OBJECTIVES

// Focus Points of CMS
// Portions of OIG 2015 Work Plan
// Inpatient Compliance Hot Topics
// Outpatient Compliance Hot Topics
// Final Thoughts
// References
FOCUS POINTS OF CMS

// Comprehensive Error Rate Testing (CERT) 2015

- AICD Insertion for Ischemic Cardiomyopathy (NCD 100.3.20.4) – Documentation Requirements – CHF status, and PH of AMI – effective 2003
- Dementia/Depression – female admitted from nursing home, crying, depressed. No documentation she was a “danger to herself” or others
- Single vs. Dual Chamber Pacemaker (NCD 20.8) – No documentation of consideration of a single-chambered pacemaker. CHF not documented as a factor, no documentation of risk of atrial fibrillation without dual-chambered pacemaker – effective 2004

// Breaking News: New CMS Policies

- IRF admissions not reasonable and necessary – documentation does not support 1) beneficiary participated in individual therapy, 2) was able to participate in therapy or 3) received the required amount of therapy minutes, CMS states “the generally-accepted standard by which it is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours a day for 5 days a week”

FOCUS POINTS OF CMS

// Comprehensive Error Rate Testing (CERT) 2015

- IRF admissions not reasonable and necessary – no supervision by a PMR physician. Per CMS, the IRF patient’s medical management and rehabilitation needs require the supervision of a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation. Note: Any licensed physician can generate the admission order.

- Inpatient medical necessity denials for encounters in which documentation did not support the need for hospital care “spanning 2 or more midnights.”
- Inpatient medical necessity denials for encounters that span over the course of a weekend.
- CBC with differential (CPT 85025) billed inappropriately due to physician’s order not documenting “with differential.”
FOCUS POINTS OF CMS

// Comprehensive Error Rate Testing (CERT) 2015

- Denial for missing physician’s order for hydration and missing drug administration record with start and stop times
- Denial for inpatient medical necessity. Patient with vascular dementia and been cared for by mother. Became too hard to care for and was admitted while family looked for a new facility to house him. Initially placed in observation, admitted four hours later as inpatient for three days then placed in SNF

// Disagreement with present on admission (POA) reporting


FOCUS POINTS OF CMS

/\ Total Knee Arthroscopy Documentation

- Pain, level of pain, worsening pain
- Pain increased with activity
- Pain interferes with ADLs
- Pain w/passive ROM
- Limited ROM
- Crepitus
- Joint swelling, effusion
- Failed trial of NSAIDS or inability to tolerate other medication. Trial of PT or external joint support (walker, cane, etc.), >= 12 weeks, did not tolerate PT

An X-ray with at least two of the following:

- Subchondral cysts
- Subchondral sclerosis
- Periarticular osteophytes
- Joint subluxation
- Joint space narrowing
FOCUS POINTS OF CMS

// Total Knee Arthroscopy Documentation

- Antalgic gait

Need to submit hospital H&P and order for inpatient admission. Also need physician office progress notes that includes:

- Documentation of worsening symptoms, not relieved by conservative measures
- Documented confirmation that the replacement surgery was discussed and agreed upon by both the provider and the patient

PORTIONS OF OIG 2015 WORK PLAN

// New Inpatient Admission Criteria

- CMS anticipates one-day stays will arise in the context of death, transfer, or departure against medical advice
- If patient improves more rapidly than expected, CMS states such instances must be clearly documented and the initial expectation of a hospital spanning two or more midnights must have been reasonable in order for this circumstance to be an acceptable inpatient admission under Part A
PORTIONS OF OIG 2015 WORK PLAN

// Inpatient Claims for Mechanical Ventilation > 96 Hrs

- Coding Clinic Guidelines Date Back to 1991
- Coders Must Refer to Respiratory Flow Sheets, Actual Start and Extubation Time
- Number of Hours Spent Weaning Patient Counts
- Rounding of Hours Requirement is not Specified. When in Doubt, do not Round Up (Example: 25 minutes, do not count as one hour)
- Data Mine and Identify Cases with LOS 4 days in which ICD-9-CM Procedure Code 96.72 was Billed

PORTIONS OF OIG 2015 WORK PLAN

// New vs. Established Patient


- Not a requirement for Emergency Room, not required for hospital-based billing since January 1, 2014
- OIG report included dates of service from 2012
- Historical data will need to be audited internally
- Average overpayment is $24 for each encounter
INPATIENT COMPLIANCE HOT TOPICS

// New Inpatient Admission Criteria
- Certification no longer required as of 1/1/15
- Beneficiaries whose care is expected to last fewer than 2 nights should be treated as outpatient
- One-day stays are subject to review
- Zero to one midnight stays would be rare and unusual exceptions
- ICU label is applied to a wide variety of services and patient assignment cannot be specific to hospital location

// New Inpatient Admission Criteria, Cont’d
- Mitigate risks that usually start in the Emergency Department
- Utilize Utilization Review (UR) in the Emergency Department
- UR reviews all daily inpatient surgery schedules to catch any outpatient surgeries scheduled inappropriately as inpatient
- Train surgery schedulers to review surgery CPT code, research and notify UR if problems (IP only procedure list)
- Assess the current UR processes, UR Plan and UR physician members and determine if needed assistance and intervention is required
INPATIENT COMPLIANCE HOT TOPICS

// Hospital Acquired Conditions (HACs)

- December 18, 2014, CMS released its Fiscal Year 2015 Results for the CMS Hospital-Acquired Condition (HAC) Reduction Program. Hospital-specific HAC Reduction Program scores are posted on the Hospital Compare website at http://www.medicare.gov/hospitalcompare/HAC-reduction-program.html

- HACs are conditions that CMS considers reasonably preventable as opposed to conditions that are present on admission (POA)

// Hospital Acquired Conditions (HACs), Cont’d

- CMS finalized the two current domains in the 2016 inpatient prospective payment system (IPPS) regulation, and based 25% of the HAC score on the first domain Patient Safety Indicator-90 (PSI-90) which includes eight PSIs - Pressure ulcer, iatrogenic pneumothorax, central venous catheter-related bloodstream infections, postoperative hip fracture, perioperative pulmonary embolism or deep vein thrombosis, postop sepsis, postop wound dehiscence, accidental puncture or laceration

- And 75% on the second domain which includes catheter-associated urinary tract infections, surgical site infections (colon and hysterectomy) and central line bloodstream infections
INPATIENT COMPLIANCE HOT TOPICS

// Hospital Acquired Conditions (HACs), Cont’d

- Hospitals receive zero to 10 points for each measure, 10 being worst. Those hospitals with a score of 7.25 or above are included in the top 25%. These facilities may be subject for payment reduction by 1% for all hospital discharges occurring on or after October 1, 2015.

- The new data will be released in December 2015.

// Hospital Acquired Conditions (HACs), Cont’d

- POA Reporting Effective October 1, 2007 – Assess the timing of when the condition presented – Billing Requirement
- October 1, 2008 – Payment impact on conditions not present on admission
- POA defined as present at time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including ER, observation, our outpatient surgery are considered POA.
INPATIENT COMPLIANCE HOT TOPICS

// HAC Documentation Tips from NGS Medicare

- POA Diagnoses: Physicians should document all conditions that develop during an outpatient encounter (ER, observation, outpatient surgery) prior to IP admission
- HAC diagnoses acquired during IP stay should be well documented
- Hospital coders should work with physicians with any unclear, conflicting or missing documentation (physician queries) prior to claim submission
- OIG Work Plan 2013 included audit of POA reporting

// Texas Health and Human Services Commission (HHSC)

- August 21, 2015, sent letter to providers that the most recent Potentially Preventable Complications (PPC) analysis (FY 2014 analytical period) contained data from the FirstCare Health Plan with inaccurate POA values
- October 16, 2015, an update was released that the External Quality Review Organization (EQRO) for Texas Medicaid is diligently re-running these calculations with the corrected data and estimation date of completion is December, 2015

OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Reporting Hours

- Begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order
- Ends when all medically necessary interventions and or related services of care have been completed
- Round to nearest hour. Example: if patient started receiving observation care at 3:03 PM (nursing assessment) and discharged at 9:45 PM, then “7” units (G0378) would be reported to Medicare

// Observation Services – Reporting Hours, Cont’d

- Observation Hours 0-30 minutes = 0 Units
- Observation Hours 31-59 minutes = 1 Unit

Medicare Claims Processing Manual, Chapter 4, Section 290

- Monitor and audit physicians that utilize observation for outpatient scheduled procedures or admit to observation post-operatively without documented complications – OIG Work Plan for 2013
OUTPATIENT COMPLIANCE HOT TOPICS
// Observation Services – Charge Capture

Diagnostic and Therapeutic Procedures During Observation

- Infusions and injections should be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per access site per encounter, including an encounter when observation services span > one calendar day.
- “Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).”

*Medicare Claims Processing Manual, Chapter 4, Section 290.2.2*

“In situations where such a procedure interrupts active monitoring and results in two or more distinct periods of observation services, hospitals should record for each period of observation services the beginning and ending times during the hospital outpatient encounter. Hospitals should add the length of time for the periods of observation services together to determine the total number of units reported on the claim for the hourly observation services.”
OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Drug Administration Services

CMS FAQ 2725 – May a hospital report drug administration services, such as therapeutic infusions, hydration services, or intravenous injections, furnished during the time period when observation services are being reported?

OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Drug Administration Services, Cont’d

If the hospital determines that active monitoring is part of a drug administration service furnished to a particular patient and separately reported, then observation services should not be reported with HCPCS G0378 for that portion of the drug administration time when active monitoring is provided.

- Example: complex drug infusion titration may require active monitoring and IV hydration may not
OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Notice of Observation
Treatment and Implication for Care Eligibility (NOTICE) Act

☐ Requires hospitals to provide notification of treatment status to Medicare patients within 36 hours of receiving outpatient medical services, or upon discharge, if sooner

☐ Compliance effective date August 2016

OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, Cont’d

☐ Explain the patient’s outpatient status and reasons

☐ Explain implications of status on services, including subsequent coverage eligibility furnished by a SNF

☐ Include appropriate additional information

☐ Written and formatted and available in appropriate languages, easy to read

☐ Include signature of patient or person acting on patient’s behalf. Signature of presenting hospital staff is patient refuses to sign
OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, Cont’d

Keys to Success

- Assess your current UR plan and revise as needed to meet the requirements documented in the Condition of Participation – Utilization Review
- Assess the staffing and current value of the UR committee and make appropriate adjustments, if needed
- Develop UR policies on the appropriate charging of Medicare observation services based on the Medicare Claims Processing Manual

Keys to Success, Cont’d

- Ensure UR team completes admission review every 24 hours on observation patients to monitor changes in acuity
- Educate and prepare physicians and clinical teams regarding the NOTICE Act
- Develop processes and procedures on the NOTICE Act information and forms to provide to Medicare patients with the required elements
Emergency Room Evaluation and Management – Facility Reporting

Facility billing guidelines should be designed to correlate the intensity of hospital services to the different levels of effort represented by the codes. Coding guidelines should be based on facility resources (nursing interventions), should be clear to facilitate accurate payments, should only require documentation that is clinically necessary for patient care, and should not facilitate up coding or gaming. 2009 CMS Final Rule

Facility reporting should not mirror the professional (physician) reporting

American College of Emergency Physicians (ACEP) ED Facility Coding Guidelines
http://www.acep.org/content.aspx?id=30428

- Contains possible interventions per level and supporting conditions (symptoms/examples) that support the interventions
- Contains the possible interventions and supporting conditions for billing critical care codes 99291 (30-74 minutes) and 99292 (75-104 minutes)
OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting, Cont’d

- ACEP guidelines are based on a number of staff interventions. Both the AHA/AHIMA Guidelines and ACEP guidelines fall into this category. This intervention model uses basic care interventions to report the lowest level of service, with higher levels assigned as complexity of hospital resources interventions increase.

OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting – Critical Care

- Time-based
- Requires high-complexity decision making to support vital organ system failure (central nervous, circulatory, or respiratory failure, shock, renal, hepatic, and/or metabolic failure)
- Documentation of hospital staff performing critical care services, start and stop times
- Educate ED coding professionals
OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting – Critical Care, Cont’d

- Services not separately billable – interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, gastric intubation, vent management, vascular access
- Any other additional procedures provided during critical care time are separately reportable
- The time required to perform CPR (CPT 92950) is NOT included in critical care time but both may be billed separately if there is documentation of at least 30 minutes of critical care

*CPT Assistant, September 2012*

OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting – Left Without Being Seen (LWBS)

**CMS FAQ 2297** – Can hospitals bill Medicare for the lowest level ER visit for patients who check into the ER and are “triaged” through a limited evaluation by a nurse but leave the ER before seeing a physician?
OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting – Left Without Being Seen (LWBS), Cont’d

CMS Response — “No. The limited service provided to such patients is not within a Medicare benefit category because it is not provided incident to a physician’s service. Hospital outpatient therapeutic services and supplies (including visits) must be furnished incident to a physician’s service and under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. Therapeutic services furnished by a nurse in response to a standing order do not satisfy this requirement”.

FINAL THOUGHTS

// Quality Improvement Organizations (QIOs)

- October 1, 2015, the QIOs assumed responsibility for conducting initial patient status reviews of providers to determine the appropriateness of Part A payment for short stay (less than two mid-nights) inpatient hospital claims, previously conducted by the MACs
- Recovery Auditor (RA) patient status reviews expired on October 1, 2015. The RAs will not conduct patient status reviews for dates of admission October 1, 2015 to December 31, 2015
FINAL THOUGHTS

// New and Revised Place of Service (POS) Codes for Professional Claims

CR Transmittal #: R3315CP, Effective January 1, 2016

- Add new POS code 19 for “off campus-outpatient hospital” and revise language for POS code 22 from “outpatient hospital to “on campus-outpatient hospital”

FINAL THOUGHTS

// Mandatory Facility Reporting of Modifier – PO, January 1, 2016

Indicates services, procedures and surgeries provided at off-campus provider based outpatient departments

CMS will capture information related to the services provided in off-campus, provider-based departments and the effect on payments and patient cost-sharing
FINAL THOUGHTS

// Copy and Paste in the EHR - Risks
// Inaccurate or outdated information that may adversely impact patient care
// Inability to identify authors or what they thought
// Inability to identify when the documentation was created
// Inability to accurately support or defend E/M codes for professional billing notes
// Internally inconsistent progress notes
// Unnecessarily lengthy progress notes
// Redundant information

http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_049706.pdf

REFERENCES

// http://www.medicare.gov/hospitalcompare/HAC-reduction-program.html
// Medicare Claims Processing Manual, Chapter 4, Section 290.2.2
// http://www.acep.org/content.aspx?id=30428
// CPT Assistant, September 2012
DISCLOSURE

Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Hospitals & physicians should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. Information contained in this presentation is not intended to cover all situations or all payers' rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.

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