

# Hospital Payment Monitoring Program

## Effective Utilization Management Strategies For Medicare Payment Error Prevention

**Effective Utilization Management (UM) Programs are good business.** The challenge is to balance clinical and financial considerations. An effective UM process ensures that a facility's resources for care delivery are used appropriately (in the right setting) and efficiently (minimizing unnecessary tests and procedures). The paragraphs below discuss UM process elements that may assist in ensuring adherence to Medicare guidelines and reduce the risks of payment error.

- ❖ **Pre-admission/Admission Screening** - Development and implementation of a pre-admission/admission screening process can provide 1) opportunities to identify physician orders for care setting that require clarification prior to registration of the patient, 2) opportunities for communication with the physician regarding clarification of care setting orders that are unclear, 3) the opportunity to obtain an order for care setting from the physician when said order is not included in the admission order set. If the care setting order is *not* present 1: the patient *should not* be registered; and 2: the claim *should not* be submitted. (**Remember**, urgent/emergent patient care should **not** be delayed in order to obtain this clarification.)
- ❖ **Post-discharge (retrospective) Review** - **It is important to remember** that the hospital is responsible for appropriate billing of *all* services, not just those services that UM staff has had an opportunity to review. Hospitals may need to consider a post-discharge (retrospective) review process to ensure appropriate billing of stays for those patients who were admitted and discharged before the UM staff knew of them.
  - A timely, post-discharge (retrospective) review process provides opportunities to 1) identify mis-match of the physician's care setting order and the registration/admission type (the care setting billed does not match the physician's care setting order), 2) identify medically unnecessary admissions/services prior to claim submission, and 3) facilitate pertinent, timely addendum(s) to the medical record to ensure adequate documentation of the services provided and substantiation of the medical necessity of these services.
  - Hospitals should make the medical necessity determinations *prior to* submission of a claim. If the care setting and/or services provided are considered to be medically unnecessary or not covered then reimbursement under the applicable payment methodology (DRG, APC, etc.) should not be sought. The documentation in the medical record should substantiate the medical necessity of the care setting and















