First Coast Service Options Inc.

August 14, 2013 -- Webcast follow-up questions and answers

Prepayment medical review of hospital claims -- inpatient DRGs (A/B)

The following questions originated in the above listed event. The question is followed by the appropriate answer and the source of the information provided. For additional information or details, please refer to the frequently asked questions (FAQs) page and the webcast recording at First Coast University.

1Q: How do you expect the final rule to affect inpatient prepayment reviews completed at First Coast Service Options Inc. (First Coast)?

1A: As the final rule has not been published, CMS is still outlining guidelines for adjudication of claims based on the proposed rule. As of October 1, 2013, First Coast has suspended all inpatient DRG edits for admission on and after October 1, 2013, until further notice.

Source: First Coast's Medical Review department; Centers for Medicare & Medicaid Services (CMS) Internet-only Manual (IOM) Pub. 100-08, Chapter 6

2Q: How does First Coast suggest case management departments appropriately screen for medical necessity given the new midnight-to-midnight expectation in the final rule?

2Q: Pending anticipated clarification from CMS to the provider community and specific instructions to its contractors, documentation in the medical record must support a reasonable expectation of the need for the patient to require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance, this must also be clearly documented in the medical record. Additionally, CMS recommends providers document any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary.

Source: First Coast's Office of Contractor Medical Director (CMD); News Release: CMS issues FY 2014 inpatient payment rule; CMS IOM Pub. 100-02, Chapter 1, Section 10; CMS IOM Pub. 100-08, Chapter 6, Section 6.5.2.A

3Q: If complications during an outpatient surgery prompt the procedure to become an "inpatient-only" procedure, how is this scenario considered?

3A: Inpatient orders are typically not written until after a procedure is performed. Inpatient admission orders written soon after surgery should reflect "admit to inpatient" and documentation should support the necessity for the level of care.

Source: First Coast's Medical Review department; CMS IOM Pub. 100-02, Chapter 1, Section 10

4Q: If a patient is admitted to the hospital as outpatient and a procedure is performed, but then later the claim is denied because that procedure is only allowed as inpatient (inpatient-only procedure), can the physician update the order to rebill the claim as inpatient?

4A: No. An order cannot be changed retrospectively.

Source: CMS IOM Pub. 100-02, Chapter 1, Section 10

5Q: If, after reimbursement, an inpatient claim is reviewed by the facility and determined to be an outpatient case, how should the facility notify First Coast of the need to change the claim and reimburse the overpayment?

5A: In this situation, you should cancel the claim in Direct Data Entry (DDE). Cancelling the claim will trigger the necessary overpayment activities. You can then resubmit the outpatient claim.

If you are unable to cancel the claim, submit a voluntary refund and then resubmit the outpatient claim.

If your claim is past the timely filing requirements, make sure to view the documentation needed to qualify for a timely filing exception.

Source: First Coast's Debt Recovery department; First Coast's Customer Service Operations

6Q: Can you clarify the use of InterQual and Milliman as to Medicare guidelines? It is my understanding that InterQual and Milliman are only to be used as a guide and final decision is according to Medicare guidelines.

6A: Every claim is checked through these screening tools, however clinical judgment is the overriding factor for all claim reviews. Although these references may provide enabling criteria to favorably adjudicate a claim, First Coast has the authority to exercise discretion when reviewing claims against these benchmark references based on Medicare's guidelines.

Source: CMS IOM Pub. 100-08, Chapter 6, Section 6.5.1

7Q: Statistically, how often are cases referred for physician review?

7A: Statistics on physician input are not retained. However, any prepayment review could be referred by a clinician for review and input by First Coast's physician advisor, the Contractor Medical Director.

Source: First Coast's Medical Review department

8Q: How many physicians do you have available for the review process?

8A: The medical review process is conducted by nurse clinicians and is overseen by two physicians -- the Contractor Medical Directors. In addition, we are in continuous contact with all physician specialties, through the Contractor Advisory Committee, which is comprised of approximately 30 members.

Source: First Coast's Office of CMD