIO short-stay inpatient review process, hospitals that are found to exhibit the following pattern of practices will be referred to the Recovery Auditor:

- Having high denial rates (although the 2016 OPPS final rule did not define a "high denial rate")
- Consistently failing to adhere to the 2-midnight rule (this includes having frequent inpatient hospital admissions for stays that do not span 1 midnight; and, outside of same-day admissions, the proposed rule did not define what would constitute "consistently failing to adhere to the 2-midnight rule")
- Failing to improve their performance after QIO educational intervention (the final rule did not define the measure of improvement necessary to avoid Recovery Auditor referral)

Does anything change for the CERTs and ZPICs?

These changes in enforcement and education strategies will not affect the reviews conducted by the Comprehensive Error Rate Testing (CERT) contractor or those reviews conducted for the purpose of identifying fraudulent behaviors, such as Zone Program Integrity Contractor (ZPIC) reviews.

Is a UR plan still important in the medical necessity review process?

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. (*42 CFR §482.30*)

The UR committee must review professional services provided in order to determine medical necessity and to promote the most efficient use of available health facilities and services. The UR plan is the documented process by which the organization will adhere to the standards identified in the Conditions of Participation, as well as the defined operational standard for the UR committee.

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