# Regulatory Updates 2019

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Physician Advisory Solutions

# The Admission Order

No longer a condition of payment as of 10-1-18

"It was not our intent when we finalized the admission order documentation requirements that they should by themselves lead to the denial of payment for medically reasonable and necessary inpatient stays, even if such denials occur infrequently." 2019 IPPS Final Rule

# The Admission Order

"If other available documentation, such as the physician certification statement when required, progress notes, or the medical record as a whole, supports that all the coverage criteria (including medical necessity) are met, and the hospital is operating in accordance with the hospital conditions of participation (CoPs), we stated that we believe it is no longer necessary to also require specific documentation requirements of inpatient admission orders as a condition of Medicare Part A payment."

# What Does that Mean?

Disclaimer- My personal opinion- discuss with your legal and compliance team. But have the CFO in the room so they know how much money is at stake.

# Present but Unsigned Order

Authentication of admission order no longer required prior to discharge

Authentication requirements should abide by your bylaws/rules/regs

# No Order at All

“we acknowledged that in the extremely rare circumstance that the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record, medical review contractors are provided with discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record.”

# Let's Break it Down

How Often is Extremely Rare?

- We don't know!
- RACs audit 0.5% of all claims so let's use 0.1%

250 bed community hospital in IL

- 50,000 outpatient Medicare visits per year = 500 per year
- 5,000 Medicare discharges = 50 per year

So what is the allowed amount? You decide!

# Let's Break it Down

How do contractors use discretion?

If chart is audited, they get to decide if it should be paid

There is no way to "ask for discretion"

# Let's Break it Down

How do we establish intent?

- Read the H&P
- Look for an Important Message
- Look at registration info- if they were registered as inpatient, someone must have intended it
- Ask the doctor!

# Let's Break it Down- Medical Admission

Admission order note absent-

Patient presented to ED with septic shock, was resuscitated in ED, transferred to ICU under care of Dr. Smith. Dr. Smith H&P states "admit to ICU." Patient registered as inpatient and IMM delivered to daughter. Patient illness severe and inpatient admission warranted. Patient discharged after 5 day stay. No inpatient order found. Per documentation and course, it is clear that intent was inpatient admission. Contacted Dr. Smith who agrees. Will bill part A.

# Let's Break it Down- Inpatient Only Surgery

Dear Dr.____

Your patient, _______________, underwent _______________ surgery. After discharge it was determined that the surgery was on the CMS Inpatient Only list. Patient was not admitted as inpatient preoperatively or during hospital stay. If the surgery was determined to be on the CMS inpatient only list prior to or during the hospital stay, would your intent have been to formally admit the patient as inpatient either preoperatively or prior to discharge?

___Yes, my intent would be to admit the patient as inpatient

___ No, I was aware the surgery was inpatient only and intended to perform it as outpatient

# Where Will You Draw the Line?

Medical patient in Obs passes a second midnight and sent home without being admitted inpatient?

Surgical outpatient who has delayed recovery or complication who stays past a second midnight without inpatient admission?

# Let’s Break it Down- Billing

Intent can only be used for total absence of admission order, not for admit orders placed later in the stay.

# Let’s Break it Down- Billing

Determine intended day of inpatient admission

Instruct billing staff to bill a “routine” inpatient claim with that date in FL-12

No requirement to indicate that hospital is declaring intent

Processed as a “routine” inpatient claim

# Implications of Intent v. Delay

Patient in ED with LE cellulitis, fever, hypotension, doctors rushing around to meet SEP-1. Registered as IN, IM given to spouse, but no written order. Patient sent to ICU, day 3 off pressors, transfers to med unit, ready to go to SNF on day 5.

Patient referred to SNF, patient transferred.

3 days later, billing calls; no admit order in chart.

Contact physician, establish intent, document it, and bill with day 1 as admission date.

# Implications of Intent v. Delay

Patient in ED with LE cellulitis, fever, hypotension, doctors rushing around to meet SEP-1. Registered as IN, IM given to spouse, but no written order. Patient sent to ICU, day 3 off pressors, transfers to med unit, admit order discovered missing so written.

SNF day counting begins on day 3; pt cannot go to SNF under part A until day 6.

But could we tell doctor to not write admission order at all and "declare intent" after discharge so can go to SNF any time????

# Is this Really a Retroactive Order?

If you don’t document a “retroactive order” then technically it is not.

If you don’t add an order to the chart, it’s not an order. If it’s not an order, it can’t be retroactive.

This is an admission without an admission order billed as intent to admit but not formally ordered.

# Summary

It's finally time we get to demonstrate a positive return on investment on our work.

Unsigned order? Bill it!

Absent order? Review it, clarify it, and probably bill it!

But continue to work to minimize it.

# Determining Status of Surgery Patients

Commercial – Ask the payer- no rhyme or reason

Check the payment- inpatient v outpatient

Don't think Inpatient always pays more than Outpatient

Don't change the status unless you talk to payer-

complications, delayed recovery, etc.

# Determining Status of Surgery Patients

Medicare – Start with Medicare inpatient only list

- If on the list, always inpatient

- If not on the list, status depends on how long they will be in the hospital (and maybe how high a risk)

- Emergency simple appendectomy- outpatient
- Appendectomy with perf- needs ATB x 48 hours- inpatient
- 90 yr old with severe COPD having hysterectomy- inpatient

# Spending the Night After Outpatient Surgery

- Routine recovery? Extended recovery (or whatever you call it)– no extra payment
  - Also ask why are they staying overnight? Standard of care or physician preference?
- Complication so could not discharge as expected? Observation or Inpatient depending on severity and time

# Observation after Outpatient Surgery

Most Medicare outpatient surgeries are Comprehensive APCs = J1

All services from start of care to discharge included- paid under fee schedule

But adding Observation hours increases total charges- you provided extra care, so show it!

What if your added hours leads to Outlier payment? Extra payment = (cost-(APC payment x 1.75))/2 if greater than $4,825

It's your call- get order and bill or not…

# Medical Necessity of the Care

Three kinds-

- Does the patient need what is being done to them?
  - Since doctors are well-shown to overestimate harms of disease (and risk factors) while underestimating harms of intervention, we often don't get a realistic picture of whether the harms of an intervention exceed the benefits.

# Medical Necessity of the Care Itself

Why a nuclear stress test and not plain?

Why a CT scan and not a clinical exam and risk scoring?

Why iv antibiotics and not oral?

Why surgery and not conservative measures?

# Why Care about Medical Necessity of the Care?

## The RACs are looking

| Issue Name | Review Type | Provider Type | MAC Jurisdiction | Date Posted |
|---|---|---|---|---|
| 0A187-Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Medical Necessity and Documentation Requirements | Complex | Outpatient | All A/B MACs | 2019-06-04 |
| 0A189-Computerized Tomography Coronary Angiography: Medical Necessity and Documentation Requirements | Complex | Outpatient | All A/B MACs | 2019-06-04 |
| 2A146-Intravenous Immune Globulin for the Treatment of Autoimmune Blistering Diseases: Medical Necessity and Documentation Requirements | Complex | Ambulatory Surgical Center; Outpatient; Professional Services | All A/B MACs | 2019-06-04 |

# Medical Care Changes

## da Vinci® Surgical System- The Future of Surgery

The da Vinci® surgical system is comprised of a surgeon's console that provides 3-D imaging of the surgical field, a patient-side cart which provides 4 robotic arms, endowrist instruments which mimic the motion of the surgeon's hands and wrists, and the vision system which provides 3-D images of the surgical field.

This innovative toolset allows our surgeons to treat various diseases through a minimally invasive approach that benefits both surgeon and most importantly our patients. Many applications of surgery have been achieved using the da Vinci® Surgical System including procedures in Cardiology, General Surgery, Gynecology, Pediatrics, Thoracic Surgery, and Urology.

As one of the world's leading robotics programs the CARES Center at UNC offers various robotic-assisted procedures in Gastrointestinal Surgery, Gynecology, Otolaryngology- Head and Neck Surgery, Pediatrics, Surgical Oncology, and Urology. Our world-renowned surgeons and academic medical facilities are leading both the State of North Carolina and the Southeast in the latest surgical treatment options.

At UNC we are Leading, Teaching, Caring.

# Medical Care Changes

ROBOTIC SURGERY CENTER

NYU Langone Health



For Physicians

**Procedures**

- A to Z Procedures Guide
- Procedures by Department

**Research**

**What is Robotic Surgery?**

## Robotic Radical Hysterectomy

### Robotic Surgery for Early-Stage Cervical Cancer

Early-stage cervical cancer is treatable either by radiation therapy or surgical removal of the cancer. The standard surgical treatment for this condition is radical hysterectomy, which entails the removal of the uterus, cervix, bilateral parametria (connective tissue in the pelvis), upper vagina, and a portion of the uterosacral ligament—combined with a pelvic lymphadenectomy (complete removal of the pelvic lymph nodes). In cases where the patient wants to preserve the option to have a child in the future, a radical trachelectomy, in which all the aforementioned organs are surgically removed except for the uterus, may be an option. This can only be decided after careful discussion with the patient's gynecologic oncologist, however.

Robotic surgery is particularly well-suited to both of these procedures, thanks to its excellent visualization of the operating field and the fact that it enhances the ability of surgeons to perform the meticulous dissections required in these surgeries.

### How Robotic Radical Hysterectomy is Performed

Once five ports have been placed in the patient's abdomen using quarter-inch incisions, the surgeon begins by dissecting the spaces inside the pelvis to define the operating field. Next, the bladder is moved away from the uterus, cervix and upper vagina, and the uterine artery is tied off and cut at its origin from the internal iliac (or hypogastric) artery. The ureter is then completely dissected away from its surrounding tissue, allowing for a resection of the entire parametrial tissue, after which the rectovaginal space is opened by incising the peritoneum and the uterosacral ligaments are resected. Finally the upper vagina is excised and the uterus, cervix, both parametria, the uretral sacral

Accessed June 19, 2019

# Medical Care Changes

## Minimally invasive surgery associated with worse survival for women with cervical cancer compared to open hysterectomy

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Two MD Anderson studies could impact surgical guidelines for early-stage disease

MD Anderson News Release October 31, 2018

When comparing standard-of-care surgical options for women with early-stage cervical cancer, two studies led by researchers at The University of Texas MD Anderson Cancer Center discovered that minimally invasive radical hysterectomy is associated with higher recurrence rates and worse overall survival (OS), compared to abdominal radical hysterectomy.

# Medical Necessity of the Care Location

Does the patient need to be in the hospital?

- Why not do the surgery in an ASC?
- Why not do the procedure in the doctor's office?

Why does the chemotherapy need to be done in the infusion center?

- Why not in the doctor office?

Why be seen in the ED?

- Why not an urgent care center or doctor office?

# Medical Necessity of the Care Location

UnitedHealthcare Commercial

## Site of Service Reviews for Certain Musculoskeletal Surgical Procedures (Arthroscopic and Foot Surgery) — Effective Aug. 2, 2019

We aim to minimize out-of-pocket costs for UnitedHealthcare members and improve cost efficiencies for the overall health care system.

# Who Benefits from ASCs?

## 3 benefits of physician ownership for ASCs

*Written by Angie Stewart* | January 22, 2019 | Print | Email

Physician ownership of ASCs improves accountability and convenience, according to the Ambulatory Surgery Center Association.

Three benefits:

1. Ownership gives physicians maximum control over the clinical environment and quality of care.

2. Physician ownership helps cut down on wait times for patients.

3. This ownership structure enables physicians to focus on a small number of procedures and offer high specialization.

https://www.beckersasc.com/leadership-management/3-benefits-of-physician-ownership-for-ascs.html

# But What else Could Influence Use of ASCs?

## Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns To Ambulatory Surgery Centers?

There is reason for concern that physician-owned facilities will contribute to a further unraveling of the fragile safety net.

**by Jon R. Gabel, Cheryl Fahlman, Ray Kang, Gregory Wozniak, Phil Kletke, and Joel W. Hay**

**ABSTRACT:** For more than three decades, Congress has struggled with potential financial conflicts of interest when physicians share in financial gain from nonprofessional services. This study asks the question: Are physicians who are leading referrers to physician-owned ambulatory surgery centers (ASCs) more likely to send Medicaid patients to hospital outpatient clinics than other patients? The comparison group is physicians who are leading referrers to non-physician-owned ASCs, using data from two metropolitan areas. Findings indicate that physicians at physician-owned facilities are more likely than other physicians to refer well-insured patients to their facilities and route Medicaid patients to hospital outpatient clinics. [*Health Affairs* 27, no. 3 (2008): w165–w174 (published online 18 March 2008; 10.1377/hlthaff.27.3.w165)]

# Medical Necessity of the Status

Why inpatient and not outpatient?

Usually unrelated to care, solely about payment

# One Midnight Expectation = Allowed Two Midnight Exception

Jan 1, 2016 OPPS Final Rule

If a physician determines on a case-by-case basis that a patient with a one midnight expectation warrants inpatient admission, that patient can be admitted as inpatient

# Orthopedists are Special - Total Knee Replacement

Previously inpatient only; now can be performed as outpatient or inpatient

Most go home on post-op day 1 so default status = Outpatient

To be eligible for inpatient admission:

- High risk surgery due to surgical complexity- 1 day expectation
- High risk due to comorbid conditions- 1 day expectation
- Medical need to go to SNF after surgery- dep on waiver
- Expected to need longer in-hospital stay- 2 MN expectation

# Orthopedists are Special - Total Knee Replacement

Applicable factors must be documented clearly

Applicable factors must be real

Admission decision made "on a case-by-case basis" must be documented

# Surgical Risk

75 yr old female with OA R knee, failed conservative measures- PT for 3 months, Rx NSAID, Synvisc. Pain limits walking and going out for activities. Xray with severe degenerative changes and osteopenia. Recent DEXA with significant osteoporosis. Schedule for surgery.

Will admit as inpatient. Significant osteoporosis will make surgery technically difficult and more prolonged with higher risk of fracture. If goes well, expect home on Post-op day 1

# Medical Risk

70 yr old Patient with type II DM requiring insulin with HbA1c of 7.8%, HTN On 3 meds with BP 150, and OSA warrants inpatient admission due to higher risk of surgery. At risk for hypo- and hyperglycemia, BP fluctuations, and apnea. Will require close peri-op monitoring and post-op glu, BP, and resp monitoring.

Be sure to order glucose checks, basal/bolus insulin, resp monitoring, BP checks. Avoid "monitoring per protocol"

# Needs SNF

85 yr old male with OA. Assessed in pre-hab class by PT and discovered widower, lives alone in split level home, no family. Will not be able to discharge home after surgery unless good mobility and able to access bathroom at house. Admit as inpatient

POD#1- Ambulating 10 steps with full assist, no stairs tolerated, cont in hospital PT to determine appropriate discharge placement

POD#2- some progress with PT- did 3 stairs up but not steady, needed full assist. Cont PT

POD#3- more progress, unable to safely go home- send to SNF today

# No Significant Risks

72 yr old male, s/p outpatient right TKA yesterday. This am confused, sees bugs on wall. PT unable to get patient to cooperate.

Admit as inpatient- review meds, order labs, hold opioids, ask family to remain at bedside.

72 yr old male s/p outpt left TKA yesterday. Called to see patient with wheezing. Hx mild COPD, uses prn albuterol at home. Exam with sig wheezing.

Admit as inpatient- Get CXR, start nebs, consider ATB and steroids.

# Self-Denying Medicare Inpatient

Always try to do CC44- much less work, faster money.

But if you miss CC44, you can self-deny

- requires review by UR committee doctor
- reuqires notification of attending
  - Agrees- self-deny and rebill
  - No answer- self-deny and rebill
  - Disagrees- go to tiebreaker with 2nd UR doc

# What’s Self-Deny and Rebill?

Hospital notifies patient/doctor in writing by mail

Hospital submits a no pay inpatient claim- M1

Hospital waits for that claim to process

Hospital submits two more claims

- 131- services before admission order
- 121- services after admission order – W2

Physicians still bill inpatient admission

SNF eligibility not affected unless “admit for SNF”

# Always Do the Right Thing; The Money will Go Where it Goes

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