Mastering the Chaos – Documentation to Support Billable Services

Presented By:
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Outline of Training – How can nursing and finance strengthen the patient's story/ relationship?

- Outlining the documentation requirements for both outpt and inpt
- Drug adm, ER, OR, Hospital based clinic, observation, Inpt, recovery, pt specific protocols, orders match billed and documented
- Nursing is a key element to support billable services
- Kings/Queens of CASH = Nursing
- Feedback process – denials, process improvement, change of internal work flow

National Error Rate
3rd Q 2010- 12.4%, 10.5% 2011, 7.0-6.0% - 2012/13

- Commitment to Reduce the Error
- President Obama recently announced the government's commitment to reduce the error rate by
- 50% (using a baseline of 12.4%) by 2012 (Was 3.8% $10.3B in 2008)
- – 9.5% for November 2010 Report
- – 8.5% for November 2011 Report
- – 6.2% for November 2012 Report
- Thru MAC, CERT, ZPIC, RAC, MIC, OIG, HEAT auditing…
- Funding PPACA by eliminating fraud, waste and abuse…

CMS Claim's Review Entities

Roles of Various Medicare Improper Payment Reviews

Timothy Hill, CFO , Dir of Office on Financial Mgt

9-9-08 presentation

Entity	Type of claims	How selected	Volume of claims	Purpose of review
QIO	Inpt hospital	All claims where hospital submits an adj claim for a higher DRG. Expedited coverage review requested by bene	Very small	To prevent improper payment thru upcoding. To resolve disputes between bene and hospital
CERT	All	Randomly	Small	To measure improper payments
MAC	All	Targeted	Depends on # of claims with improper payments	To prevent future improper payments
RAC	All	Targeted	Depends on the # of claims with improper payments	To detect and correct past improper payments
PSCZPIC	All	Targeted	Depends on the # of potential fraud claims	To identify potential fraud
OIG	All	Targeted	Depends on the # of potential fraud claims	To identify Fraud

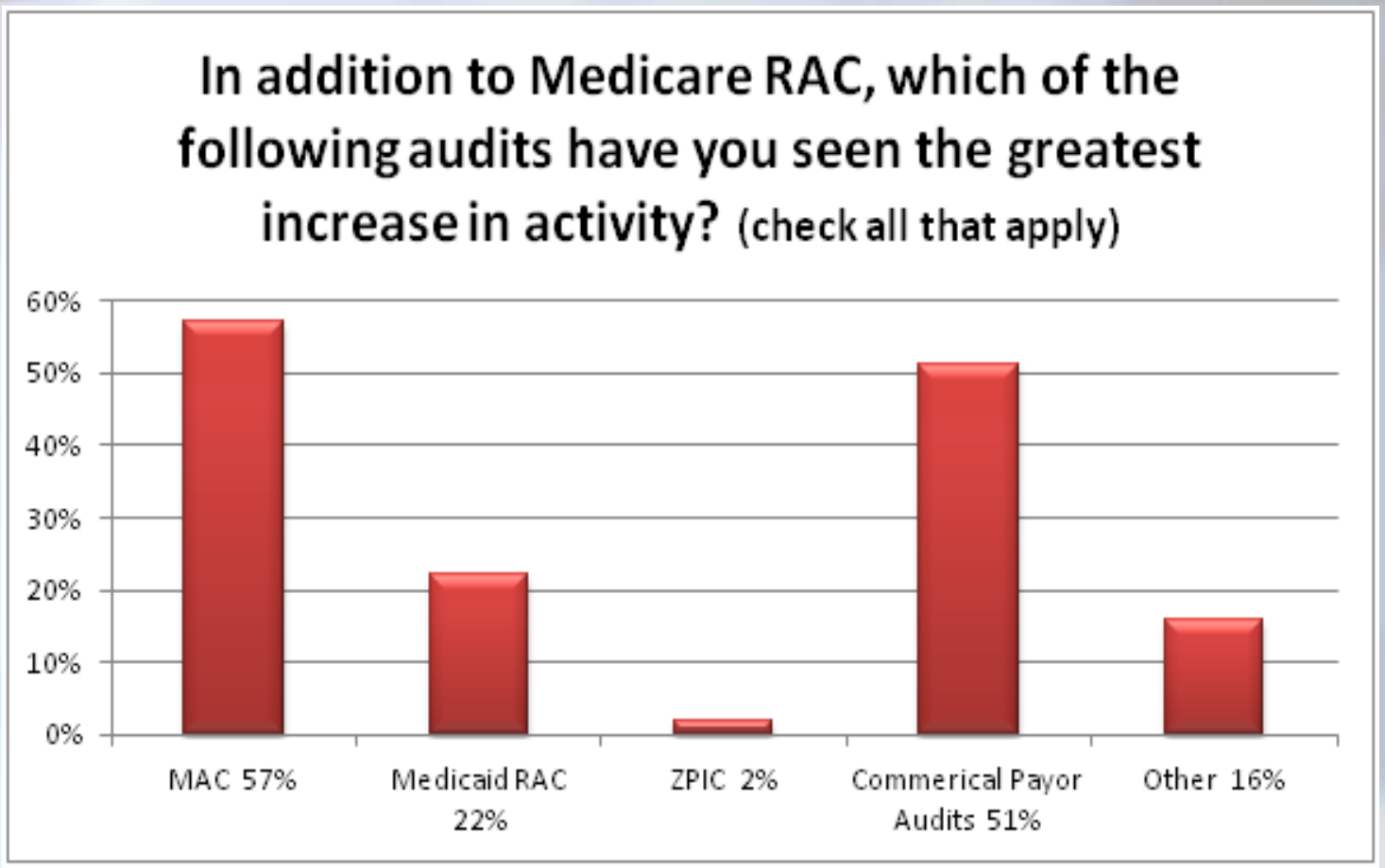
Goal of the Audit Culture

- 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. (setting)
- Physician Order matches what was done matches what was documented matches what was billed.

BUT THE WORLD TILTED…

- The MACs/Medicare Claims Contractor increased the risk thru pre-payment auditing.
- Many MACs have began pre-payment auditing: auditing for the appropriateness of the documentation to support the procedure/service.
- The facility is not paid until the documentation is reviewed to determine if the record can support the status. If the hospital is not pd, some MACs are then recouping the provider's accompanying payment.

Attendee feedback/360 Compliance audio 2-2013



Govt Audits – in a nutshell

RAC

- Post payment –up to 3 yrs last payment activity, New Issue Bd
- Pre –payment Demo project, slated for 3 yrs, 11 states

MAC

- Pre-payment-identified items/inpt and outpt, physician, MAC specific
- Post payment – probes, CERT, other, MAC specific

Medicaid

- Internal, state-specific fraud unit
- MIC – up to5 years back
- RAC for Medicaid – incentivized for recoupment/% of $-3 yrs back (OH, VA 3-13)
- +OIG+QIC+ZPIC

AHA/RAC Denials by Reason: 4thQ 2012

96% of denied $ were complex

RAC Denials by Reason, 4th Q 2012 by $$ impacted					
Region	**A**	**B**	**C**	**D**	**All**
Medically Unnecessary Admission/incorrect setting	**71%**	**70%**	**85%**	**81%**	**78%**
Incorrect DRG or other coding error	**24%**	**26%**	**11%**	**7%**	**17%**
Other	**2%**	**3%**	**3%**	**8%**	**4%**
No or insufficient documentation	**1%**	**1%**	**1%**	**2%**	**1%**
Incorrect APC or OP billing code	**2%**			**2%**	

Complex Denials/Setting By Dollar

% of Complex Denials for Lack of Medical Necessity for Admission – thru 4th Q 2012/4th Q 2011- by $$ Impacted	
Syncope and collapse (MS-DRG 312)	14/17/25/21
Percutaneous Cardiovascular Procedure (PCI) w drug-eluting stent w/o MCC (MS-DRG 247)	21/23/24/14
T.I.A. (MS-DRG 69)	0/0%/6%/8%
Chest pain (MS-DRG 313)	13/10/9/8
Percutaneous Cardiovascular Procedure (PCI) w non-drug-eluting stent w/o MCC (MS-DRG 249)	0/0/4%
Esophagitis, gastroent & misc digest disorders w/o MSS (392)	13/10/3/0
Back & Neck Proc exc spinal fusion w/o CC/MCC	5%/5%//

RAC Appeals:

4th Q /3rd Q/ 1st Q 2012 (More than 1/3 overturned during discussion period. 81% of hospitals with any appealed denials.

	% of denials appealed	Appeals pending (3/4 still unresolved, 3rd Q as well as 2 previous Q)	% of denials overturned on appeal
Region A	**50/51/41**	**6810/6,177* PIP**	**81/82/70**
Region B	**38/39/40**	**15,121/12,199**	**74/82/84**
Region C	**39/37/27**	**30,565/25,873**	**75/77/79**
Region D	**48/48/43**	**26,499/23,636**	**62/61/55**
National	**42/42/34 %**	**70,493/68,45**	**72/74/ 75%**

CMS Quarterly Newsletter – *Jan –March 31, 2012 (1st Q totals)

Region	Overpaymts ($ in millions)	Underpaymt	Total Corrections (Based on actual collections	FY to Date Corrections Data)
Region A/DCS	$ 112.6	$ 11.3	$ 123.9	$146.3
Region B/CGI	$ 60.8	$ 4.8	$ 65.6	$137.7
Region C/Connolly	$ 202.8	$ 20.1	$222.9	$343.0
Region D/HDI	$212.2	$ 25.3	$237.5	$390.2
Nationwide Totals	$588.4	$ 61.5	$649.9	$1,072.6

Top Issues per Region: Jan-March 2012

- Three of the four RACs had the same issue that reflected the majority of the denials:
  - Cardiovascular procedures (medically incorrect setting)

  HDI – continues to post minor surgeries and other treatment billed as an outpt. (1 issue continues to exceed all others from the 3 RACs)

  CMS RAC program update Oct 2009-May 2012

  Overpayments $1.86B

  Underpayments $245M

  Total corrections: $2.1B

Medicare Fee for Service RAC Program , FY 2010 – FY 3rd Q 2012

	FY 2010 Oct 09-Sept 10	FY 2011 Oct 10-Sept 11	FY 12, 1stQ Oct 11-Dec 11	FY 12, 2nd Q Jan 12-Mar 12	FY 2012 3rd Q Apr 12-June 12	Total National Program
Overpaymts Collected	$75.4M	$797M	$397.8M	$588.4M	$657.2M	$2.5B
Underpaymt Returned	$16.9M	$141.9M	$24.9M	$61.5M	$44.1M	$289.3M
Total Corrections	$92.3M	$939.3M	$422.7M	$649.9M	$701.3M	$2.8B
Overpaymentissues	Region A/ Proformant/DCS Cardiovas Procedures/ Inpt	Region B/CGI Cardiovas Procedures/ Inpt	Region C/ Connelly Cardiovas Procedures/ Inpt	Region D/HDI Minor surgery and other treatment billed as inpt	PENDING APPEALS? May significantly change figures.	

Outpt documentation requirements

Drug Administration

- Billable in outpt: ER, observation, Hospital based clinic
- Documentation must be auditable. Start and stop times of the bags; add up all the times; complete hierarchy correctly.
- Charge capture analyst?

ER visits & procedures

- E&M leveling criteria must be facility specific; not automatically the same as the providers.
- Closely watch the bell curve. Outpt comparison:
- 99281 9%; 99282 32%

99283 39%; 99284 15%;

99285 5%

Outpt documentation requirements

Hospital based clinic

- Technical component of employed providers
- Outpt depts of the hospital – IV infusion, cancer, wound, pain clinic
- 99211-15 billable with separate E&M leveling criteria for the service; separate from the providers.
- Watch bell curve

Protocols

- Nov 2009, Noridian issued their example.
- UA ordered; based on results a culture was done. The ordering physician ordered the UA only. Who ordered the culture , pt specific?
- Revise original order to add' follow protocol' &/OR get the order revised as needed.

Other documentation requirements

Recovery

- Billable – outpt up to 4-6 hrs anywhere
- Must be documented anywhere in the hospital to be billed anywhere
- EX) PACU = level 1 recovery, per min.
- Outside PACU up to 6 hrs = phase 2.
- Inpt = PACU only

Surgery

- Different approaches – timed, procedure
- Determine best method – can do either
- Procedure = no ability to revise for unplanned costs
- Timed = higher cost, slower doctor.

Inpatient vs Observation Making it Easier

The Florida Experience
MAC Focused Probe, 2009 & 2010
Preliminary results , FHA, RAC summit 9-10
Common w/all: No Physician order for inpt
Update: 2011/moved to pre-payment for 313, 552

DRG	Description	2009 Error Rate	2010 Error Rate
313	Chest pain	55.16%	76.71%
552	Medical back pain w/o MCC	70.92%	71.25%
392	Gastro & misc disorders w/o MCC	49.08%	41.93%
641	Nutrition misc metabolic disorder w/o MCC	49.27%	48.43%
227	Cardiac defib w/o cath lab w/o MCC	20.65%	45.43%

And more MAC auditing

- **Highmark/(now) Novitas Solutions –Prepayment Auditing**
  - Probe for DRG 470/Major Joint Replacement or reattachment of lower extremity w/MCC
  - Probe for DRG 244 Permanent Cardiac Pacemaker implant w/o CC or MCC
  - Requires documentation of efforts to address on an outpt basis first. Not successful.

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.

EMR Challenges

- Hybrid records present extreme challenges in identifying the skilled care/handoffs of intensity of service between the care areas.
- EMRs tend to present the patient's history in a 'cookie cutter' concept without pt specific issues.
- Treatment/outcomes/results of ordered services are often omitted from the clinical record.

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?
- FIX: Clarify and ensure that all ER /admitting dialogue is well documented so the decision process of the final admitting provider can be easily identified.
- FIX: Tie the pivotal ER event into the reason for an inpt.

Learning from audit denials

- 1) Obs 1st. 1 hr prior to discharge, doctor converts to inpt. CMS denied based on the fact that when the inpt order was written, there was no indication of the need to convert at that time.
- 2) Admit decision: Admit elderly woman to evaluate and treat malignant tumor which would have justified an inpt admission. However, there was no treatment given during her stay. CMS denied : at the time the decision was made to admit the pt to inpt status, the pt was in no acute distress, she was no requiring pain meds, she was able to handle her secretions, her vital signs and oxygen saturation were normal, her lab data revealed normal findings and she was admitted for an outpt workup."
- 3) Pt was placed in inpt with : "given her memory deficits and difficult with ambulation, I will arrange 23-hr admission to the hospital for colonoscopy prep." Pt was wheelchair bound and lives alone. CMS denied stating – inpt care, rather than obs or outpt services, is required only if the medical condition , safety or health would be significantly and directly threatened if care was provided in a less intensive setting.'

- **TAKE AWAYS**: Orders take effect when written..pt's condition must support inpt status AT THE TIME THE ORDER IS WRITTEN. PLUS always speak to and treat the clinical reasons that were addressed when the inpt decision is written and FINALLY, social admits are very hard to justify an inpt admission.

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?
- TIE known risk factors into the reason for inpt admit- today

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 physicain 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

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."

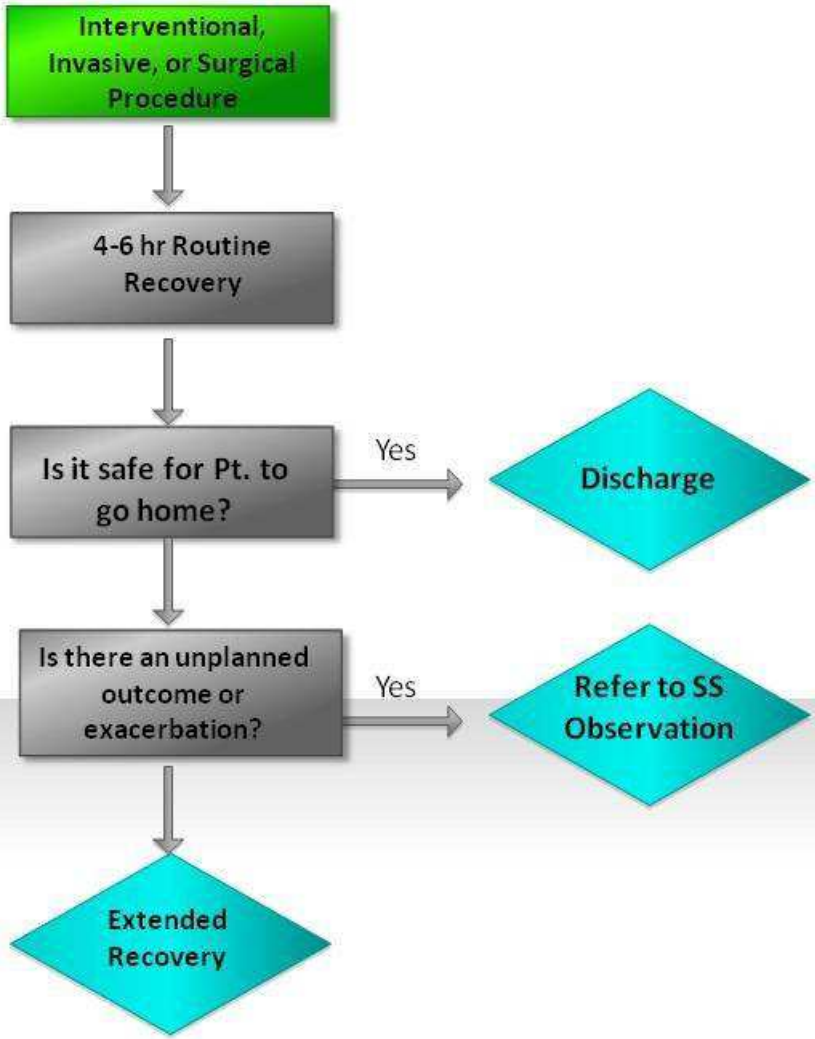
Expanded 2006 Fed Reg Info

- **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, 12 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

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.

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?

RAC Post Payment recoupment impact

June 26, 2009/CMS Website

- CMS reversed earlier decision to AUTO recoupment SNF payment if the hospital is denied/recouped its 3 day qualifying stay.
- If the hospital is recouped for any activity, Part B/physician will be evaluated, but not auto recouped.
- Will look but not auto recoup in both.

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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