Is Your Medical Staff Looking at Medical Necessity?

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Is Your Medical Staff Looking At Medical Necessity?

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Background
- Historically
- Review of a practitioner’s activities in a health care entity setting focused on the quality of care provided to patients
- The review was conducted by other practitioners who practiced at the same location
- The review was maintained as confidential information (either due to peer review privilege or custom) and was not shared with Administration
The review focused primarily on the care that was provided and the outcome of that care.

Poor documentation was a secondary issue (i.e., care could be found appropriate based on conversations with the practitioner and others or by additional records, such as the practitioner’s office file).

**Background**

- Physicians were responsible for their acts of malpractice, regardless of the setting in which the malpractice occurred (office, hospital, etc.).
- The tort of negligent credentialing did not start being recognized until 1990 (and 2017 for Kentucky) (i.e., even if a medical staff engaged in poor peer review, there was no claim against the hospital).

**Peer Review**

- The impact of poor care is generally civil:
  - Professional liability
  - Negligent credentialing
  - Suspension or loss of clinical privileges at Hospital X, Managed Care Plan B, etc.
Background

- Billing and coding errors were traditionally treated as overpayments and administratively resolved by refund
- Overpayments were considered to be the result of mistakes in the billing process

Background

- The concept of “medical record review” continued to dwell predominantly in the world of professional liability and credentialing
- 1990+: Federal government’s position of giving health care providers the “benefit of the doubt” began changing
  - Began to aggressively enforce the False Claims Act as a civil matter
  - Criminal prosecutions jumped from 83 cases (116 defendants) in 1992 to 246 cases (450 defendants) in 1996

False Claims Act

- Knowingly presenting (or causing to present) to an officer or employee of the United States government a false or fraudulent claim for payment or approval
  - Knowingly makes or uses (or causes to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the Government
  - Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid
False Claims Act

- The criminal statute (18 U.S.C. § 287)
- Whoever makes or presents a claim or demand for payment to any person or officer in the civil, military, or naval service of the United States, or to any department or agency thereof, knowing such claim to be false, fictitious, or fraudulent, shall be imprisoned not more than five years and shall be subject to a fine.

What did the government do?

Began investigating:
- Billing for services not rendered
- Upcoding for services
- Unbundling services
- Overbilling in general
- Billing for services not rendered
- Billing for services not medically necessary

Billing For Services Not Medically Necessary

- Section 1862(a)(1)(A) of the Social Security Act: Medicare will not cover services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member”
- Documentation needs to support the level of service reported
Medically Necessary

- Easy examples of what is “not medically necessary” [for purposes of insurance coverage]:
  - Tummy tuck
  - Botox for wrinkles
- Not so easy examples:
  - Treatment for vitiligo
  - Experimental treatment for a disease

Medically Necessary

- Submitting claims for medically unnecessary services is a false claim
- Submitting claims for care that was truly awful (i.e., worthless) is a false claim
- Submitting claims for more than what you did or for something you did not do is a false claim

False Claims Act

- Penalties of $10,957 to $21,916 per claim plus treble damages
- Liability extends to a failure to make timely repayment of an obligation to the government
  - Timely repayment = Report and refund the overpayment within 60 days of “identifying” the overpayment
Background

- In 1993, DOJ collected $180 million in civil litigation recovery related to health care fraud
- In 1994, the amount was $411 million
- In 2016, the amount was $2.5 billion

Background

- July 2016: MD2U, a home health provider, agreed to pay almost $22 million over 10 years for submitting claims for patients who were not homebound and for services that were either not medically necessary or upcoded
- September 2016: North American Health Care Inc. (NAHC) and two executives – the chair of the board and a senior VP of reimbursement – agreed to pay $30,000,000 for rehabilitation services alleged to be medically unnecessary

What Is Happening Today?

- April 2017: Norman Regional Health System, COO, and 6 radiologists agreed to pay $1.6 million to settle qui tam allegations that the radiologists had submitted claims for services that had been performed by radiological practitioner assistants without the appropriate level of supervision
What Is Happening Today? (con’t.)

- **April 2017:** FL Ophthalmologist convicted on 67 counts in Medicare fraud scheme involving false diagnoses of macular degeneration and performing and billing for medically unnecessary tests and procedures
- And beware – cardiac catheterizations, open heart surgeries, and orthopedic surgeries

What is Happening Today?

- **2015/2016:** DOJ settled with nearly 500 hospitals for a total amount of $257,650,000 to resolve allegations of improper billing related to cardioverter defibrillators
- **December 2016:** Southeast Orthopedic Specialists settled with DOJ for $4,448,000 to resolve allegations of medically unnecessary ultrasound-guided injections; excessive physical therapy, and excessive appointments

What is Happening Today?

- **January 2017:** EMH Regional Medical Center agreed to pay almost $4 million and North Ohio Heart Center over $500,000 to settle claims of medically unnecessary stents
So What Does This Mean?

- If you have a situation with the potential of “medically unnecessary” care, you have several decisions to make:
  - Will it be handled by the Medical Staff, Compliance, or both
  - Will you be working with attorney client privilege, peer review privilege, or both
  - Will you be performing 1 review or will you be performing 2 reviews

Will It Be Handled By The Medical Staff, Compliance, Or Both?

- It should probably be both
- Medical Staff takes time
- Compliance has 60 days to decide if it needs to make a repayment
- Medical Staff focus is quality of care to patient
- Compliance focus is appropriate billing for appropriate care

Medical Quality Review

- Medical quality review may be used for a number of purposes:
  - To determine that no concerns exist
  - That remediation is appropriate (care or documentation)
  - That the matter should be trended
  - That corrective action should be initiated
  - It will provide substantially more information than is necessary for a medical necessity determination
Medical Quality Review

- In most states, a medical quality review will continue to be peer review protected even if it is:
  - Shared with a practitioner as a means of improving care
  - Relied upon as part of a fair hearing proceeding
  - Submitted as part of the underlying fair hearing record in an appeal by a practitioner to the court

Medical Necessity Review

- The reviewer is looking at the events that led up to the procedure or care episode and the procedure or episode that occurred (i.e., the focus is on the service for which a bill has been submitted)
- Generally performed under attorney-client privilege

Medical Necessity Review

- More focused in scope than a medical quality report
  - Listing of payor type
  - Listing of procedure/test/intervention
  - Summary of case
  - Brief discussion of findings
  - Statement of findings to support/not support medical necessity
Can You Share The Reviews?

- Yes, but you need to understand the consequences.
  
  - Sharing a medical quality review with Compliance will most like result in the peer review privilege no longer applying to the report
  - Sharing a medical necessity review with a peer review committee will most likely result in a waiver of the attorney client privilege

So What Should You Do?

- Have a process that is triggered when either side becomes aware of a potential concern
  
  - If Compliance determines that a practitioner is an outlier with respect to volume, it should notify the Medical Staff
  - If the Medical Staff determines that a practitioner has performed one or more unnecessary surgeries, it should notify Compliance
  - Each can do its own medical review

What Does This All Mean?

Medical Necessity

- Issues generally presented to the Compliance Office to determine if potential overpayment/false claim resulted
- The focus is on whether the documentation supports the necessity of the care provided and billed
- The Compliance Office has a short time frame in which to act once an issue is determined to exist
What Does This All Mean?

Medical Necessity (con’t.)

- The care could be appropriate but the documentation awful – and a false claim may be found to exist
- The care could be poor but the documentation good – and a false claim may be found not to exist

What Does This All Mean?

Peer Review

- Issues generally presented to the Medical Staff
- The focus is on whether the patient received quality care
- The process can take months before it is completed and there is no government “clock” ticking

What Does This All Mean?

Peer Review (con’t.)

- The care could be appropriate but the documentation awful – and a determination made that (a) care is appropriate, but (b) documentation is not
- The care could be poor but the documentation good – and a determination made that (a) care is not appropriate
What does this all mean?

- Medical Staff needs to understand that a review by the Compliance Office does not mean that the Medical Staff is being supplanted.
- Compliance Office needs to understand that if quality issues exist, the Medical Staff should also be notified.
- Collaboration, Communication, Coordination.

Questions?

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