Shared risk areas

- Pre-payment MAC audits.
- First Coast, Novitas, Trailblazer – if the prepayment hospital claim is never paid, the physician’s accompanying claim will be paid.
- However, it will be recouped if no hospital claim is ever approved.
- Share ‘at risk’ prepayment issues.
- EX) DRG 470/Joint replacement
- Send letters to the providers to alert them that their records are being audited.
Top Issues per Region/9–2011

- Region A: Renal & Urinary Tract Disorders (medically necessary/incorrect setting)
- Region B: Surgical Cardiovascular Procedures (medically necessary)
- Region C: Acute inpt admission neurological disorders (medically necessary)
- Region D: Minor surgeries and other treatment billed as an inpt (medically necessary)

*When pts with known dx enter a hospital for a specific minor surgical procedure and is expected to keep them less than 24 hrs, they are considered outpt regardless of the hour they present to the hospital, whether a bed was used or whether they remain after midnight.
Change the Inpt surgery process

- Surgery director and surgery scheduler join the preventive team.
- UR reviews all inpt surgeries prior to surgery. Reviews the H&P, discusses how well the surgeon has tied in the risk to the reason for a normal outpt to be done as an inpt.
- Works with provider and Surgery to potentially revise to an outpt, wait for the adverse/unexpected event and move to obs or inpt or improve the inpt documentation.
- Involved nursing in the education as they will be the bedside eyes of the pt status.
Only physician’s can ….

- Determining correct status
- Clarifying order of the status
  - Examples of weak orders: Admit to Dr Joe, Admit to tele, Transfer to the floor, admit to 23:59, admit to medical service, admit to FIT. None clearly define: Admit to inpt status and why –add (intent of the order)
- Directing the clinical team as to the intensity of services that need provided when the pt ‘hits the bed’ as well as thru the course of treatment.
- 42 CFR 482.12 (c) (2) “Patients are admitting to the hospital only on a recommendation of a licensed practitioner permitted by the state to admit pts to the hospital. “
- Medicare State Operations Manual “In no case may a non–physician make a final determination that a pt’s stay is not medically necessary or appropriate.” Case Mgt protocol can ‘recommend’ to the providers but only takes effect when the provider has authenticated it.
Concurrent auditing of 2\textsuperscript{nd} opinions for pt status

- Ensure the provider receiving the 2\textsuperscript{nd} opinion carries the recommendation into the record and directs care from the recommendation.
- Auditing of the primary provider’s documentation should include: Clearly outlining the severity of illness in the admit note/order PLUS nursing documenting to the Intensity of services that must be done as an inpt.
- Nursing is usually unaware of the status they are documenting.
As of 2–14–11, modified changes

Limits based on physician or non PP’s billing Tax ID # as well as the first three positions of the ZIP code where that physician/non PP is physically located.

EX: Group ABC has TIN 12345 and two physical locations in ZIP code 4567 and 4568. This group qualifies as a single entry for additional documentation requests/ADR.

Ex: Group XYZ has TIN 12345 and two physical locations in ZIP 4556 and 5566. This group would qualify as two unique entities for ADR.
More on Physician ADR

ADR limits will be based on the # of individual rendering physician/non-PP reported under each TIN/ZIP combination in the previous calendar year. Reserves the right to exceed the cap if indicated.

<table>
<thead>
<tr>
<th>Group/Office Size</th>
<th>Maximum # of requests per /each 45 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 or more</td>
<td>50 records</td>
</tr>
<tr>
<td>25–49</td>
<td>40 records</td>
</tr>
<tr>
<td>6–24</td>
<td>25 records</td>
</tr>
<tr>
<td>Less than 5</td>
<td>10 records</td>
</tr>
</tbody>
</table>
Physician Focus Areas

- Place of Service – outpt hospital vs office
  (SE1104 Med Learn; 11 vs 22 or 23)
- Separate E&M leveling within the surgical/CPT bundle period
- New vs Established
- Level of service conflicts with the hospital – doc /inpt; hospital/OBS
- Based on CERT audit results/ West coast, the following was targeted for audit: (2011)
  - 99214
  - 99223 (Initial day)
  - 99233 (Subsequent hospital visit)
  - Cert audits can trigger requests for records if provider history shows an abnormal volume/risk for targeted CPT codes
- Office E&M leveling is not a focus of the RAC audits..yet
MACs are beefing up prepayment auditing – with physician impact

- **Trailblazer**: to increase consistency in Medicare reimbursement, effective 11–11, Trailblazer will begin cross-claim review of these services. The related Part B service (E&M, procedures) reported to Medicare will be evaluated for reimbursement on a post payment basis. Overpayments will be requested for services related to the inpt stay that are found to be in error.

- **First Coast & HighMark/Novitas**— similar 3–12 TX hospital lost 470; provider recouped
OB – protocols

Physicians/extended must order/direct pt care, pt specific.

Protocols are excellent clinical pathways, but the physician must order the protocol.

EX) Pt is 26 weeks. Nursing implements protocol for under 27 weeks. Doesn’t call the provider until results from first items on the protocol. Not billable. Must contact the provider to initiate protocol, then follow protocol. Billable.
Protocols – Challenges with Fixes

- CERT audits have continued to identify weakness in the use of Protocols.
- EX) Lab urine test ordered but culture done as 2nd test due to protocol. (Noridian/Nov 2009)
- EX) Without contrast but 2nd one done with contrast based on protocols.
- Ensure the order is either updated or the initial order clearly states ‘with protocol as necessary.’
- YEAH – how about including the protocols that are referenced in the record when submitting for audit?
Addition documentation letter received read:

- “Good Cause for Issue: Chronic Obstructive Pulmonary Disease DRG 88 MS–DRG 190, 191 (Medical Necessity Review and MS–DRG Validation). During the course of the DRG validation, the RAC will also review the record for inpt admission order.

- The documentation is being requested because COPD is one of CMS’s top volume DRGs. Therefore, DRG 88, currently MS–DRG 190 and 191 was selected to determine if the principle and secondary diagnoses were assigned inappropriately resulting in overpayments to the hospitals. An analysis of your billing data indicates that a potential aberrant billing practice may exist for these MS-DRGs.
Read the ADR’s – excellent teaching opportunity

- Dec 9, 2010 letter from Region A/DCS outlining rationale for why they were requesting medical records for numerous DRGs. They also gave a great outline of inpt vs obs.
- “Inpt care rather than OBS is required only if the pt’s medical condition, safety or health would be significantly and directly threatened if care was provided in a less intensive setting. A patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpt basis.”
- When auditing for ‘what does severity and intensity look like– look for the above issues to be addressed in the physician admit note/order and the nursing bedside documentation.
Physician and Hospital Shared Risk – Pt Status

- Trailblazer/MAC Jurisdiction 4, 8–30–10 “Inappropriate Hospital Admission vs Outpt Observation”
- Medicare requirements that the inpt admission begins when the admission order is written. Additionally, all physician orders must have a date and a legible signature.
- Physician’s decision to treat the pt as an outpt or inpt are reflected in the physician’s orders. The pt’s condition, history and current dx test results, along with the physician’s medical judgment, availability of treatment modalities and hospital admission policies should be considered when making a decision to provide inpt level of care. If a physician determines additional information is making a medical decision for inpt admission, the physician may elect to place in OBS outpt status.
More from Trailblazers

- **Scenario 1**
  - An inpt claim is submitted for medical review
    - The claim is without a written and signed physician order for admission
    - The documentation is without an admit note describing the reason for admission to an inpt level of care/LOC
    - The services rendered could have been rendered in an outpt setting
    - The screening tool indicates the intensity of services and the severity of illness of the pt’s condition as documented did not support the medical necessity for inpt LOC
    - Medical review decision: Denied because documentation does not support the medical necessity for an acute level of care
    - **IF THE PATIENT’S CONDITION REQUIRES INPT ADMISSION, the physician needs to document an inpt admission order with a progress note describing the medical decision for the inpt admission and the intended treatment plan to address the patient’s condition.**
    - Internet Only Medicare Manual (IOM) Pub 100–04, Medicare Claims Processing Manual; chapter 1, section 50.3; chapter 3, section 40.2.2.k
Working together to reduce risk and improve the pt’s story

- **Joint audits.** Physicians and providers audit the inpt, OBS and 3 day SNF qualifying stay to learn together.
- **Education on Pt Status.** Focus on the ER to address the majority of the after hours ‘problem’ admits.
- **Identify physician champions.** Patterns can be identified with education to help prevent repeat problems.
- **Create pre–printed order forms/documentations forms.** Allows for a standard format for caregivers.
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