

The Third National Medicare RAC Summit

Major Hospital Vulnerabilities II:

Medical Necessity and Clinical Documentation

Issues in Medicaid and RAC Audits

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Temple University Health System

- 746 bed academic health system
- Located in the North Philadelphia area, largely an underserved, lower socioeconomic community
- Comprehensive inpatient and outpatient services
- Both community hospital and tertiary referral center
- Chief training site for Temple University School of Medicine
- Medical Staff
 - Academic
 - Primary Care Physician Network
 - Community based providers
- Multiple disease specific accredited programs- including transplants



Medical Necessity and Clinical Documentation Agenda

- Hospital Vulnerabilities
 - a. Cases at risk
 - b. Process risks
- Medical Necessity
 - a. Definitions
 - b. Physician buy-in
 - c. Utilization Review Program
- Clinical Documentation
 - a. Severity of illness/Intensity of service
 - b. Concern/risk/intent
- Summary

RAC Demonstration Results

Claim RAC only thru 3/27/08

- Overpayments collected from all providers- \$979.9 million
- 85% of all overpayments were inpatient hospital claims
- 40% due to Medically Unnecessary care
- 62% of these were for medical unnecessary services or settings
- 35% due to incorrect coding
- 8% due to lack of documentation
- 17% other

Other Reasons for RAC Denials

- Failed to meet InterQual Criteria
- Not a CMS Inpatient Only procedure
- Admission Order Status ambiguous
- Service could be done in an alternative setting
- Lack of documentation in the medical record to justify the service in the setting

Cases at Medical Necessity Risk

- Surgical procedures in the wrong setting-
- Outpatient procedures done as inpatients
- Procedures not on the Medicare Inpatient Only list
- Elective cardiac procedures-
AICD, Cardiac Cath, PTCA
- Treatment for heart failure and shock
- Short Hospital Stays-
- 1-2 day stays
- Chest pain
- Low back pain
- Near Syncope/Syncope
- TIA
- Esophagitis/Gastroenteritis
- 3 day SNF qualifying stays



Processes at risk

- Medical Necessity determinations are based on clinical documentation. Physicians don't know enough about screening criteria and tend not to document their care plan well
- Physicians don't understand the difference between observation and inpatient level of care and admission orders are often ambiguous
- Hospital admissions occur 7 days a week and hospitals are expected to review all cases for medical necessity
- Case Managers are usually the utilization review experts
- There needs to be teamwork, communication, and a robust Utilization Review process to ensure that the documentation is there to support the appropriate level of care in the correct clinical setting
- Often there is lack of agreement between the hospital and the physician- which can raise flags with CMS

Moving Target

- As healthcare cost have spiraled out of control, there is more scrutiny on cost containment
- Successful patient outcomes are supporting that care can be rendered safely and effectively in less costly settings
- The IOM's goals of effective and efficient care, Patient Safety issues, and Continuity of Care across the Continuum require physician practice pattern behavioral changes
- Payers are pushing the bar towards the outpatient setting and this is forcing a change in provider behavior- ready, welcome, or not

Doesn't it always feel like we're targets of external forces?



Bummer of a Birthmark Hal

Why are Providers Vulnerable?

- Too many definitions of medical necessity
- Definitions are either too vague or too restrictive
- Payer, State, and Court interpretations are inconsistent
- Providers don't understand medical necessity and supporting documentation- either are not aware or too busy and don't understand the risks
- CMS serious about protecting the Medicare Trust Fund- whole host of auditors, including the RAC, MIC, ZPIC, etc...



What are the auditors looking at for Medical Necessity?

When considering Medical Necessity, three main questions are raised:

- Is the treatment necessary and appropriate for the patient?
- Is the treatment setting the appropriate one for the service/patient? – this is often interpreted as the lowest cost safe alternative setting
- Does the documentation in the medical record support the right service in the right setting for the right patient?

Hospital Level of Care

- A Hospital patient can be an “Observation” level of care or an “Inpatient” level of care
- On average a hospital might receive a \$5K payment for an inpatient v.s. \$500 for an observation case- this is a delta of \$4500 per patient
- In general, physicians don’t know the difference between these levels of care- even though the level of care and its supporting documentation is a physician responsibility

What makes a person an inpatient?

According to the Medicare Benefit Policy Manual, Chapter 1- Inpatient services covered under Part A:

- Formally admitted with the expectation that he or she will remain overnight, even if doesn't actually remain overnight
- Physician decision
- Complex medical judgment
- Some factors to consider:
 1. Severity of the signs and symptoms exhibited
 2. Medical predictability of something adverse happening
 3. Need and availability of diagnostic studies
- Length of time the patient spends in the hospital is not the sole determining factor

What are outpatient observation services?

According to the Medicare Benefit Policy Manual, Chapter 20.6:

- Services for the short term treatment, assessment, and reassessment before a decision is made regarding a patient's need for inpatient admission or discharge from the hospital setting
- Usually this determination can be made in less than 48 hours, most less than 24 hours
- Just because a patient stays longer than 48 hours, does not make them inpatient. It is the medical necessity, not the length of time that determines a patient's status

Observation is NOT

- Routine outpatient services like blood transfusions or chemotherapy
- Routine preparation for diagnostic testing
- Routine recovery from outpatient surgical procedures (there is a 4-6 hour post operative standard recovery period)
- Services provided for the convenience of the patient, patient's family, or physician
- Custodial care

Why is the correct patient status important?

From the Hospital Point of View:

- Compliance issue- if not correct and a standard process of utilization review is not used, there is risk of a False Claims issue and risk of an OIG audit and corporate compliance integrity agreement
- Revenue Integrity issue- if overuse inpatient level of care, may lose revenue on audit. If overuse observation level of care, lose potential revenue
- If overuse observation, it will artificially elevate your length of stay and it can impact the qualified stay (3 day rule) for skilled care benefits
- Patients may get unexpected financial responsibilities (co-pay and deductibles)

Physician Buy-in

- Patient Safety and improved clinical care
- Reimbursement/Resources to Practice
- Compliance/Fraud risks
- Physician Leadership

Utilization Review

- CMS Conditions of Participation [42CFR482.30(c)] requires review of Medicare and Medicaid patients with respect to the medical necessity of hospital admissions
- As screening criteria are often not accurate enough (up to 20% error rate), cases that don't meet inpatient level of care should be escalated for a secondary physician level review- since the decision to admit or discharge a patient needs to be made by a physician
- This process allows for team communication and an opportunity to clarify physician "concern", "intent", and "plan of care". These elements along with support from the screening criteria guidelines will help document and clarify the appropriate level of medical necessity (care)

Utilization Review Program

- Medical necessity screening at all entry points
- UR reviewer uses a screening tool
- Cases not meeting inpatient level are referred to a Physician Advisor for secondary review and peer to peer discussion
- Timely Legible Documentation
- 24/7 Process
- ED review is key
- UR Committee oversight
- Hospital-Physician Concordance mechanism
- Code 44 Process
- Observation letters
- Education, training
- Frequent feedback

Condition Code 44

- An important mechanism allowing for the correction of an inappropriate level of care designation
- When a patient initially is assigned an inpatient status inappropriately and is changed to observation status
- Excessive use of Code 44 may be an audit flag
- Currently RACs are focusing on denying inpatient cases more than observation cases but Code 44 is still a compliance issue

Condition Code 44- Transmittal 299

- Change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital
- Hospital has not submitted a claim to Medicare for the inpatient admission
- A physician concurs with the utilization review committee's decision; and
- Physician's concurrence with the utilization review committee's decision is documented in the patient's medical record

Screening Guidelines and Physician determinations

- According to 42 CFR 482.12(c)(2): Only a licensed practitioner is permitted to admit patients to a hospital
- There are several commercially available screening criteria sets- two popular ones are: 1. InterQual and 2. Milliman
- Ultimately the decision to admit, retain, or discharge a patient is a physician decision

Clinical Documentation

The criteria set stress two components-

Severity of illness- how sick is the patient?, and

Intensity of service- what services did the patient receive?

Together these help address whether the patient received the right treatment in the right setting- i.e. meeting medical necessity

It is important to also note that Medical Necessity is:
Not for the convenience of the patient/family, and,
“Physician ordered” does not necessarily mean medically necessary

Concern/Risk/Intent

Since patient and clinical care is complex, and screening criteria are limited, medical necessity often comes down to the medical uncertainty and predictability of an adverse clinical outcome. Physician “concern” and “intent” are paramount to any documentation

Clinical Documentation

- The physicians are taught to document using the SOAP format:
- Subjective
- Objective
- Assessment
- Plan

It is important that documentation is complete, consistent, and supportive of the level of care claimed

SOAP

- S (subjective): What signs/symptoms brought the patient for admission? How sick is the patient? Did they fail outpatient therapy? Is there a significant change from their baseline?
- O (objective): Physical Examination and ancillary testing that support the subjective complaints
- A (assessment): What is the presumptive and differential diagnosis? Better to document a working diagnosis or R/O than to just put a non-specific symptom
- P (Plan): What is our evaluation and treatment plan. This is our “intensity of service” and should support the need to manage the patient in the inpatient setting



Elective Procedure- appropriate setting and documentation

Patient with stable angina admitted for an elective PTCA. Has a PMH of CAD, DM, CHF, and CRF

Is a PTCA in this patient appropriate for the outpatient or inpatient setting?

Usual documentation- patient with history of chest pain. Plan PTCA

Needed documentation to support procedure be done as inpatient:

- risk of heart failure from hydration to protect kidneys from dye
- risk of worsening renal function from dye load
- risk of heart failure from renal dysfunction, fluid balance shifts
- high risk of adverse outcome

Outpatient in a bed

- An area of risk is overnight stays for elective outpatient surgeries/procedures
- These events have an associated “recovery period”
- Admission overnight for monitoring routine recovery or for patient convenience does not qualify these cases for either observation or inpatient admission
- If there are complications meriting further evaluation and treatment, these must be documented and the admission order appropriately assigned



Keys to medical necessity and documentation success

- Documentation of the clinical “severity of illness” and “intensity of service”
- Screening criteria can help guide documentation
- Documentation of “concern, intent, risks” that support the clinical care provided. The critical factor is the judgment of the admitting physician
- A robust Utilization Review Program
- Documentation Education
- Communication, Understanding, and Teamwork

Questions?

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