

Preparing for RAC Audits in Wisconsin

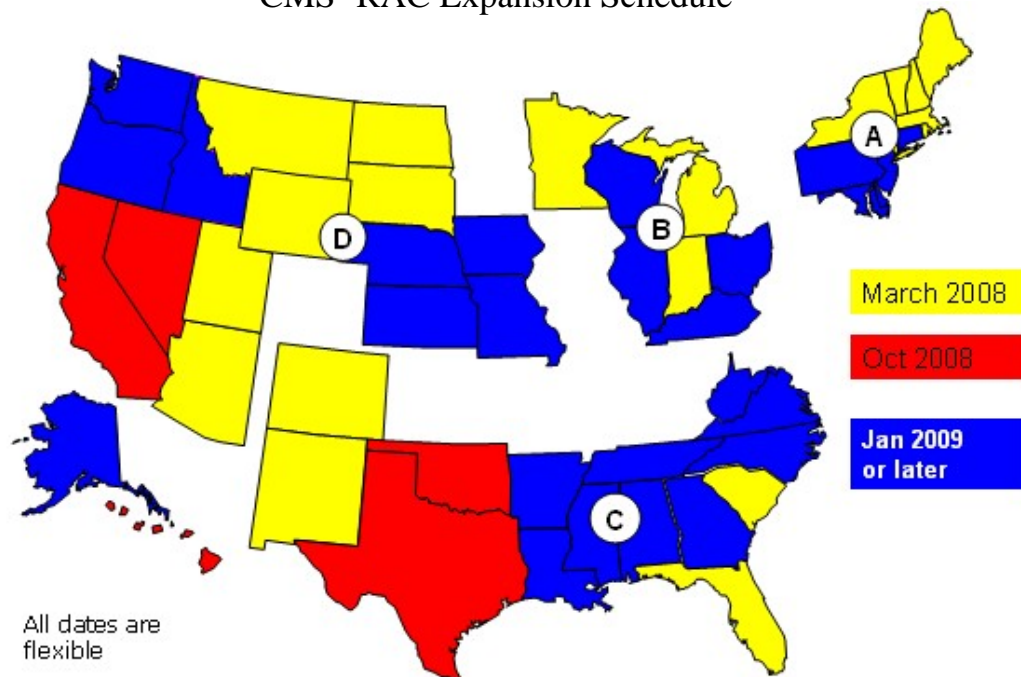


The Recovery Audit Contractor (RAC) Program is Coming to Wisconsin Are You Ready?

Background

In the *Medicare Modernization Act of 2003*, Congress established the Medicare Recovery Audit Contractor (RAC) program as a demonstration program in California, Florida and New York to identify improper Medicare payments – both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify. In the *Tax Relief and Health Care Act of 2006*, Congress authorized the expansion of the RAC program to all 50 states by 2010. This was approved before the demonstration program was complete or a thorough evaluation of the program was completed. To date, the Centers for Medicare & Medicaid Services (CMS) has expanded the program to Massachusetts and South Carolina. The national expansion will roll out in three stages beginning in March 2008.

CMS' RAC Expansion Schedule



This paper summarizes experiences from the RAC demonstration project, highlights various components of claims review, and includes “best practices” from Wisconsin hospitals to assist you and your staff in focusing on those areas that could be audited by RACs when the rollout of the national program begins. In particular, it highlights the types of inpatient claims that were targeted during the RAC demonstration (CMS RAC Status Document). It also refers you to the QIO PEPPER reports, the OIG workplan and compliance guidance, AHA and WHA materials, along with other strategies and tools your organization can utilize to minimize the impact of future RAC audits. This information is provided only as a guideline. Consult with legal counsel and your financial experts before finalizing any policy or practice.

RAC Demonstration Audits and Denials

In a recent RAC Status Document (<http://www.cms.hhs.gov/RAC/>), CMS reported that during fiscal year 2007 RACs collected \$357.2 million in overpayments and repaid \$14.3 million in underpayments. Hospitals accounted for approximately 92 to 94 percent of overpayments collected by RACs. According to CMS, the improper payments fell into the following categories:

- 42 percent – Incorrect coding;
- 41 percent – Medically unnecessary, or no or insufficient documentation; and
- 17 percent – Other.

Utilizing this information, you have an opportunity to prepare for RAC reviews that will ultimately affect hospitals in every state. RACs will have the ability to review claims that are up to three years old, but may not review claims with a paid date prior to October 1, 2007. As a result, hospitals have a valuable opportunity to proactively ensure the accuracy of their admissions, discharges, record documentation as well as coding and billing practices to minimize the risk of RAC denials.

Hospitals in Wisconsin can benefit from lessons learned in the five demonstration states. Common examples of inpatient acute services that were the subject of significant review and denial activity by RACs during the demonstration, which varied by state, are summarized below:

Short-stay Claims. Short-stay claims were targeted by the RACs in Florida and New York. These RACs specifically sought out short-stay claims in an attempt to validate whether the admissions met Medicare’s medical necessity criteria. Some hospitals affected by a high rate of short-stay claims denials experienced significant Medicare recoupment. Large numbers of one-day stays were denied based on RAC determinations that the cases should not have been admitted for inpatient care because they were clinically appropriate for outpatient observation or other less-intensive care. One-day stays by chest pain patients are an example of a short-stay condition targeted by RACs.

Many three-day stays were denied based on RAC findings that they were inappropriately extended in order to qualify a beneficiary for Medicare Part A coverage of post-acute skilled nursing care. Medicare rules allow patients to qualify for up to 100 days of skilled nursing care after at least three days as a medically necessary inpatient in an acute-care hospital. Observation days do not count toward the three-day requirement.

Debridement. RACs have targeted several debridement diagnosis-related groups (DRGs). Skin graft and/or debridement for skin ulcer or cellulitis cases (DRG 263/MSDRG 573) were cited for incorrect coding as “excisional” debridement, which was either not documented in the chart or the RAC believed was not justified by the medical chart. Cases of wound debridement and skin graft, exc. hand for musculoskeletal and connective tissue disease (DRG 217/MS-DRGs 463, 464 and 465) also were denied for being incorrectly coded at the “excisional” debridement level.

Back Pain. RACs found certain claims for medical back problems (DRG 243/MS-DRG 551) to be medically unnecessary if they determined the care could be provided on an outpatient basis and the patient was primarily admitted for three days in order to qualify for skilled nursing

coverage. Substantiating the medical necessity of an inpatient admission for treatment of back pain requires comprehensive documentation of all clinical and other complicating factors that require inpatient-level care.

Outpatient vs. Inpatient Surgeries. RACs are denying a host of procedures that are not found on Medicare's "inpatient-only list." If a procedure is on Medicare's inpatient list, the patient must be an inpatient at the time the procedure is performed in order to qualify for payment. For procedures not on Medicare's inpatient-only list, the physician must document a medical reason for performing the procedure on an inpatient basis. This documentation, including lab results, X-rays and any failed outpatient procedures, must become part of the patient's permanent medical record to justify the medical necessity of inpatient surgery.

Transfer Patients. RACs also have targeted inpatients discharged to another hospital or post-acute provider where the hospital received a full DRG payment rather than the per-diem payment associated with transfers.

Tools to Address RAC Inpatient Target Areas

To minimize the risk of RAC audit, hospitals should take steps now to ensure the highest level of admission and claim accuracy. The methods below have been used successfully by hospitals to conduct process improvements to minimize Medicare denials. Your hospital may already have some of these systems and protocols in place. However, you may wish to revisit them with a focus on the patterns of denials that emerged during the RAC demonstrations.

Conduct a Self-assessment of RAC Risk. Many hospitals are conducting a risk self assessment to identify error-prone claims identified by the RACs. This process and other RAC activities are often overseen by an interdisciplinary RAC team. The process improvements outlined below can help you identify and correct the root causes of any identified errors:

- Review available data on claims, admissions, discharges, documentation, coding, billing and claims to identify any patterns of errors related to, for example, specific DRGs, admission level of care, readmissions within 24 hours, discharge status codes, particular specialties or groups of contract providers.
- Audit a sample of cases associated with patterns of errors to identify the scope of the problem (OIG's Corporate Integrity Agreement Guidance for Compliance Programs suggests a probe sample of 50. Be prepared to conduct a statistically valid audit should your error rate exceed the OIG's suggested 5% error threshold).
- Share the findings of your audit with key clinical, financial, compliance, legal counsel, coding, billing and medical records staff. Use this cross-department team to review your audit findings to identify the root causes for any identified errors.
- Develop and implement a corrective action plan to address and change the root causes and thereby prevent avoidable errors.
- Monitor new or revised protocols periodically to assess their effectiveness, and modify as needed.

Additional auditing tools and resources can be found at the Association of Healthcare Internal Auditors (AHIA) website at <http://www.ahia.org/auditsurvey.shtml>.

QIO Resources for RAC Preparation. CMS-contracted Quality Improvement Organizations (QIOs) have developed a wide array of resources to help hospitals improve claims and payment accuracy. While it appears their role is changing under a new CMS contract that begins in August 2008, QIOs remain a valuable source of online materials and recommendations related to payment accuracy. Wisconsin's QIO is Metastar. To learn about Metastar's provider education material available through July 2008, contact them at <http://www.metastar.com>.

Examples of resources available to address areas targeted by the RACs include several tools developed by the Texas QIO, TMF Health Quality Institute (TMF). These tools are available free of charge as part of the Medicare program at <http://hpmp.tmfhqj.net>. In addition, the CMS Web site, <http://www.hpmpresources.org>, provides a list of successful payment accuracy improvement initiatives in 25 states, which can be replicated by other hospitals.

Utilization Review and Case Management. Utilization review committees and case management teams play critical compliance and process improvement roles. You may want to consider these both for proactive and ongoing RAC preparation. While many of the methods summarized below are based on common process improvement principles, they should be given special consideration as RAC tools since they have been successful in reducing Medicare denials. Some of these strategies may be appropriate for your hospital depending on the outcome of your RAC self-audit:

- Develop a watch list of particular error-prone DRGs, such as short-stay cases and cases that are eligible for both outlier and inpatient payment.
- Authorize case management to assess incoming patients at all entry points into the hospital, including the emergency department, day surgery units and direct admissions on a 24-hour-a-day, seven-days-per-week basis. Under this model, admission screening criteria can be used to assess medical necessity for all incoming patients.
- Use special forms, such as TMF's "One-Day Stay Inpatient Audit Tool" (Appendix A), a one-page audit checklist that helps validate whether a patient's admission is medically necessary. This tool helps hospitals route patients to the medically appropriate setting, highlights key admission screening criteria, and includes guidance on appropriate medical necessity documentation, billing and coding.
- Communicate changes in patient status through appropriate documentation that justifies the changes. This has reduced RAC denials related to documentation and medical necessity. The TMF "Status Change Matrix Tool" (Appendix B) highlights necessary clinical criteria, signatures, dated orders, medical record documentation, billing/payment changes and other necessary actions that must be reviewed if a patient's status changes.
- Implement an "admit-to-case management" program to reduce one-day stays through closer monitoring of admissions. As part of this effort, some hospitals include clinical vignettes in each medical chart to support a patient's correct admission status.

Physician Education on RAC Risks. As physicians play a critical role in referring and admitting patients, hospitals must ensure they are educated about RACs, including the top admission and documentation problems identified by your RAC self-assessment. Consider these RAC resources for physicians:

- The “Medicare Outpatient Observation: Physician Guidelines” tool (Appendix C) clarifies for physicians the Medicare rules distinguishing inpatient admissions from outpatient observations. This tool can be customized by hospitals to match their priorities and state regulations.
- The “Chest Pain: Observation vs. Inpatient” decision tree (Appendix D) helps physicians determine if chest pain patients need observation only or a full inpatient admission. The tool highlights key risk factors that tend to influence the admission versus observation decision for chest pain patients. It is consistent with Medicare compliance guidelines and includes reminders for appropriate medical necessity documentation.

To decrease the rate of Medicare denials, the process improvement tools and methods above have been used to target common causes of claims and admissions errors, including:

- The lack of seven-day-per-week/24-hour availability of case management to review medical necessity of hospital admissions.
- The lack of seven-day-per-week/24-hour availability of a physician to support admission screening.
- Inadequate training and re-training of physicians and other clinicians reviewing admissions.
- The lack of periodic quality assessment of admission review protocols to ensure effectiveness and consistency across hospital departments.

Identifying Other Potential RAC Vulnerabilities for Your Hospital

Thus far, CMS has failed to conduct provider education based on experience of the RAC program such as how to prevent payment errors identified in the demonstration. Therefore, it is critical that hospitals proactively use the data resources available to assess and mitigate risk. RACs use several data resources, including the tools summarized below, to focus their audit activities on the most error-prone claims. Your hospital can use the same data to help you focus your performance improvement efforts towards your greatest risks related to medically unnecessary admissions, discharges, documentation, or coding and billing errors.

PEPPER. A key tool in assessing your hospital’s claim accuracy is the Program for Evaluating Payment Patterns Report (PEPPER), a provider-specific report (Appendix E). Today, each QIO prepares and distributes a PEPPER to each hospital in its state. It remains unclear which CMS entity will generate PEPPERS upon completion of the current CMS-QIO contract.

PEPPER identifies claims patterns that are considered outliers relative to other hospitals within your state. It also provides a “Top 20” list of DRGs that are prone to certain billing errors as well as other problem areas, which vary by state.

PEPPER data can be assessed in combination with additional hospital data for the same corresponding time period. This additional information helps hospitals understand the scope of problem areas relative to the hospital’s total operations. Tracking such data over time is helpful in identifying seasonal or other patterns and deviations, including:

- Total medical inpatient admissions;
- Total outpatient observation admissions;
- Observation admissions as a percent of total admissions;
- Number of DRGs in the 75th or greater percentile for all hospital admissions; and
- Number of DRGs that have shifted more than 25 percentile points over the prior two periods.

If your hospital is not accessing its PEPPER on a regular basis, contact your QIO (Metastar) immediately for assistance. (<http://www.metastar.com/web/Default.aspx?tabid=119>)

RTP Reason Codes Hospitals should be reviewing their RTPs and claim denials for potential billing risks. There can be many reasons to have a claim RTP'd. One of the reasons for the RTPs/denials may be linked to errors on hospital charge description masters. Wisconsin's fiscal intermediary UGS/NGS posts quarterly top 10 reason code descriptions for claims denial on their website. Those reports can be found at http://www.ugsmedicare.com/provider_education/information/reason_codes.asp

CMS Payment Reports. Every year, CMS studies a national sample of Medicare claims to identify the most common types of billing errors made by hospitals and other providers. The most recent data can be found on the CMS website at https://www.cms.hhs.gov/apps/er_report/index.asp. The table below highlights the diagnoses with the highest rates of medically unnecessary admissions, which accounted for \$3.5 billion of the errors identified by CMS contractors in 2007.

DRG / MS-DRG	Paid Claims Error Rate	Projected Improper Payments
CHEST PAIN (143)	20.1%	\$118,194,148
MEDICAL BACK PROB (243)	15.5%	\$58,879,136
ESOPH, GASTROENT & MISC DIG DISOR AGE >17 W CC (182)	11.9%	\$164,182,142
NUTR & MISC METAB DISOR AGE >17 W CC (296)	10.7%	\$99,252,860
CIRC DISOR EXC AMI, W CAR CATH W/O COMPL DIAG (125)	9.8%	\$45,758,977
OTH CIRC SYS OR PROC (120)	9.6%	\$42,310,159
DIABETES AGE >35 (294)	9.2%	\$35,996,770
SYNCOPE & COLLAPSE W CC (141)	8.1%	\$39,879,723
CAR DEFIBRILLATOR IMPL W/O CAR CATH (515)	8.0%	\$145,493,621
Blood glucose/reagent strips (A4253)	7.9%	\$80,823,935
OTH VAS PROC W CC W/O MAJ CV DX (554)	5.5%	\$51,440,246
RENAL FAILURE (316)	4.9%	\$82,828,870
KIDNEY & URIN TRACT INFECT AGE >17 W CC (320)	4.1%	\$42,156,470
SNF-inpatient or home health visits (Part B only) (22)	3.3%	\$44,616,705
EXT OR PROC UNREL TO PRINC DIAG (468)	3.2%	\$39,051,720
HEART FAILURE & SHOCK (127)	1.4%	\$47,473,236
Overall	1.3%	\$3,553,336,758

Source: Improper Medicare Fee-For-Service Payments Report - November 2007 Report

OIG Workplan and Compliance Program Guidance. Every year, the Office of Inspector General (OIG) under the Department of Health and Human Services (DHHS) produces a publication that describes activities that the OIG plans to initiate or continue to address with respect to the programs and operations of DHHS.

The OIG Work Plan addresses issues related to the Centers for Medicare & Medicaid Services program featuring work related to such issues as integrity of Medicare and Medicaid payments, prescription drug costs, and quality of care in long term care settings to name a few.

The 2008 OIG workplan can be found online at

http://oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf.

The OIG also has published Compliance Program Guidance (CPG) for hospitals. This document provides voluntary guidelines to assist hospitals and health systems in identifying significant risk areas and in evaluating and, as necessary, refining ongoing compliance efforts.

The latest OIG CPG can be found online at

<http://www.oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>

AHA Advisories. The American Hospital Association (AHA) has been following the development of the RAC Program very closely and has developed resources to help hospitals prepare. This information can be reviewed at

<http://www.aha.org/aha/issues/RAC/resources.html>.

The AHA is also developing a tool called RACTrac, a Web-based national advocacy survey tool that will ask hospitals to report their RAC experience on a quarterly basis. AHA also offers a basic Excel template to help hospitals track claims to respond to the RACTrac survey. This template and other tools will be available soon at www.AHARACTrac.org, with data collection beginning this fall. AHA will use the aggregate data from RACTrac to identify trends and to advocate for needed changes to the program.

WHA Information. The Wisconsin Hospital Association, with the help of its RAC Taskforce has information on its website to help hospitals prepare for the RAC Program. This information is available at <http://www.wha.org/governmentRelations/rac.aspx>.

Wisconsin Hospitals “Best Practices” for Billing Compliance

Given the diversity of the hospital industry, there is no single “best” hospital compliance program. The hospital industry is very complex and there are many differences among hospitals and hospital systems. Some hospital entities are small and may have limited resources to devote to compliance measures; others are affiliated with well-established, large, multi-facility organizations with a widely dispersed work force and significant resources to devote to compliance.

Accordingly, the information provided is not intended to be one-size-fits-all. Rather, WHA, through the help of its RAC workgroup, is presenting information to help hospitals identify and focus their compliance efforts on those areas of potential concern or risk that are most relevant to

their individual organizations. Compliance measures adopted by a hospital to address identified risk areas should be tailored to fit the unique environment of the organization (including its structure, operations, resources, and prior enforcement experience). In short, each hospital should use this information to adapt the objectives and principles underlying these policies and procedures to its own particular circumstances.

Members of the WHA RAC workgroup contributed billing compliance charters, audit processes and policies that they use in their daily efforts to comply with billing issues. Also included are materials and policies to help with level of care assignments. Appendices F-K contain these documents, which hospitals can use and modify to fit their organization's needs.

Conclusion

This document and other RAC resources will be constantly evolving as the RAC program rolls out in Wisconsin. WHA will be working with the membership to help them as they continue their compliance efforts, respond to RAC requests and denials, and improve their processes. The WHA RAC Taskforce will be closely monitoring developments as they occur and will be providing feedback on issues as they develop.

TMF QIO's

One-Day Stay Inpatient Audit Tool



ONE-DAY INPATIENT STAY AUDIT TOOL							
Patient:		Admitting Diagnosis:		DOB:			
Attending Physician:		Reviewer:		MR #:			
Dates of Service:		Coder:		Date Reviewed:			
Was the patient initially admitted to observation status? If NO, skip to questions 5.				YES	NO	N/A	Measure
1	Does the medical record contain an order for observation status?						
2	Was the patient's condition/treatment appropriate for observation status (as opposed to outpatient or inpatient) at the time the patient was placed into observation?						
3	Does the medical record contain a physician's order to change the patient status to inpatient?						A2
4	If yes, does the order contain a time and date?						
5	Does the medical record contain an inpatient admission order for the date of admission?						A3
6	Was admission-screening criteria applied?						B2
	Was admission-screening criteria applied in a timely manner?						
7	Did the patient's condition/symptoms require treatment in an inpatient setting at the time of inpatient admission? If yes, describe the condition:						B1
8	Did the patient require treatment that could only be performed in the inpatient setting? If yes, list the treatment:						B1
9	Does the medical record contain physician documentation to support medical necessity of admission?						E1
10	If admitted for an inpatient procedure, list procedure:						
	Was the procedure medically necessary? If no, did the patient have other conditions and treatment requiring admission?						
11	Per non-physician review, did this appear to be an appropriate one-day inpatient stay? (If YES, stop here) (If NO, review case with physician and complete Question #13)						R1
12	Was the discharge billed with the appropriate status (observation vs one-day inpatient admission)?						D1
Physician Utilization Review				YES	NO	N/A	Measure
13	Per physician review, was this an appropriate one-day inpatient stay?						R1
	If NO, was outpatient observation status appropriate for this patient?						C1

TMF QIO's
Status Change Matrix
Sample Hospital Bed Request Form



STATUS CHANGE MATRIX

This tool is intended to be used as a guide for determining patient admission status, documentation needed, and potential effect on payment only and does not address all possible situations that may arise.

Status change	Criteria Required	Signed/ Dated Order Required?	Additional Medical Record Documentation Required	Payment Affected by Status Change?	Notes
Observation to Inpatient	IP screening criteria	Yes	Medical necessity for IP admission	¹ Yes	¹ CMS Claims Processing Manual, Ch. 3, Sec. 40.3
Observation to Outpatient Surgery/Procedure	Medical necessity for OP procedure	Yes	Medical necessity for procedure	Yes	
Outpatient to Inpatient	IP screening criteria	Yes	Medical necessity for IP admission	Yes	
Outpatient (ER, chemo, PT, etc.) to Observation	Observation criteria	Yes	² Support for need for observation	³ Maybe	² FR vol. 69, No 219, p. 65828-31, Sec. D ³ Additional payment for observation dx of asthma, CP, or CHF
Outpatient (ER, chemo, PT, etc.) to Outpatient Surgery/Procedure	Medical necessity for OP procedure	Yes	Medical necessity for procedure	⁴ Yes	⁴ CMS Manual 100-4, Ch. 4, Sec. 10.5
Outpatient Surgery to Inpatient	IP screening criteria (surgery complication)	Yes	Medical necessity for IP admission	¹ Yes	¹ CMS Claims Processing Manual, Ch. 3, Sec. 40.3
Outpatient Surgery to Observation	Observation criteria	Yes	Support for need for observation	⁵ No	⁵ Elective documentation on claim for CMS info
Inpatient to Observation	Condition Code 44 Obs criteria (did not meet IP criteria)	Yes	⁶ Need for Obs UR Committee notes Physician concurrence with UR decision	⁷ Yes	⁶ MLN Matters #SE 0622 ⁷ CMS Change Request CR 3444

Originally created and published by New Mexico Medical Review Association. Revised by TMF Health Quality Institute 08/2006.

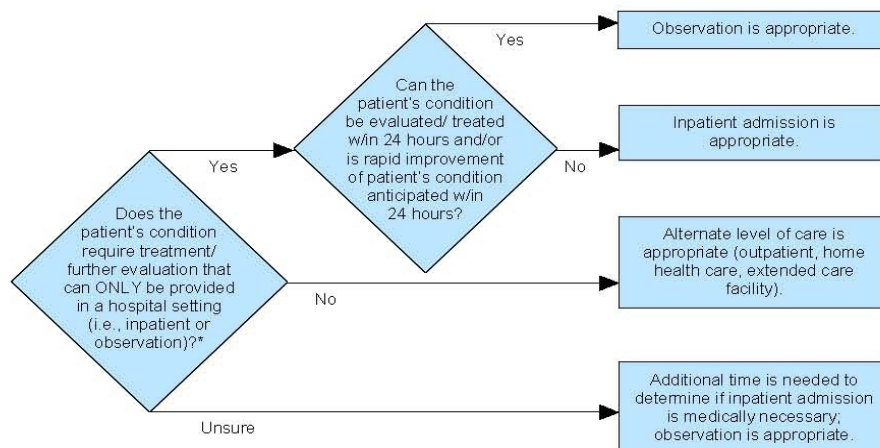
This material was prepared by TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
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TMF QIO Physician Tool: Medicare Observation vs. Inpatient Admission

MEDICARE PATIENTS: Observation or Inpatient Admission?



To aid the physician in determining when observation may be appropriate, TMF Health Quality Institute (TMF) has developed a decision tree outlining the thought process for determining whether observation or inpatient admission is appropriate. TMF hopes that this tool will be valuable to physicians when having to make this decision.



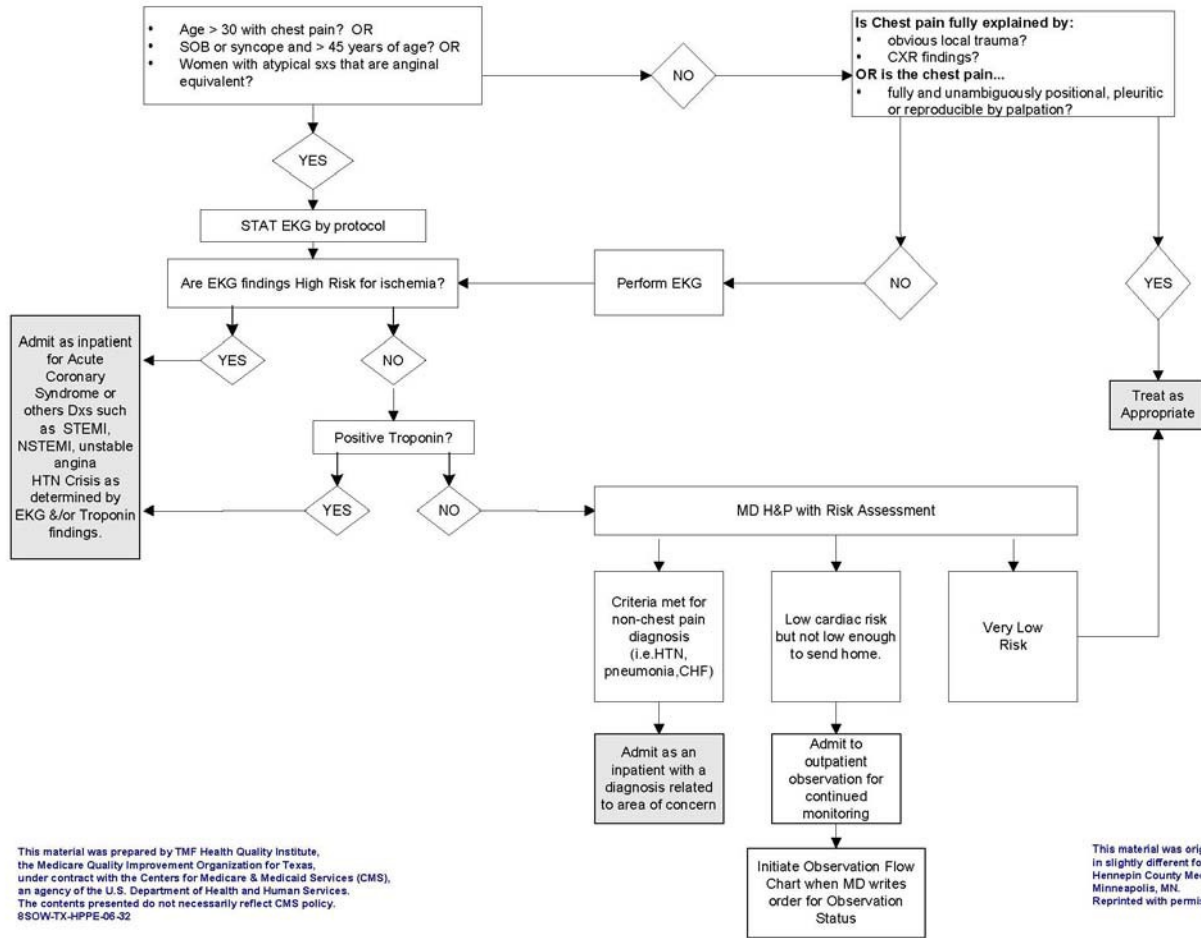
* The decision to admit a patient as an inpatient requires complex medical judgment including consideration of the patient's medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents.

Key Points to Remember:

- Outpatient observation services are reimbursed under the Outpatient Prospective Payment System.
- Using outpatient observation as an alternative to admission will allow you time to determine if admission is necessary, reduce denials for unnecessary admissions and ensure that some payment is received for services rendered.
- Care in outpatient observation can be the same as inpatient care, but reimbursement is different. Patients with chest pain, CHF and asthma are paid under specific observation Ambulatory Payment Classifications (APCs). Payment for all other conditions is bundled into the APC package.
- An order simply documented as "admit" will be treated as an inpatient admission. A clearly worded order such as "inpatient admission" or "place patient in outpatient observation" will ensure appropriate patient care and prevent hospital billing errors.
- Medicare coverage for observation services requires at least eight hours of monitoring and is limited to no more than 48 hours unless the fiscal intermediary grants an exception. The hospital is only reimbursed for 24 hours. The clock starts with the nurse's note reflecting initiation of observation care/arrival to observation site. The clock ends with staff sign-off of the discharge order and when all clinical or medical interventions have been completed.
- An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.
- **Hospitals can convert and bill an inpatient case as an outpatient if the hospital utilization review committee determines before the patient is discharged and prior to billing that this setting would have been more appropriate.** A physician must concur with the decision of the committee, and the physician's concurrence and status change must be documented in the medical record.
- Services that do not qualify for outpatient observation include services for convenience reasons, routine prep for and recovery after diagnostic testing, certain therapeutic services, normal post-procedure recovery time (4-6 hours) and procedures designated as "inpatient only" or that are inappropriate as inpatient.
- Documentation must support the level of care provided (inpatient admission versus outpatient observation).

TMF QIO Decision Tree: Observation vs. Inpatient Admission

Algorithm For Chest Pain Patients Observation Status vs. Inpatient Admission



This material was prepared by TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-TX-HPPE-06-32

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Sample State PEPPER Report

HPMP Administrative Reports of

X X Any State PPS Hospitals for

One-Day Stay Top 20 DRGs

Statewide Top 20 DRGs for One-Day Stay Discharges* in Q3 FY 2005

In Descending Order by One-Day Stay Totals Per DRG

DRG	DRG Description	One-Day Stay Count	Total Discharge s for DRG	Proportion of One-Day Stays to Total Discharges	Statewide Average Length of Stay for DRG
527	Percutaneous cardiovascular proc w drug-eluting stent w/o	6,930	10,565	65.6%	2.1
143	Chest pain	5,061	13,141	38.5%	2.4
127	Heart failure & shock	1,473	31,820	4.6%	6.2
125	Circulatory disorders except AMI, w card cath w/o complex	1,205	3,258	37.0%	2.9
182	Esophagitis, gastroent & misc digest disorders age >17 w	1,202	13,256	9.1%	5.5
142	Syncope & collapse w/o CC	1,137	4,488	25.3%	3.0
534	Extracranial procedures w/o CC	1,136	1,643	69.1%	1.8
116	Other permanent cardiac pacemaker implant	1,112	4,906	22.7%	5.4
141	Syncope & collapse w CC	1,097	8,255	13.3%	4.3
139	Cardiac arrhythmia & conduction disorders w/o CC	1,072	4,022	26.7%	2.9
183	Esophagitis, gastroent & misc digest disorders age >17 w/o	1,006	4,461	22.6%	3.3
088	Chronic obstructive pulmonary disease	953	19,367	4.9%	5.7
138	Cardiac arrhythmia & conduction disorders w CC	947	9,429	10.0%	5.0
395	Red blood cell disorders age >17	927	5,625	16.5%	4.9
294	Diabetes age >35	804	6,484	12.4%	5.0
296	Nutritional & misc metabolic disorders age >17 w CC	793	11,661	6.8%	6.2
518	Percutaneous cardiovasc proc w/o coronary artery stent or	749	2,112	35.5%	4.4
132	Atherosclerosis w CC	722	5,615	12.9%	3.3
124	Circulatory disorders except AMI, w card cath & complex	691	4,347	15.9%	5.2
524	Transient ischemia	688	5,538	12.4%	4.1
Top 20 DRGs Statewide		29,705	169,993	17.5%	4.7
All DRGs Statewide		61,263	561,945	10.9%	6.7

* Excludes deaths, transfers and leaves against medical advice.

Note that some DRGs changed for FY 2005. The User's Guide cites source for more detailed

Sample Hospital Compliance Department Charter Audit Services

Mission:

The mission of the Compliance Department as it relates to audit services is to provide independent, objective assurance and consulting services designed to enhance and improve compliance with state and federal statutes and regulations related to coding and billing conducted by Sample Hospital.

Scope:

The scope of the Compliance Department's audit services is to determine whether the organization's network of risk management, control, and governance processes, as designed and represented by management, is adequate and functioning in a manner to ensure that:

- Risks are appropriately identified and managed.
- Significant legislative or regulatory issues impacting the organization are recognized and addressed appropriately.
- Employee's actions are in compliance with policies, standards, procedures, and applicable laws and regulations.
- Interactions with various governance groups occur as needed.
- Quality and continuous improvement are fostered in the organization's control process.

Opportunities for improving management control, profitability, and the organization's image may be identified during audits. These opportunities will be communicated to the appropriate level of management.

Independence

To provide for the independence of auditing services, Compliance Department personnel report to the Chief Compliance Officer.

Authority

Compliance Department staff is *authorized* to:

- Have unrestricted access to all functions, records, property and personnel.
- Have full and free access to the Compliance Work Group and Compliance Oversight Committees
- Obtain the necessary assistance of personnel in units of the organization where they perform audits, as well as other specialized services from within or outside of the organization
- Allocate resources, set frequencies, select subjects, determine scopes of work, and apply the techniques required to accomplish audit objectives

Accountability

The Compliance Department shall be accountable to the Compliance Work Group to:

- Report significant issues related to the processes for controlling the activities of the organization and its affiliates, including potential improvements to those processes, and provide information concerning such issues through resolution.
- Provide annually an assessment on the effectiveness of the organization's processes for controlling its activities and managing its risks in the areas set forth under the mission and scope of this Charter.
- Periodically provide information on the status and results of the annual proactive audit plan and the sufficiency of department resources to complete that plan.
- Coordinate with and provide oversight of other controls and monitoring functions such as Risk Management, Utilization Management, Health Information Management, Legal, Finance.

Responsibility

The Compliance Department staff has the responsibility to:

- Develop a flexible annual audit plan using the Office of Inspector General's Annual Work Plan as guidance. Plan should include any concerns identified by management. The audit plan will be submitted to the Compliance Work Group for review and approval.
- Implement the annual audit plan, as approved, including as appropriate any special tasks or projects requested by the Compliance Work Group.
- Assist in the investigation of significant suspected fraudulent activities within the organization and notify appropriate management, the Compliance Work Group and the Compliance Oversight Committee of the results.
- Evaluate and assess new or changing services, processes, operations and controls in the development, implementation and/or expansion of services provided by Sample Hospital.
- Assess procedures and records as to their adequacy for accomplishing intended objectives within an activity or function under audit review.
- Maintain a professional audit staff with sufficient knowledge, skills, experience and professional certifications to meet the requirements of this Charter.
- Consider the scope of work of the external auditors and regulators, as appropriate for the purpose of providing optimal audit coverage to the organization at a reasonable overall cost.
- Issue periodic reports to the Compliance Work Group, Compliance Oversight Committee and management summarizing results of audit services as well as keeping them informed of emerging trends in the practice of internal auditing.
- Appraise the adequacy of the actions taken by operating management to correct reported deficient conditions.

Associated Policies:

Compliance Audit Standards

Compliance Audit Process – Standard Operating Procedure

Approved by Compliance Workgroup on July 7, 2006.

Sample Hospital

Compliance Program – Process Control Document

Audit Process

Applicable to:

This process applies to Sample Hospital.

Purpose:

The purpose of this process is to verify compliance with internal and external coding and billing related guidelines and regulations as published by Sample Hospital, the Centers for Medicare and Medicaid Services, the Department of Health and Family Services, the Office of Inspector General and JCAHO.

This process acts as a guideline for developing and conducting either data or process related compliance audits based on both regulatory and financial risk to Sample Hospital.

Compliance Issue Tracking Database:

All audits performed by the Compliance Department are entered into the Compliance Issues Tracking Database that provides Compliance Department staff with a centralized and confidential means of documenting, tracking and reporting compliance issues. The database houses all compliance issues, reactive and proactive audits as well as research projects. The database allows staff to closely monitor projects so that direction, education and support can be provided with greater efficiency.

Risk Assessment:

Risk to Sample Hospital is determined through the review of various resources including but not limited to the Office of Inspector General's Annual Work Plan, CMS Updates and Coverage Determinations, professional journals and publications, as well as through assessment of Sample Hospital's internal processes. Please refer to policy Compliance Auditing Standards for information regarding prioritization of audits.

AUDIT PROCEDURE**Determine the area and scope of the audit**

1. Proactive or Reactive audits are determined and prioritized based on the Compliance Auditing Standards Policy
2. Audits may also be prioritized and conducted at the request of department leadership

Meet with department leadership

1. Introduce the department leadership to the Compliance Department and staff
2. Share with department leadership the purpose and goals of the review
3. Provide the department leadership with an outline and timeline of the audit process
4. Identify any concerns the department leadership may have
5. Identify department contact in which the Compliance Specialist will communicate, arrange interviews and conduct site visits.

Audit Development

1. Conducted on both reactive and proactive issues
2. Conducted either concurrently or retroactively
3. Audit scope is determined based on type of audit and data sample size
4. Audit tool is developed based on type and size of audit
5. Standard probe audit sample is 50 records per 12 month time period
6. Probe sample is pulled by one of the following methods:
 - a. Random intermittent sample determined by dividing probe sample volume by total sample size
 - b. Utilization of the Office of Audit Services Statistical Sampling Software; RAT-STATS

Conducting the Audit

1. Review all internal policies and procedures as well as applicable official guidelines to understand all aspects of the audit to be conducted
2. Interview staff and observe processes
3. Pull audit data and review
4. Determine error percentage based on dollars verses volumes

Audit Results

1. If the error percentage is less than 5% (this percentage is based on the Office of Inspector General's Corporate Integrity Agreement Guidance) individual refunds are made in the event we received reimbursement that we were not entitled to and the summary of findings are reported to the stakeholders including department leadership and the Compliance Workgroup and Oversight Committees.
2. Error percentage of 5% or above requires the completion of a statistically valid audit going back no further than four (4) calendar years (42 C.F.R. §405.300). Consultant(s) are occasionally utilized to assist in establishing a statistically valid audit sample.
3. Upon completion of the statistically valid audit, results are submitted to the contracted consultant who will extrapolate the findings against the entire data population to determine an overpayment amount within a 90% confidence and 25% precision level, except as otherwise approved by the Compliance Work Group.

- i. Refunds are calculated based on actual payments received if actual payment information is available, or,
- ii. Calculated on the Medicare Fee Schedule amount for the year in which the service was provided

Resulting and Reporting

Reporting of audit results are submitted to the Compliance Workgroup and Compliance Oversight Committee through the Director of Compliance. All results are protected under attorney/client privilege. The Director of Compliance and the Compliance Workgroup and/or Compliance Oversight Committee will determine any additional communication of results.

1. Summary of findings report is prepared for submission to the Director of Compliance and the Compliance Workgroup.
2. Based on findings, a department corrective action plan will be developed indicating Compliance recommendations
3. Meet with department leadership to review findings and initiate department corrective action plan.
4. Obtain department feedback to prepare final report.
5. Submit all refunds based on audit results.

Corrective Action Plan

1. Corrective Action Plan developed based on the audit results and documented in a spreadsheet
2. Educate department on changes or updates to process as needed
3. Assist the department with the implementation of changes as necessary
4. Assist in the development of self auditing and monitoring methods
5. Verify the completion and implementation of all components of the corrective action plan
6. Schedule follow-up monitoring audits at 6 months and 12 months respectively.

Annual Reporting

All audits, either reactive or proactive, are reported to the Compliance Oversight Committee on a quarterly basis with an annual report submitted to the Compliance Oversight Committee, the Board of Directors and Board of Trustees.

Storage of Data

All closed proactive and reactive project data including working papers, data files, summary reports, refund checks, communications and corrective action plans are stored either electronically or in paper format for ten (10) years. Any audit files in paper format that are older than three (3) years are placed in off site storage.

Associated Policies:

Compliance Audit Standards

Compliance Audit Charter

Process approved by the Compliance Workgroup on ____July 7, 2006_____
(date)

Next Scheduled Review: 6/1/2008

Sample Hospital

Policy

Subject:	Compliance Audit Standards	Index Number:	
Type:	Corporate	Original Date:	05/25/2004
Section:	Compliance and Ethics	Last Revised:	11/06/2006 12:15:13 PM
Subsection:	General	Last Reviewed:	11/06/2006 12:15:13 PM
Category:	Policy	Next Review:	11/06/2009
		Contact:	

References

Office of the Inspector General Program Guidance for Hospitals, February 23, 1998.

Applicable To

This policy applies to all Compliance Department employees and other staff of Sample Hospital conducting audits relating to the Compliance Program.

Policy

It is the policy of Sample Hospital to have a Compliance Program that establishes effective internal controls that promote adherence to applicable federal and state laws and the program requirements of federal, state, and private health plans. An important component of the Compliance Program is the use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.

Sample Hospital recognizes the need for internal controls, but also realizes that resources are limited. Therefore, this policy focuses on Sample Hospital's resources to effectively and efficiently audit risk areas.

Implementation

The Chief Compliance Officer, or his/her designees, will recommend and facilitate auditing of identified risk areas related to compliance with laws and regulations as well as organizational policies, procedures and standards of conduct. Risk areas may be identified through the regular course of business, external alerts or internal reporting channels.

In order to prioritize compliance audits, the Chief Compliance Officer, or his/her designees, will assess the risk level based on both the regulatory and financial risk to Sample Hospital. Audits assessed as a high risk shall be given a higher priority than those assessed as a medium or low risk. The following table serves as a guideline to assess the risk level:

Assessing the level of risk:

HIGH RISK

1. The OIG Work Plan is evaluated, prioritized and assigned annually to the appropriate person(s) or department(s) for follow-up and documented resolution.
2. New initiatives, programs, rules and regulations will be monitored.
3. Suspicious AR activity (CPT, ICD-9, APC, DRG, denial management, account reviews through customer service calls, etc.)
4. Reported issue(s) in violation of Sample Hospital's Standards of Conduct.
5. Reported issue(s) through the Sample Hospital's Compliance Hotline
6. Reported issue(s) by outgoing staff obtained during the exit survey process

MEDIUM RISK

7. Staff believe there may be an issue worthy of investigation
8. Issues from the past that resurface
9. Data suggesting a potential issue

LOW RISK

10. Enforcement of disciplinary actions resulting from compliance violations
11. Review of internal processes and procedures

Audit Process:

Generally, the audit process shall adhere to the following format:

1. Determine the focus of the audit
2. Determine the sample size:
 - Often based on risk and complexity of the reported issue
 - Utilize sample size calculator available at:
<http://www.researchinfo.com/docs/calculators/samplesize.cfm>
3. Determine and define the data elements of the audit
4. Collect the data
5. Analyze the data for results
6. Report results as described below
7. Develop action plan (educate, change process, etc.)
8. Maintenance and follow-up as necessary

Audits shall be conducted by internal or external auditors as deemed appropriate by the Chief Compliance Officer or his/her designees. The auditing process may include the following techniques: on-site visits; interviews; review of written materials and documentation; trend analysis studies; and questionnaires

Reporting Process:

Audit results are reported to the Compliance Work Group through the Chief Compliance Officer. All results are protected under attorney/client privilege. The Chief Compliance Officer, or his/her designees, shall also be responsible for periodic reporting on no less than an annual basis to the Compliance Oversight Committee and the Board of Governors and Board of Trustees. Such reporting shall include the general status and outcome of compliance auditing as well as the outcome of specific audits as deemed appropriate by the Chief Compliance Officer and/or the Compliance Work Group.

Related Documents

Compliance Audit Process - Process Control Documents - July, 2006,
Compliance Department Charter - July_2006
(see Appendix F and G)

Forms Required

None

Attachments

Approver Signatures:

Signed by:

11/02/2006 07:47:53 PM

Signed by

11/06/2006 11:17:22 AM

Signed by

11/06/2006 12:06:06 PM

Signed by

The following URL will link directly to this policy:

END OF DOCUMENT

PROJECT ASSESSMENT & DEFINITION TEMPLATE
What Are We Trying to Accomplish?

Project Title: UMS in ARCC
Date: December 07
Project owner/sponsor:
Submitted by:

Project Purpose: To design a pilot program whereby UMS staff is involved (and physically located in the Admission/Referral Coordination Center for pre-determined days/hours) in assisting with initial level of care assignment on all unplanned hospital admissions.

In Scope: Unplanned hospital admissions

Out of Scope: Planned hospital admissions and continued stay reviews

Background:

In mid-2004, "Hospital" was contacted by Metastar, the Quality Improvement Organization for CMS and notified that "Hospital" was an outlier in WI for one day stays in the hospital. Metastar conducted a focus review of a sample, to see if all patients with one-day stays were medically necessary to be hospital inpatients. Metastar found that % of the records reviewed were not medically necessary and that these patients could have been on observation status or taken care of at another facility.

The Provider Medical Management Committee thought we could impact this issue by educating doctors and other healthcare providers about medical necessity criteria and level of care determinations. We, as a facility, are obligated to provide the patient with a letter of non-coverage (HINN) when we determine that Medicare may not pay for the stay in the hospital as an inpatient. An advanced beneficiary notice (ABN) will be given if we determine that Medicare may not pay for observation level of care. We implemented an ABN policy/procedure in January 2006.

In October 2004, Medicare regulations changed and allowed a patient's level of care to be changed from inpatient to outpatient, with a physician order written while the patient is still in the hospital (Code 44).

UM Services started reviewing Medicare medical admissions through TEC on 11/15/04. In March 2005 we increased that review to 100% of all government payer admissions. We focused on one-day inpatient stays, reviewing all to assure they met medical necessity criteria for inpatient level of care. If medical necessity was not found, UMS intervened to improve the documentation, change the level of care, or authorize a no-pay bill. Mid-2005 we initiated review of the surgery schedule to verify that government payer patients were scheduled appropriately as inpatient or outpatient, using the Medicare inpatient-only or outpatient-only lists. We continued individual and department-based medical staff education about level of care criteria for inpatient status and outpatient/observation status. Policy 6038 "Designation of Hospital Level of Care" was updated along with several decision trees to be used as quick references. In September 2005 the Executive Committee and the Administrative Services Team (AST) requested that Utilization Management Services expand their hours of availability to 24x7 to provide consultation and assistance to the medical staff in making level of care decisions. Two additional FTE were approved and recruitment initiated.

One FTE was hired in November 2006 and a second 0.8 FTE was hired in February 2007. Both are in process of completing their 12-month training program. In 2006 and 2007, Utilization Management Services expanded its hours of availability to 0600 to 2400, 7 days/week. We participated in the design and implementation of ARCC, providing level of care education to the ARCC Coordinators. As of May 2007 ARCC is assisting physicians with LOC determinations for patients referred/transferred to "Hospital". ARCC will begin to assist with TEC admissions in summer 2007.

The Compliance Risks of Under Use of Observation

CERT – Comprehensive Error Rate Testing (2004, \$19.9 billion in improper Medicare FFS payments; 17.2% due to medically unnecessary services; 43.7% due to insufficient documentation)

HPMP – Hospital Payment Error Monitoring Program (PEPPER-DRGs targeted in One-Day Stay Project)

RAC – Recovery Audit Contractors (2006-3 States, expanding; ID over- and under-payments; \$68.6 million in overpayments collected - \$14.5 million in cost = \$54.1 million back to Trust Funds)

The Financial and Patient Satisfaction Risks of Over Use of Observation

Very low Medicare payment to the hospital for services provided

Higher out of pocket expense to the patient

Loss of 3-day qualifying stay for SNF (Jan – August 2007: 22 potential cases at "Hospital")

Increased inpatient LOS and cost in public report cards

Stakeholders: Who are those people that will be impacted by changes you will make?

Utilization Management Services

PMM (Provider Medical Management) Committee

Patient Business Services

Medical Staff

Social Services

ARCC – Admission Referral Coordination Center

*** above information provided by Director in report to Compliance**

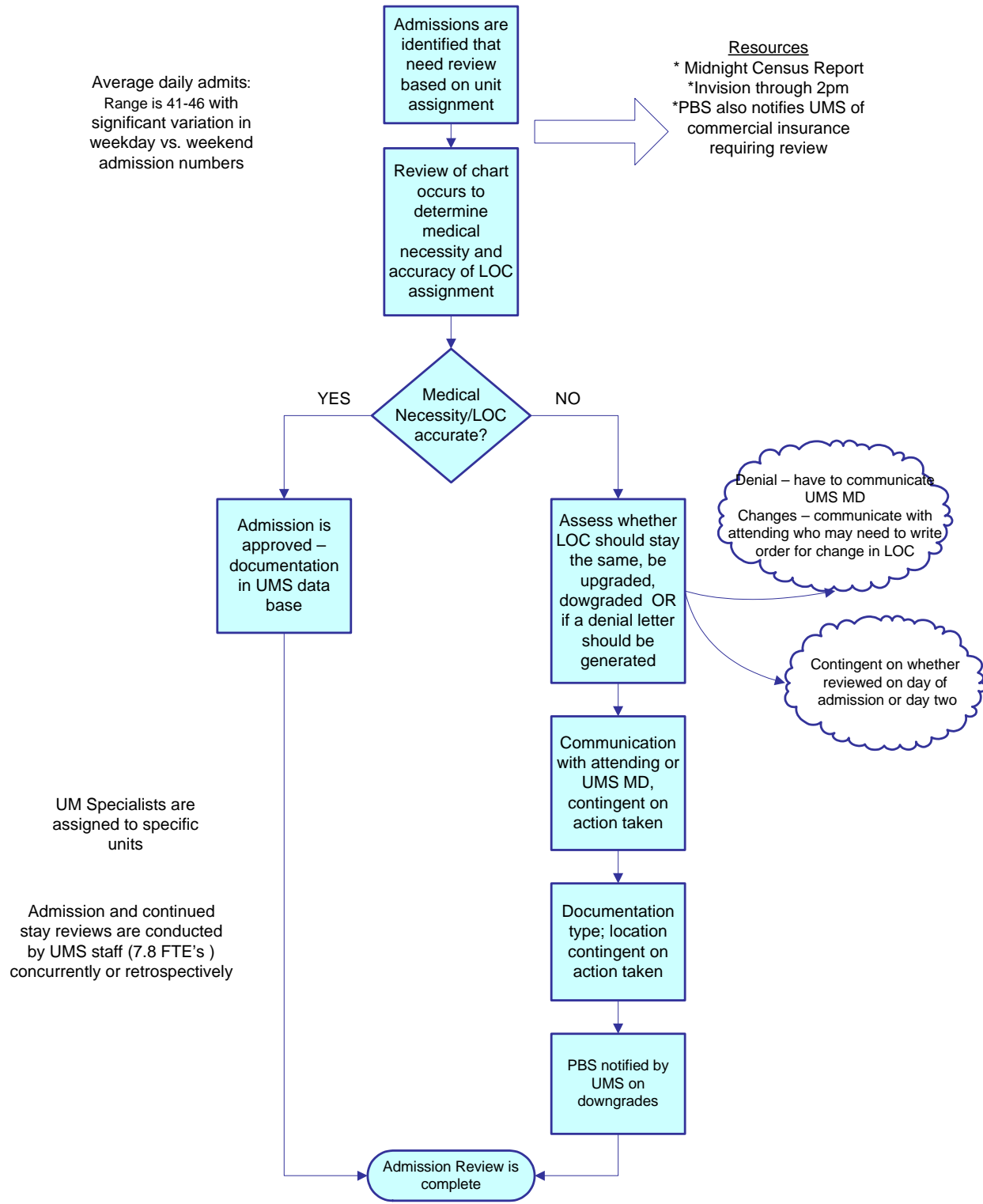
The Admission/Referral Coordination Center was designed as a new hospital operations department in 2006 as part of the Lean Inpatient Flow initiative. The Center went “live” operationally (phase 1/external referrals only) on April 24, 2007 with three part-time ARCC RN’s. They were educated in level of care assignment at that time, when the entire department and their job was brand new.

Now, nearly 9 months later, ARCC is operational with admission sources of external referrals, TEC, and internal unplanned admissions. January 08 is targeted as the timeline for implementation of planned admissions to be processed through ARCC as well. Since April 2007, ARCC has added 2 more permanent part-time ARCC RN’s and a float RN to cover the additional admission volumes. ARCC went from an initial call volume of 50-60 calls per week, to approximately 200 calls per week.

Current State:

See flow chart on next page

UMS Process for Admission Review Current State



Objectives: (all below objectives would be applicable only to the days that the UMS staff member is piloting in ARCC)

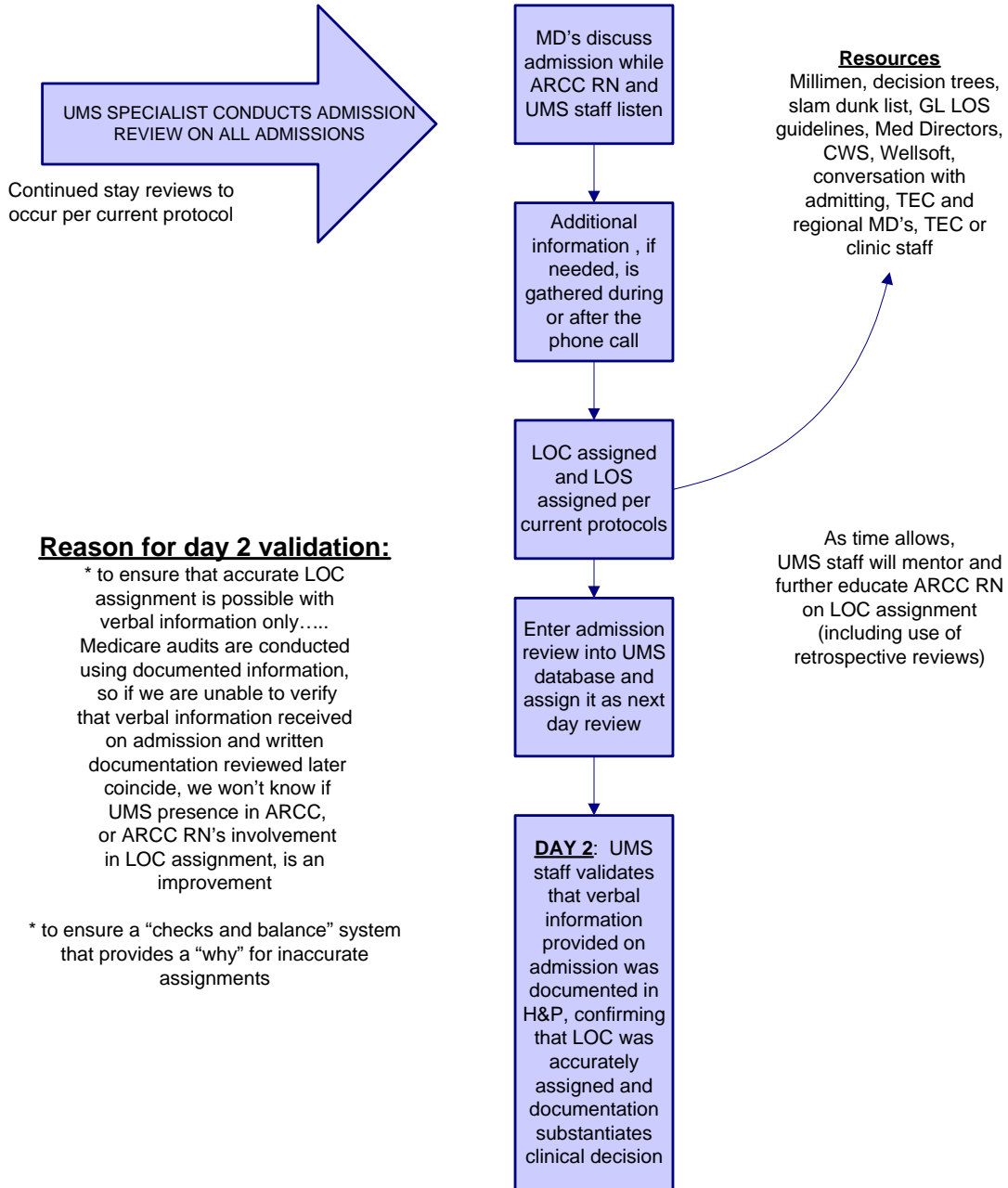
1. Increase accuracy of level of care assignment on admission by 15%
2. Decrease number of “missed interventions” in relation to inappropriate assignments of level of care by 15%
3. Decrease workload for UMS staff on hospital units by 15%
4. Increase frequency that documented information supports level of care assignment (by 15%)

How Will We Know That A Change Is An Improvement?					
Metrics & Measures: Based on your objectives, what will be your measures? Is there historical data available for baseline? Have you developed a mechanism to document improvement in the quality measures? Are the measures of quality both outcome and process focused?					
<u>Objective</u>	<u>Measure</u>	Baseline	Goal	Final Outcome	Units
Increase accuracy of level of care assignments on admission (government payer/one day stays)	Monthly total of inaccurate assignments of one day stays/government payer				
Decrease # missed interventions	Monthly total of missed interventions (H23's)				
Decrease # inappropriate upgrades/downgrades on the units (i.e. Initial reviews) due to inappropriate assignment of level of care	Monthly total of upgrades/downgrades on the units (interventions)				
Documentation supports level of care assignment	Log kept				

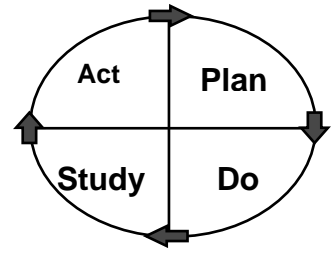
* = # admissions assigned inpatient level of care that should have been observation ** = # admissions assigned observation level of care that should have been inpatient

Future State:

**UMS PROCESS FOR ADMISSION REVIEW
FUTURE STATE/PILOT**



What Changes Can We Make That Will Result In Improvement?



Project Planning Grid

TASK	RESPONSIBLE PERSON	DUE DATE	COMMENTS
Determine hours/days of pilot			
Identify staff member who will be assigned to pilot this process			
Determine physical space for UMS staff in ARCC office			
Determine computer and phone needs for UMS staff			
Complete written description of work to be done by UMS staff on pilot days (clarify UMS role on phone calls; regional vs. internal calls)			
Train UMS staff member assigned to pilot this process			
Identify process for follow-up to provider issues			
Assess ARCC RN competency in level of care assignment <ol style="list-style-type: none"> 1. Complete Written General Skills Assessment 2. Determine how/when assessment will be given to RN's 3. Correct tests 			
Develop log for Jenny to track admissions she was involved in during pilot			
Develop log for 2 day validation of admission review			

Sample Hospital

Policy

Subject:	Hospital Level of Care Designation	Index Number:	
Type:	Corporate	Original Date:	02/07/2006
Section:	Patient Care	Last Reviewed:	
Subsection:	Admission/Discharge/Transfer	Next Review:	02/15/2009
Category:	Policy	Contact:	

References

Applicable To

All staff of “Clinic/Hospital” with privileges to admit patients.

Policy

The clinician writing a timed and dated order for placement in the hospital will be responsible for assigning the most appropriate level of care based upon assessment of the patient at the time of their presentation to the Medical Center. The clinician may choose an inpatient level of care (admit inpatient) or an outpatient level of care (place in observation) giving consideration to the signs, symptoms and diagnostic/treatment services required to establish an accurate diagnosis. **Medicare will not pay for Observation Level of Care services when the patient qualifies for inpatient level of care. Medicare will not pay for Inpatient Admission if the patient fails to meet acuity criteria and qualifies for observation.**

The staff of Utilization Services provide consultation and advice to clinicians regarding Level of Care. Currently the phone is covered Monday through Friday from 6:00 am to 6:00 pm, Saturday and Sunday 7:00 am to 5:00 pm. Coverage 24X7X365 is planned to begin July 2006.

Generally Appropriate for Observation Level of Care

Patients who require additional time for assessment beyond their Trauma and Emergency Center (TEC) visit (an anticipated several hour stay) might likely be appropriate for Observation Placement. Patients in an observation setting are assessed frequently to determine stability for discharge or need for inpatient admission. Examples of subsets of patients who might be placed in observation include:

- Adverse Drug Reactions
- Chest Pain (Medicare Observation acceptable if criteria met per flow sheet)
- Asthma (Medicare Observation acceptable if criteria met)
- Congestive Heart Failure (Medicare Observation acceptable if criteria met per flow sheet)

- Acute pain, etiology unknown
- Threatened labor
- Vomiting/Diarrhea/Mild Dehydration
- Syncope/Pre-syncope, etiology unknown
- Respiratory distress
- Post-ictal state, monitoring
- Post syncope cardiac monitoring
- Unexplained fever
- Hemodynamically stable GI bleeds
- Acute conditions requiring very short-term treatment

Generally Not Appropriate for Observation Level of Care

Hospital-based treatment does not constitute an order for “Observation” level of care.

- **Elective** administration of blood products or planned chemotherapy while a patient occupies a hospital bed does not justify billable “Observation” care. These are examples of **Outpatient Procedure**.
- **Outpatient Surgery Patients** go home the day of the procedure. A period of post-procedure recovery (usually up to 6 hours) is included in the global billing for outpatient surgical procedures.
- Patients with **significant post-procedure complications** may require admission to the hospital. Patients with minor ongoing post-procedure complications (protracted nausea and vomiting requiring IV fluids and/or anti-emetics) may be placed in observation for ongoing care in the post-operative period. Documentation of the circumstances necessitating use of observation must be entered into the medical record.
- Patients who are **recovering late into the evening** should remain outpatient but “**be transferred to floor for continued recovery**”.

A lack of congruity exists between the requirements of Medicare and the requirements of some private insurers, specifically in the area of surgical procedures requiring an overnight stay. Utilization Management staff can assist clinicians in navigating specific requirements. If the insurer requires prior approval for a procedure requiring an overnight stay, but refuses to approve inpatient admission while sanctioning an overnight stay, then compliance with the payer’s request is appropriate.

Observation Level of Care

Observation begins at the time documented on the nursing admission note and ends at the time the patient is released from the hospital bed.

Patients can be upgraded to inpatient admission from an observation status if acute medical admission criteria are met. A timed verbal or written clinician order for admission is required. If the patient does not meet medical criteria for inpatient admission, yet refuses discharge, contact Utilization Management to issue a denial letter.

Patients generally cannot be discharged from an inpatient level of care to observation. Under special conditions, Medicare now allows a change from inpatient to observation status. See the specific conditions outlined later in this document under the title of “Condition Code 44”.

Medical observation services require a dictated “Hospital Outpatient Note” by the attending clinician caring for the patient. This may be incorporated into a “Discharge Summary” if the clinician prefers. The note shall document:

- Pertinent history and physical findings supporting observation stay
- Summary of care and treatment provided
- Diagnosis
- Procedures and/or treatments performed
- Patient’s disposition, including medications and follow-up plans.

Outpatient surgical cases discharging on the same day, late-in-the-day procedures with uneventful recoveries and outpatient surgical cases placed in observation for minor post-operative complications do **not** require a dictated “Hospital Outpatient Note”.

Condition Code 44

Medicare regulations now allow Utilization Management staff to assist a clinician with changing a patient’s level of care from an Inpatient status to an Observation status. Medical necessity criteria **must support** this change.

Utilization Management reviews the chart and will discuss the case with the attending member of the medical staff if there are any questions regarding the level of care. All of the following conditions are met without exception:

- The change in patient status from Inpatient to Outpatient (observation) must be made prior to discharge or release, while the patient (beneficiary) is still a patient in the hospital.
- A clinician concurs with Utilization Management's decision regarding level of care change based on medical necessity.
- The clinician’s concurrence with the Utilization Management coordinator’s decision is documented in the patient’s medical record.
- An order for appropriate level of care is written and signed by an attending member of the medical staff.

Implementation

Utilizing criteria approved by the Provider Medical Management Committee and Health Information Management, the Utilization Management staff shall review the health care record for each government payer admission to assess the medical necessity of ordered level of care.

When medical necessity for Observation care is not substantiated by documentation available in the medical record, a physician advisor will re-review the record. If no additional documentation is found, written notification will be sent to the clinician regarding inappropriate use of Observation. The determination of lack of medical necessity for observation is communicated to the patient via an Advance Beneficiary Notice (ABN) See *Advance Beneficiary Notice - Medicare*.

Following three notifications of inappropriate use of Observation, an educational meeting will be scheduled to assist the clinician with appropriate use of Observation. Upon the fourth occurrence in a running 12-month period, a meeting will be scheduled with the clinician, the clinician's Department Chair and a physician member of Utilization Management. Minutes from this meeting will be forwarded to the Medical Vice President and will include an action plan. Future noncompliance will be brought to the attention of the Executive Committee.

Related Documents

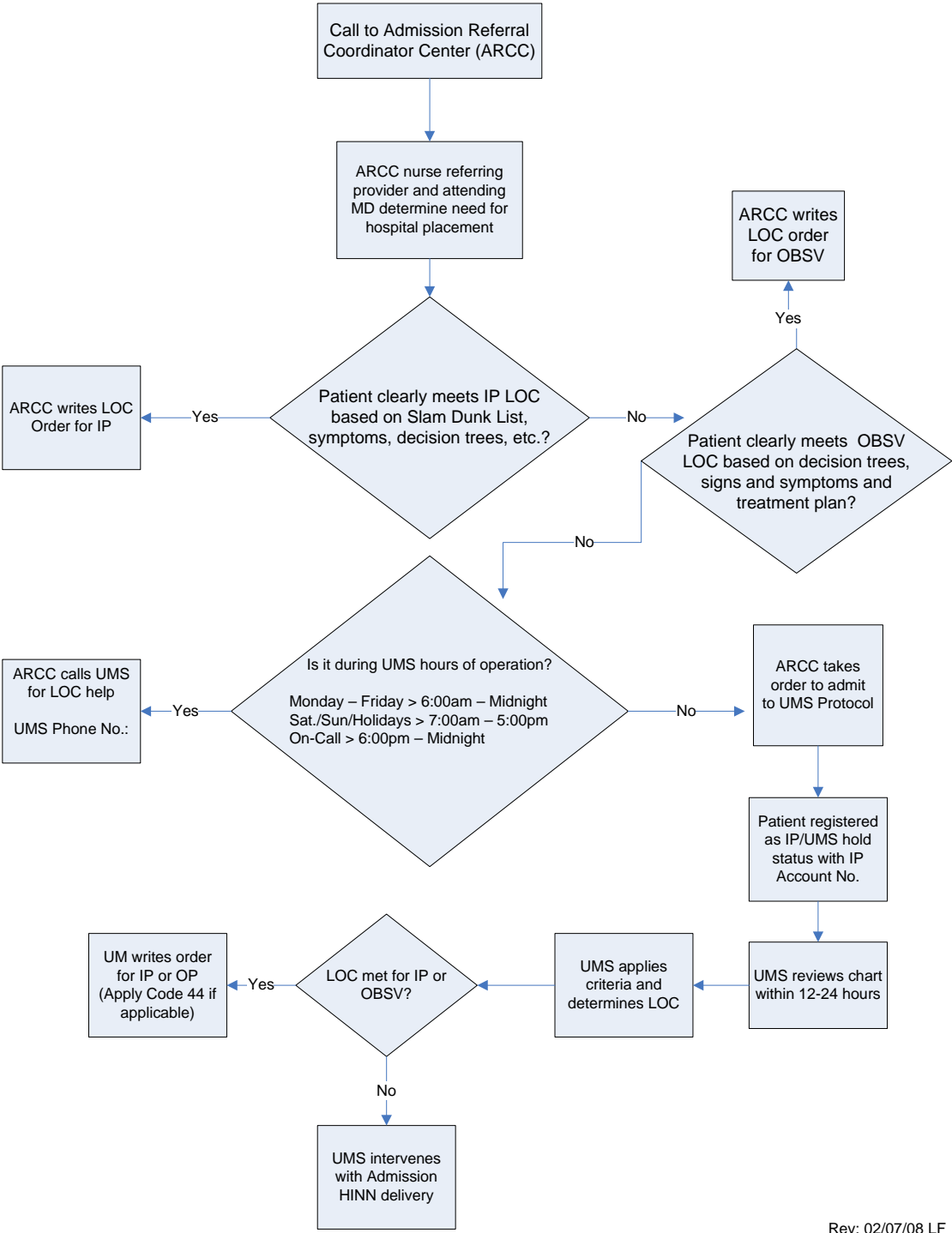
Advance Beneficiary Notice - Medicare

Forms Required

None

Attachments

Admission per UMS Protocol



Special Thanks to the WHA RAC Workgroup:

Tammy Ree, Gundersen Lutheran Health System
John Bartell, Bay Area Healthcare Consulting
Sue Wong, Wheaton Franciscan Health Care
Marie Wiesemann, Fort Healthcare
Nancy Schallert, Froedtert and Community Health
Brian Potter, Wisconsin Hospital Association

