

Audits are Real- Physician and Hospital Shared Risk



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Goal of the Audit Culture

- To ensure billed services are reflected in the documentation in the record
- To ensure billed services are in the medically correct setting for the pt's condition
- To ensure billed service reflect the 'rules' regarding billing for the specific service
- To ensure documentation can support all billed services according to the payer rules.
- **Physician Order matches what was done matches what was documented matches what was billed.**



Powerful Transmittal

- Transmittal 47, Interpretive Guidelines for Hospitals June 5, 2009 www.cms.hhs.gov/transmittals/downloads/R47SOMA.pdf
- “All entries in the medical **record must be complete**. Defined by: sufficient info to identify the pt; support the dx/condition; justify the care, treatment, and services; document the course and results of care, treatment and services and promote continuity of care among providers.
- “All entries must be **dated, timed and authenticated**, in written or electronic format, by the person responsible for providing or evaluating the service provided.”
- “All entries must be **legible**. Orders, progress notes, nursing notes, or other entries (Also CMS covers in SE1024 MedLearn release)³



More on Signature Transmittal 327, 3-10 8 ways to meet requirements

- Provide a legible full signature (a readable first name and last name)
- Provide a legible first initial and last name
- Write an illegible signature over a typed or printed name.
- Write an illegible signature on letterhead with information indicating the identity of the signer. (EX: a prescription has an illegible signature but the letterhead of the prescription lists three physician names. Circle the name of the physician who wrote the prescription.
- Use an illegible signature accompanied by a signature log or attestation statement.
- Write initials over a typed or printed name.
- Write initials not over a typed or printed name, but accompanied by a signature log or attestation statement.
- Neglect to sign a portion of a handwritten note, but other entries on the same page in the same handwriting are signed.



Protocols- Challenges with Fixes

- CERT audits have continued to identify weakness in the use of Protocols. (9-27-09/Noridian/MAC)
- EX) Lab urine test ordered but culture done as 2nd test due to protocol.
- 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 indicated' or similar language.
- ***YEAH – how about including the protocols that are referenced in the record when submitting for audit?***



MAC potential focus areas

Carefully watch for educational notices from the MAC as these could represent potential focused reviews.

- EX) Noridian sent notice of "Proper Use of Protocols." 9-27-09

"An increase in incorrect coding for Complete Blood Count (CBC) and Urinalysis (UA) laboratory services. Recent Comprehensive Error Rate Testing (CERT) analysis indicates providers are performing additional laboratory services based on a standard written or implied protocol, rather than a pt-specific physician order. Protocol is a routine plan to carry out a study or treatment regime."

Ex of improper protocol: White cells or bacteria discovered during a urine test will prompt the lab to perform a urine culture based on protocol without a specific order from the physician to perform the culture."

NOTE: Not a judgment of 'care' – but a need for a pt specific order. 6



**THEME – ONLY A PHYSICIAN
OR AN EXTENDER CAN
DIRECT CARE FROM THE
ADMIT ORDER OR ADMIT
NOTE**




Inpatient vs Observation Making it Easier



Handoffs between ER & Hospitalist & Admitting Provider

- What are the internal guidelines on which providers can order the pt's status? Orders take effect when orders are written – but what if the ER doc only has 'transitional/temporary' privileges? What if the Hospitalist or the Admitting provider changes the ER 's doc initial admission status?
- Clarify and ensure that all ER /admitting dialogue is well documented so the decision process of the final admitting provider can be well identified.



Medicare's Inpt definition

Medicare Benefit Policy Manual C

Chpt 1,S 10

- An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.”
“However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:
 - The severity of the signs and symptoms exhibited by the patient;
- – **The medical predictability of something adverse happening to the patient...”**



Telling the Story ... Beginning to End

Severity of Illness

- What brought the pt to the hospital?
- Has the pt failed outpt treatment?
- Does the pt's condition require admission to an acute setting?
- Is the pt sick enough to require hospital level of care NOW?



What does Intensity Look Like?

- Clinical documentation tied to the severity of the condition the pt was admitted for.
- What is currently being done for this patient?
- Does this treatment require an inpt level of care?
- Applies to each separate day. (all care givers)



CMS reiterates guidance on inpt admission determinations, SE 1037 2-3-11

- CMS refers hospitals to Medicare Program Integrity Manual and reiterates that CMS requires contractor staff to use a screening tool as part of their medical review process of inpt hospital claims. While there are several commercially available screening tools...such as Milliman, Interqual and other PROPRIETARY systems... CMS does not endorse any particular brand.
- CMS repeats that contractors are not required to automatically pay a claim even if screening indicates the admission was appropriate and conversely, contractors are not automatically to deny claims that do not meet screening tool guidelines
- **“In all cases, in addition to the screening instruments, the reviewer shall apply his/her own clinical judgment to make a medical review determination based on the documentation in the record.”**
- The guidance restates that the Medicare Benefit Policy Manual, Chpt 1, instructions that a physician is responsible for deciding whether the pt should be admitted as inpt.



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 physicaian admit note/order and the nursing bedside documentation.



More from Trailblazers/MAC

- 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



Golden Rule

- Orders take effect when orders are written.
- There is no ability to 'retro 'orders for status
- EX) If the doctor changes the status from OBS to inpt, the pt's condition must warrant the higher level of care at the time of the inpt order. Took effect when written based on condition.



Clinical Team Focus Areas

- ▶ Physician – focus on the admit orders/admit note to clearly state why the pt needs to be in an inpt bed? Severity of the condition, medical indicators, potential of adverse events. (Direct care from the admit note)
- ▶ Nursing – focus on the ongoing care that will support the billed status – intensity of care/inpt



Only Physician's can

- ...direct pt care ...thru
- Determining correct status
- **Clarifying order of the status**
 - Examples of weak orders: Admit to Dr Joe, Admit to tele, transfer to medical floor, admit to 23:59, admit to medical service. None clearly define : Admit to inpt status and include why = dynamic, action oriented 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.
- ADMIT To Inpt; Place in outpt OBS= correct



If a Non-attending/admitting...

- Many facilities are using outside physician advisors or are growing their own advisors – many times the UR physician.
- Ensure that any 2nd opinion by a non-treating provider is 'validated' and used for directing care by the attending/admitting. Otherwise it is just another non-treating opinion. Additionally, look for educational opportunities thru patterns --dx, documentation, doctor.
- Double check with the QIO for their opinion during audit.



What is OBS? Medicare Guidelines

- **APC regulation (FR 11/30/01, pg 59881)**

“Observation is an active treatment to determine if a patient’s condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged.”

- **Medicare Hospital Manual (Section 455)**

“Observation services are those services furnished on a hospital premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible as an inpatient.”



Expanded 2006 Fed Reg Info

- **Observation** is a well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, before a decision can be made regarding whether a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.
- *Note: No significant 2007, 08 ,09 , 10 , 11 reg changes*

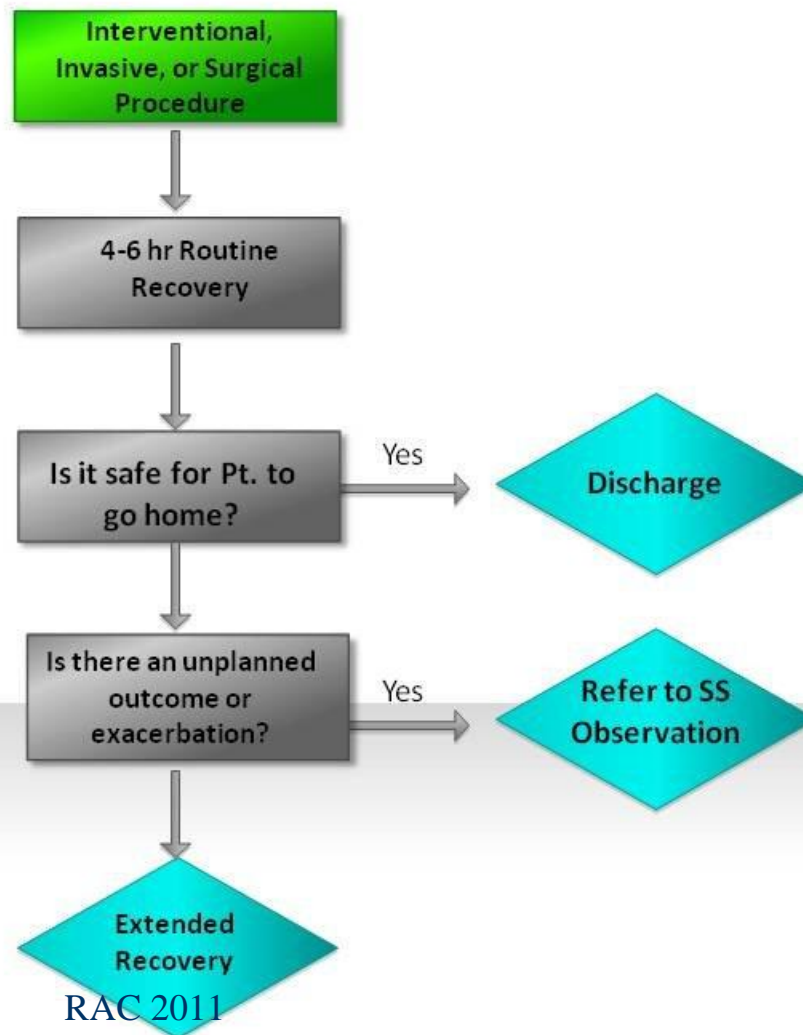


More 2006 Regulations

Observation status is commonly assigned to pts with **unexpectedly** prolonged recovery after surgery and to pts who present to the emergency dept and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. (Fed Reg, 11-10-05, pg 68688)



OBSERVATION DECISION TREE



Need an updated order



Physician Order Sample- Action Oriented w/ Triggers

- **Refer/Place in Observation**
- **Dx:** "Dehydration"
- **Treatment:** "2 Liters IV fluid bolus over 2 hours followed by 150cc/hr"
- **Monitor for** "hypotension, diarrhea, vomiting, urine output, etc.."
- **Notify physician when:** Patient urinates or 3 liters have been infused



EX of Pt Status Changes

- Pt is seen in the ER for potential appendicitis. (ER status)
- Provider places in OBS for further evaluation and determination if surgery is necessary. (OBS status, can be done in the ER)
- Results indicate surgery is appropriate (SDS status PLUS up to 4-6 hrs of routine recovery anywhere in the hospital.)
- Status follows the changing patient condition.



Incorrect Surgery Status

- If the 'normal' outpt surgery is ordered as an inpt surgery, the acute level of care must be clearly documented.
 - Scenario: Pt has a scheduled lap choley, but the surgeon orders it as an inpt because of a history of post procedure problems.
 - Unfortunately, it is not allowed to 'forecast' an unplanned event that would either move the pt to OBS or Inpt. OR clearly document the history of events/conditions that led to the need for an inpt order of a normal outpt procedure.
 - More correct: Start as an outpt surgery, wait to see how the routine recovery advances, move to the higher acuity AS IT OCCURS – OBS or INPT.



Surgery Pt Status Ugly

- If the hospital's inpt status is denied, there is no ability to rebill anything on the outpt side except ancillary services. No surgery, no recovery, no anesthesia.
- At the present time, there is no automatic recoupment of the Part B/physician services. (CMS RAC Website June, 2009) It will be evaluated for all Part A/hospital denials.
- Prevent – UR looks at all inpt surgeries!
 - Part B on a Part A: RAC FAQ 9462, 12/2/08
 - Timely filing, Transmittal 1818, 15-27 months, 8-29-03
 - Claims processing manual, Chpt 1, Section 70



HOT: 3 Day SNF Qualifying Stays

- “Admit to Inpt” orders should clearly speak to the clinical reasons for the admit.
- Each day should continue to speak to the intensity of the services the pt is receiving ...not just the need for the 3 day SNF qualifying stay. (SOI =day 1; IOS = all 3 midnights)
- Difficult – as social issues are prevalent.



Broken Process in Pt Status

- Rapid turn around of calls from UR in discussing problematic admit orders
- Coordinate any 2nd opinions with rapid turn around
- Explore expanding UR function –with a dedicated focus on surgery, direct admits, OBS and ER bed placement.
- Ongoing education as it occurs.



EMR Ideas

- As providers and hospitals move to more electronic documentation, explore 'hints/ques' to guide providers/SOI; providers and nursing/IOS –to help define the acute care being provided.
- Additional 'hints/ques' can help provider triggers for OBS orders being complete with more intervention required.



Contracted or Employed Providers

- If the provider and the hospital share the same Tax ID # - if the provider has a denial/recoupment, the hospital actually repays the funds.
- Whatever the arrangement, the 'entity' will be repaying any losses.
- What joint auditing and training is occurring to reduce risk?



And it is all about the pt

- Yes, CMS will notify the patient of any denials/repayments/recoupments as it will impact their out of pocket.
- ALL funds must be returned to the pt or their supplemental insurance- regardless of whether there are other pending payments. (Conditions of participation agreement.)



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/documentation forms. Allows for a standard format for all caregivers.



Questions and Answers

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