Hospital Payment Monitoring Program (HPMP)

Compliance Workbook

March 2006

557 Cranbury Road, Suite 21
East Brunswick, New Jersey 08816-5419
Phone: 732-238-5570 ❖ Fax: 732-238-7766
Website: www.hqsi.org

ORIGINAL MATERIALS DEVELOPED BY TMF HEALTH QUALITY INSTITUTE. THIS MATERIAL WAS PREPARED AND ASSEMBLED BY HEALTHCARE QUALITY STRATEGIES, INC., THE MEDICARE QUALITY IMPROVEMENT ORGANIZATION FOR NEW JERSEY, UNDER CONTRACT WITH THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), AN AGENCY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. THE CONTENTS PRESENTED DO NOT NECESSARILY REFLECT CMS POLICY. 8SOW-NJ-HPMP-06-02

Table of Contents

Tab I **Introduction** **3**

Tab II **Coding for Compliance** **7**

Tab III **Utilization Management and Compliance** **23**

Tab IV **Documentation and Compliance** **37**

Tab V **Compliance Monitoring and Auditing Strategies** **43**

Tab VI **Evaluating a Compliance Program** **55**

Tab VII **References** **67**

Tab VIII **Appendices** **69**

I. Introduction

Purpose of this Workbook

This workbook, originally released on February 1, 2000, as the Payment Error Prevention Program/Compliance Workbook, has been revised in an effort to further assist hospitals and Quality Improvement Organizations (QIOs) in meeting the goals of the Hospital Payment Monitoring Program (HPMP), formerly called Payment Error Prevention Program (PEPP). The workbook was revised and further developed by Catherine Boerner, JD, Senior Vice President of The Moore Consulting Group, LLC (MCG), under contract with TMF Health Quality Institute (TMF), which serves as the Texas QIO and the HPMP Quality Improvement Organization Support Center (QIOSC), with input from QIOs, the Centers for Medicare & Medicaid Services (CMS), the Healthcare Compliance Association (HCCA) and working compliance officers.

This workbook was designed to give practical guidance and provide helpful tools related to identifying and improving hospital compliance program structures and processes that contribute to payment error outcomes. This workbook was also designed to assist in enhancing the effectiveness of hospitals' compliance programs. It is important for compliance officers to understand that one of the key synergies they can create is with Utilization Management and Quality Improvement within their hospitals to uncover the root causes of improper payments due to medically unnecessary services, admission screening criteria compliance, and insufficient medical record documentation. Compliance officers need to have an ongoing relationship with their QIO and be copied on all correspondence in requesting records or conducting reviews. Many such requests have payment error issues that are appropriately addressed as compliance concerns.

This workbook focuses on issues related to inpatient hospital prospective payment system (PPS) payment error monitoring and prevention. Discussion of other areas critical to the effectiveness of compliance programs has been limited in order to target issues more relevant to the HPMP. You should not, however, limit your compliance program efforts only to inpatient Medicare or the Medicare program.

In developing or enhancing a hospital compliance program, you should review *The Office of the Inspector General's Supplemental Compliance Program Guidance for Hospitals (released January 2005)* and *The Office of the Inspector General's Compliance Program Guidance for Hospitals (released February 1998)* in detail. This workbook references the Office of Inspector General (OIG) Supplemental guidance but is **not all-inclusive.** If the settings are applicable to your organization, you should also review other OIG Compliance Guidance documents previously released for clinical laboratories, home health agencies, hospices, nursing homes, etc.

This workbook is not to be considered as providing legal advice. As you know, compliance programs need to be tailored to meet the unique needs of your organization. Please feel free to utilize and tailor the sample policies and tools in the Appendices to meet the needs of your compliance auditing and monitoring efforts.

As healthcare regulations change, so will some of the advice offered in this workbook. Please note that the tools provided in the appendix may also become outdated as regulations change, and you are encouraged to verify their accuracy prior to using them. Therefore, it is important that you maintain a system for receiving, disseminating, and acting on regulatory changes; this will include updating your compliance program as necessary in order to achieve your compliance outcomes.

HPMP Background

CMS has established two programs to monitor the accuracy of the Medicare Fee-for-Service (FFS) program: The Comprehensive Error Rate Testing (CERT) program and HPMP. HPMP monitors PPS inpatient hospital admissions only. The Comprehensive Error Rate Testing (CERT) program monitors all other claims. Each program comprises approximately 50% of the Medicare FFS payments.[1]

HPMP calculates the error rate for all individual PPS acute care hospitals nationally based upon the claims reviews conducted by QIOs. The QIOs are responsible for monitoring the quality of care, medical necessity of admissions, and accuracy of Diagnosis Related Group (DRG) payment related to Medicare inpatient hospital admissions. The net improper payment amount which is calculated by subtracting underpayments from overpayments for **inpatient hospital admissions** in FY 2004 was a **3.6% error rate or $3.1 billion** of the Medicare Trust Fund.[2] The majority of the improper payments due to medically unnecessary services were for claims for which the QIOs were responsible for reviewing, 1.6% net errors as a percentage of the total dollars sampled for both HPMP and CERT in FY 2004.[3]

The Purpose and Goal of HPMP

The purpose of HPMP is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments, including errors in: DRG coding; provision of medically necessary services; and appropriateness of setting, billing, and prepayment denials. Reducing such errors will, in turn, protect the Medicare Trust Fund. The long-term goal of HPMP is to help inpatient prospective payment system hospitals monitor payment patterns by analyzing data, conducting focused audits, and implementing system changes to prevent payment errors.

The Role of the QIOs in HPMP

As stated earlier, QIOs are responsible for monitoring the quality of care, medical necessity of admissions, and accuracy of DRG payment related to Medicare hospital admissions. As part of the CMS Healthcare Quality Improvement Program (HCQIP), QIOs have been responsible for collaborating with hospitals and physicians to improve quality of care. HPMP represents an expansion of these collaborative efforts to include improvement of hospital structures and processes that contribute to payment errors.

---

[1] See U.S. Department of Health and Human Services, Center for Medicare and Medicaid Service (CMS), *Improper Medicare Fee-for-Service Payments Report FY 2004*, Rev. 2 1/5/05, pages ii, 3.
[2] Id. at iii
[3] Id. at 16, 53

It is the desire of CMS for each QIO to have the autonomy and ability to identify the problem areas in its state and how best to solve them. Therefore QIOs will work locally to identify patterns of payment errors in part with the help of the Program for Evaluating Payment Patterns Electronic Reports (PEPPER) provided to them by TMF. When patterns are identified, QIOs will collaborate with hospitals to identify causes of payment errors and develop interventions to prevent them.

Implementation of HPMP in the Eighth Scope of Work (8SOW)

QIOs began working on the 8SOW contract with CMS beginning August 1, 2005. QIOs' responsibilities under HPMP represent a continuation of work from the Seventh Scope of Work with additions to the program. First, all QIOs will be required to either conduct an HPMP project (a focused intervention involving a specific area prone to payment errors and/or specific hospitals) in their state, or justify why they do not need to conduct one. Second, long term acute care hospitals (LTCHs) will become a focus for reducing Medicare payment errors as QIOs will be asked to monitor data for LTCHs in their state. QIOs may choose to conduct a HPMP project involving LTCHs.

The Role of Hospitals in HPMP

Hospitals can directly reduce payment errors, and support HPMP, by having effective utilization review and quality improvement programs that work with compliance officers to adhere to coding and billing regulations. Hospital compliance officers can also support HPMP efforts by requesting their organization's PEPPER reports to review inpatient discharge data trends and incorporating this information into their compliance program's monitoring and auditing efforts each quarter.

CMS has compiled each hospital's Medicare inpatient discharge data compared to all other short-term, acute care PPS hospitals within each state. This data identifies if your hospital appears unusual in target areas identified as having payment errors high in either dollars in error or proportion of payment errors, for example, DRG 416 (septicemia age > 17) potential overcoding errors. Many of these target areas also relate to the medical necessity of an inpatient stay and may cause you to question whether your hospital's admission screening criteria is appropriately used, for example, for DRG 143 (chest pain) one-day stays. Compliance officers need to work with utilization review to determine if care should have been provided on an outpatient basis (outpatient observation) and if there are training needs in these compliance areas.

The role of compliance officers is crucial to reducing the incidence of improper payments, especially those that result from medically unnecessary services. This workbook provides guidance, suggestions, and tools for hospitals seeking to develop, update, or strengthen their compliance programs, and also suggests hospitals utilize resources provided by QIOs to support and enhance their efforts.