

Overview of Hospital Utilization Review

Legal Authority

The Inspector General (IG) hospital utilization review function operates under guidelines and regulations contained in:

Texas Administrative Code (TAC)

- TAC, Title 1, Part 15, Chapter 371, Subchapter C, Sections 371.200 - 371.208

Code of Federal Regulations (CFR)

- CFR, Title 42, Part 456, Subparts A, B, and C

Overview

The Utilization Review Unit performs retrospective utilization reviews of paid inpatient hospital claims for services provided to Medicaid recipients to assess the medical necessity for inpatient care; appropriateness of the Diagnosis Related Group (DRG) assignment, including whether diagnoses are supported by the information in the medical record and whether coding was consistent with federal coding guidelines; and quality of care provided during the inpatient stay. IG selects inpatient hospital claims for review based on an assessment of risk.

Risk Assessment

The Utilization Review Unit selects a sample of claims for review from the total population of Medicaid inpatient hospital claims for a given period of time, using a combination of risk-based sampling and focused case selection. Fee-for-service claims data is maintained in the Texas Medicaid Healthcare Partnership (TMHP) data warehouse and in the IG Medicaid Fraud and Abuse Detection System (MFADS).

IG runs queries of claims data using Business Objects, a business intelligence data mining tool, to identify claims that have certain characteristics or meet specified criteria. The results of these queries identify lists of claims associated with each of the following risk categories:

- Short stays (zero to two days)
- Newborns with an associated significant condition and a length of stay of two days or less
- Psychiatric in-patient services for Medicaid recipients under the age of 21
- Day outliers
- Cost outliers

- Admissions and readmissions of an individual to the same hospital within 30 days of discharge from the first admission
- Children's hospitals (reviewed annually under the Tax Equity and Fiscal Responsibility Act methodology)
- Freestanding psychiatric hospitals and rehabilitation hospitals
- Diagnoses noting chemical dependency without an accompanying diagnosis of medical complication or condition
- Complex or premature deliveries, including:
 - Premature or low birth weight infants with significant complications
 - Full term or normal birth weight newborns with significant complications
 - Vaginal delivery with complicating diagnoses
 - Cesarean section delivery with complicating diagnoses
 - Extreme immaturity or respiratory distress syndrome diagnoses

Because the volume of claims is more than can be reviewed within a reasonable period of time, the Utilization Review Unit selects samples from each list, based on the relative risk of each risk category. For example, short stays represent a higher risk than day outliers, so the Utilization Review Unit selects a sample representing 50 percent of short stays claims, but selects only a limited number of day outliers claims for review.

During fiscal year 2016, IG plans to select approximately 87,000 paid inpatient hospital claims for review, using a mixture of selection methodologies and percent of identified claims to be sampled, depending on the risk category, as detailed in the following table.

Risk Category	Methodology of Selection	Percent of Claims
<ul style="list-style-type: none"> • Short stays • Newborns • Complex & Premature Deliveries 	Random sample	50%
<ul style="list-style-type: none"> • Admissions and readmissions 	Random sample	25%
<ul style="list-style-type: none"> • Psychiatric in-patient services • Children's hospitals • Freestanding psychiatric hospitals • Rehabilitation hospitals • Chemical dependency diagnoses 	All identified claims	100%
<ul style="list-style-type: none"> • Day outliers • Cost outliers 	Judgmental sample, based on the length of stay and diagnoses submitted	A limited number (Discretionary)

The inpatient hospital claims the Utilization Review Unit is reviewing during fiscal year 2016 include primarily fee-for-service claims with paid claim dates during the periods from the fourth quarter of fiscal year 2011 through the end of the first quarter of fiscal year 2014.

Utilization Review Process

The Utilization Review Unit provides a notification letter to the hospital with a list of the hospital claims selected for review. The hospital must provide copies of the medical records to IG within 30 days of the notification.

Utilization Review Unit staff evaluate the medical necessity of the patient's admission by reviewing documentation in the medical record against MCG, an evidence-based guideline. According to TAC, medical necessity means the patient has a condition requiring treatment that can be safely provided only in the inpatient setting.

DRG validation consists of nurse reviewers using the International Classification of Diseases coding guidelines to substantiate DRG assignments. If Utilization Review Unit staff's review of medical records identifies an error in the DRG assignment, such as an additional or missing diagnosis, the correct diagnosis information is entered into 3M Core Grouping software, approved by the federal Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), to validate the addition or deletion of diagnoses and determine the final DRG assignment.

Utilization Review Unit staff perform a quality of care review to determine whether the care provided to the patient meets generally accepted standards of medical and hospital care practices, or if it placed the patient at significant risk of injury or death.

If the review of medical records identifies findings related to medical necessity, assignment of a diagnosis, or quality of care, a physician consultant, contracted with the Texas Health and Human Services Commission (HHSC), performs a subsequent review of the medical record to validate the finding. If the physician consultant determines that the services provided were not medically necessary, should have been provided in a previous admission, or were not provided in the appropriate setting, IG notifies the hospital in writing that the claim associated with the services provided is denied. If the physician consultant confirms that the medical record does not support the stated diagnosis, the physician consultant will change, delete, or add a diagnosis supported by the medical records, a Utilization Review Unit certified coder (Registered Health Information Technician) will appropriately code an adjusted claim based on the revised diagnosis, using the applicable version of 3M Core Grouping software approved by CMS, and the claim will be reprocessed, often resulting in a payment adjustment.

The Utilization Review Unit provides a final notification letter to the hospital with the results of the review and, when applicable, an explanation of findings identified during the review. When the review identified claims that need to be reprocessed, the Utilization Review Unit submits a request to TMHP to re-adjudicate the claim.

Appeals Process

If the hospital disagrees with any of the review findings, the hospital may appeal to the Medical Appeals Section within the HHSC Medicaid Office of the Medical Director. The request for an appeal must be submitted within 120 days of the date on the final notification letter and must include copies of the complete medical record, final notification letter, and a properly completed and notarized affidavit in the format approved by HHSC.

Additional information on the appeal process is included in the Texas Medicaid Policy and Procedure Manual.

Results

In fiscal year 2015, the Utilization Review Unit reviewed 21,350 medical records for 401 hospitals, and identified underpayments of \$104,355 and overpayments of \$15,536,822, due to revisions in diagnoses, admission denials, and technical denials.

Hospital Assessment Error Trends

The results of Utilization Review Unit hospital claims reviews indicate the most common recurring reasons contributing to denials and adjustments are:

- Outpatient procedures billed as inpatient in an inpatient setting
- Diagnoses issues
 - Diagnoses not supported by the medical record
- Coding issues
 - Improper sequencing of obstetrical diagnoses
- Treatment or care that was not provided on the initial admission, resulting in a readmission

Additional Hospital Claims and Payment Information

Historical data shows that the number of fee-for-service hospital paid claims remains a significant portion of health services delivered to Medicaid recipients, although recent fiscal years demonstrate a decline due to Medicaid managed care expansion.

The total recovered in fiscal years 2014 and 2015 represents approximately 1.86 percent and 1.13 percent of the \$1.5 billion and \$1.3 billion paid to hospital providers for inpatient Medicaid claims.

Fiscal Year	Total Paid Claims	Total Dollars Paid	Claims Reviewed	Dollars Recovered
2014	416,282	\$1,550,101,372	28,378	\$28,891,505
2015	383,914	\$1,370,305,849	21,350	\$15,536,822

Education and Training

The Utilization Review Unit provides education and feedback to hospital providers during onsite reviews and exit conferences to optimize standards of care and maintain sound fiscal management.

Guidance for the proper submission of inpatient hospital claims is also available in the Texas Medicaid Provider Procedures Manual (TMPPM) and the Inpatient and Outpatient Hospital Services Handbook.

Changes and Updates

In Senate Bill 207, 84th Legislative Session, two requirements were added for the Utilization Review unit, including specific requirements to comply with federal coding guidelines during reviews and audits, and present annual education to providers on diagnosis related validation criteria.

The hospital provider community has submitted suggested language in anticipation of rule revisions related to the requirement for compliance with federal coding guidelines. IG is reviewing these suggestions and considering whether rule revisions are needed to support or clarify statutory language.

The Utilization Review Unit is examining approaches it may develop or improve to meet the annual education requirement of the bill.