Addressing the Two Midnight Rule Documentation Challenges:

*Plus!* Findings from MAC Probe & Educate

GUEST PRESENTER:
Day Egusquiza, AR SYSTEMS
Compliance 360°

- GRC Software

SAI GLOBAL

- Compliance and Ethics Training
- Ethics Reporting
- Code of Conduct Services and Training
- Compliance 360 GRC Software
Compliance 360 Software Users at a Glance

Compliance, Risk and Audit Solutions for Healthcare

- 250,000+ Active Users
- 800,000+ Regulations
- 350,000+ Policies
- 150,000+ Contracts
- 90,000+ Assessments

Customer Satisfaction #1
Mastering the Chaos – Attacking The 2 Midnight Rule ++ Probe & Educate Highlights 2 FINDING YOUR LOST INPATIENTS

Instructor: Day Egusquiza, Pres AR Systems, Inc
The 2 MN rule is alive and well! In effect since Oct 2013. No ‘grace period’ for compliance. MACs are continuing to audit.


(b) Limitations– the Sec of HHS shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contactors/RAC under section 1893 (h) of the Social Security Act for inpt claims with dates of admission Oct 1, 2013 – March 31, 2015, unless there is evidence of gaming, fraud, abuse of delays in the provision of care by a provider of services.

Probe & ED / MAC audits thru March 2015.
More Updates – Office of Inspector General work plan 2014

- OIG 2014 work plan
- “New inpt admission criteria”
- “We will determine the impact of new inpt admission criteria on hospital billing, Medicare payments, and beneficiary payments. ...determine how varied among hospitals in FY 2014.

- “Context: Previous OIG work found overpayments for short inpt stays, inconsistent billing practices among hospitals and financial incentives for billing Medicare inappropriately.

  ...expected 2 MN = inpt, less than 2 MN= outpt. The criteria represent a substantial change in the way hospitals bill for inpt and outpt stays.

- PS. Sleep study audit – stay tuned as MACs are revising denials. (8–14) REFUNDS ARE TO BE COMING! (11–14) Check with your MAC.. ERROR MADE
August 4, 2014 – Due to the continued delay in awarding new Recovery Auditor contracts, the CMS is initiating contract modifications to the current Recovery Auditor contracts to allow the Recovery some reviews. Most reviews will be done on an automated basis, but a limited number will be complex reviews of topics selected by CMS.

Work continues on the procurement process for the four Part A / Part B Regions and the national DMEPOS/HH&H Region. The CMS remains hopeful that the new round of Recovery Auditor contracts will be awarded this year. Anticipate for complex: **KX therapy, spinal infusion, DME, prosthetics** (Thanks, Dr Hirsch/Accretive) DRG VALIDATION = heavy focus

Aug 27, 2014 – A contract modification, allowing the current Recovery Auditors to restart some reviews has been completed for Regions A, B, C & D. Most reviews will be done on an automated basis, but a limited number will be complex reviews of topics selected by CMS. (Don’t forget the Supplemental Medicare Review Contractors/SMRC – as sites are seeing new activity. Ex: Inpt pysch.)

Dec 24, 2015 – **CMS extends the active recovery auditing period** for existing four Medicare fee for service RAC contracts thru Dec 31, 2015 by which time they anticipate being able to award the new contracts. Not doing any Inpt complex/pt status audits. Administrative and reconciliation thru April 2017. (But they can do medical necessity of the procedure – like joints, pacers, ICD, chemo, scans, blood products... high dollar= 20% error rate as reported by CMS)
New RAC Procurement

- Nov 4, 2014 – “The new contracts for RAC Regions 1, 2, & 4 remain under a pre-award protest, which is expected to continue into late summer of 2015. However, the procurement process continues for Region 3 (Part A/Part B claims reviews), which includes FL, TN, AL, GA, West VA, VA, NC and SC and for Region 5, which will be the national contracts for DMEPOS and Home Health & Hospice claim reviews. CMS remains hopeful that these two new contacts will be awarded by the end of this year/2014.” (CMS Website)

- PS New Statement of Work will also be released.
AHA sued CMS on April 14th along with 4 hospital associations and 4 hospitals. Some key elements: "The hospitals take issue with the wholly arbitrary requirement that a physician must certify at the time of admission that a Medicare pt is expected to need care in the hospital for a period spanning two midnights to be considered an inpt.' and "The lawsuit also contents that the 0.2 percent cut in payment for 2014 the agency implemented to offset the increased costs to Medicare program the agency says are likely to result from the 2 MN rule is arbitrary and should be revoked. (2 lawsuits) UPDATE: Dismissed 9–17–14. No refunding of .02 or future reductions.
RAC Program Improvements 12–14

- 20 new program improvements: Reducing provider burden; Enhancing CMS oversight and Increasing program transparency.
  - ADR limits based on provider’s compliance with Medicare rules. If increase denials, increase ADRs. Diversity across all pt types = ADRs  ADR limits for new providers
  - RAC can only do a 6 month look back from DOS when the hospital submits the claim within 3 months of DOS
  - RAC will have 30 days to complete complex reviews and share findings.
  - RAC must have contractor Medical Director with open access to providers to speak to MD.
  - RAC must wait 30 days to allow for discussion request before sending the claim to the MAC for adjustment. RAC must confirm receipt of discussion request within 3 b/days.
  - RAC will not receive a contingency fee until after the 2nd level of appeal is exhausted. Previously RAC was paid immediately upon denial & recoupment of the claim.
  - CMS will provide public info regarding data related to appeals.
  - RAC must maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims corrected during the appeal process.
More Audit changes.....

- RAC will be required to maintain an accuracy rate of at least 95%. Failure to maintain an accuracy rate of at least 95% will result in a progressive reduction in ADR Limits.
- Independent Auditor of the RACS: Performant/Region A 99.1%’ CGI/B 96.8% Connolly 92.8% (which just received the HH/DME/Hospice Region 5 contract) and HDI 97.0%
- CMS establishes a provider relations coordinator to offer more efficient resolutions
- CMS will post provider compliance tips on CMS’s website.
- CMS will require the RACs to post more detailed review information concerning new issues to their websites.
- CMS will consider developing a provider satisfaction survey.

MORE AND MORE

*Med Learn CR8583, Effective April 1, 2015* Providers will not be granted additional time to submit records beyond the 45 day period. Failure to respond by day 45 will result in a denial. (Note: Some MACs are requiring pre-payment in 30 days...vs post payment with the RACs.)

OIG reports to House Committee on Ways and Means. 3 areas of focus: a) 2 MN must be carefully evaluated, b) CMS should enhance oversight with the RAC program and c) Fundamental changes are needed in the Medicare appeals system.


Change obs and inpt = 1 flat rate for short stay hospitalization, regardless of obs or inpt historical status. Reduced for less than 2 MN = SSP.

If change to DRG payment methodology, how will the critical access hospitals (1334ish) be paid as they are not paid by DRG but a per diem rate on weekly remittances?

AHA’s comment: 6–26–14, CAH/96 hr, SSP rate, obs fix & 2 MN rule (Short stay = less than 2 MN = transfer $, 2 MN = full $) NOACTION for 2015/Final IPPS/Aug 2014
If I was a skeptic –

- 2015 IPPS discussion: Reducing payment to a flat fee for ‘short stays’ = how much?
- Will it eliminate audits for ‘being in a bed at all?’

“If, based on the physician’s evaluation of complex medical factors and applicable risk, the beneficiary may be safely and appropriately discharged, then the beneficiary should be discharged and hospital payment is not appropriate on either an inpt or outpt basis.” CMS’s FAQ 2 MN Inpt Admission Guidance & Pt Status Review for Admissions on or after Oct 1, 2013.

- BE CAREFUL WHAT YOU ASK FOR! Short stays Today = full DRG payment.
- PEPPER is targeting 1 day surgical, 2 day Surgical, same day medical, and same day surg.
MED PAC RECOMMENDATIONS

- Nov 2014
- **Hospital short stay policy issues.**
  - Staff presented a **short stay payment policy** that would reduce payment differences between short inpatient and similar outpatient hospital stays. They modeled this by looking at 94 existing DRGs and split each into a DRG for stays of at least 2 days and a DRG for 1–day stays only. They then collapsed the 94 1–day stays into 44 DRGs by grouping similar conditions together. The new model reduces the payment cliff between outpatient and 1–day inpatient stays, but also creates a new cliff between 1–day and 2–day inpatient stays.

- **Staff also presented policy changes to RACs, which included the following:**
  - Targeted RAC reviews of short stays for those hospitals that have a higher rate of short stay admissions (e.g. top 10%);
  - Allow hospitals to rebill denied inpatient claims as outpatient claims within some period after the RAC notice of denial or shorten RAC look–back period for review of short hospital stays;
  - Modify RAC contingency fees to be based in–part on the RAC’s overturn rate.

- Lastly, staff presented options for addressing beneficiary concerns related to observation, including 3–Day SNF qualifying stay and self–administered drugs.
Error rate...and new focused audit results – LCD/Cataracts

- Health and Human Services/HHS – released end of Nov, 2014. (Fee for service)
- Error rate: rose from 10.1 2013 to 11.8% 2014

- CGS/a MAC – released their probe of their LCD for Cataracts (2 states) Note: highest outpt procedure for Medicare. ALL states should use this guideline
  - Kentucky 85.6%
  - Ohio 88.7%

- **HINT:** At the first point of contact/scheduling – ensure all elements are met. (Maturity of the cataract disease process, visual acuity and ability to perform activities of daily living.) All documented, signed by the surgeon – yes!
Proposed/FINAL change to Certification (Effective 1–1–15)

- “In CY 2014, IPPS Final Rule, CMS adopted revised certification requirements for all inpt admissions. Because all elements of the new certification had to be signed by the physician prior to discharge, this requirement has created a great deal of difficulty for hospitals and arguably required the most changes to computerized documentation systems of all changes in 2014. The proposal would modify the regulation on certification to ONLY require the certification for OUTLIER cases and long stays, defined as 20 days or longer. CMS is careful to note that the order requirements from the Final Rule are not proposed to change and an order complying with the new order requirements is still necessary to demonstrate the patient is considered an input during the stay.” (Final: pg 901–912; http://3.amazonaws.com/public-inspection.federalregister.gov/2014-26146.pdf)

- **We still need:** OPPS FINAL RULE, Nov 2014, effective 1–1–15 – CLARIFICATION
  
  An order to admit to “inpt” (beginning of the pt story)– **STILL REQUIRED** and signed prior to discharge.
  
  A reason for admit/WHY the pt needs 2 MN in a ‘hospital’ (middle)
  
  A discharge note/plan (ending/wrap up)
  
  The full medical record must support the REASON/plan demonstrated Just **no longer a statement:** “I Certify..by provider directing care/mid levels.”
  
  PLUS if mid levels have admitting privileges – MD does not have to countersign.
  
  96 hr certification for critical access hospitals – **still required.**
Inpt hospital reviews/CMS is offering an administrative agreement to any hospital (CAH too) willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount.) DOS prior to 10–13. The hospital may not chose to settle some claims and continue to appeal others/to clarify as CMS must agree with the selection. Pt portions–DENIED claims!! Supplements requesting refunds/United. [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html)

NOTE: Per CMS, around 1000 hospitals have accepted the settlement.

And more updates– Part C

- Managed Medicare Plans/Part C = HUGE
- They do not have to adapt Traditional coverage rules.
- Treat them like a Commercial Payers – get pre–certs, determine if they are using ‘2 MN’ rule methodology and/or clinical guidelines.
- Update contracts to CLEARLY outline the tools used to determine: what is an inpt.
- Always use: Physician order with rationale for why? (Sound familiar??)
- Big increase in denials…
New referrals for audit—
Medical necessity of the procedure, not if 2 MN was met
MS – DRG 004 – Tracheostomy with mechanical ventilation 96+ hrs
Trastuzumab (Herceptin) – multi vial waste
Blepharoplasty (eyelid lifts and repairs)
Intensity Modulated RadiationTherapy

Cancelled Inpt surgeries – OIG–100 records/80 without justification ‘why an inpt.”

**Guidance:** if cancelled during the pre-op process of an inpt ordered surgery, reasons for cancellation were identified, change to outpt as no inpt surgery was able to be done – known prior to beginning. **Create a reduced charge/pre-op chg/prior to anesthesia.**

**Guidance:** if cancelled after the surgery has started/cost has started, ensure the record indicates ‘why’, **create a reduced charge/after anesthesia** and bill as inpt.
Clean up the records– Prior to submission. Can you find the pt story? 1EMR copied
What’s New In the World of Audit?

Pre-payment MAC – all J’s impacted
PROBE & EDUCATE
Hot updates
Hot updates – March 2014

- Effective 3–6, Medicare contractors may automatically deny claims that are ‘related’ to other claims that have been denied as a result of a pre or post payment review.
- Contractors need not issue ADRS for the ‘related’ claims prior to issuing the denial.
- MAC, RAC, ZPIC have the discretion to deny – ‘related’ if documentation associated with one claim can be used to validate another.

- An inpt claim denied – the physician claim can be determined not to be reasonable and necessary.
- A dx test denied – the professional component denied.
- The change could impact coverage of payment for numerous services and products including, for instance episodic care, (eg SNF, home health and hospice) and rented DME.

RESCINDED Transmittal 505, effective March 17, 2014! WATCH for update

Update Sub regulatory Guidance/FAQ 3–12–14
HOT: Related Claims Denials
Effective 9–8–14  Transmittal 534/now 540/now 541

- "Claims that are related"
- **Purpose:** to allow the MAC and ZPIC/Audit groups within Medicare to have discretion to deny other ‘related’ claims submitted before or after the claim in question. If documentation associated with one claim can be used to validate another claim, those claims may be considered ‘related.’

- **Situations:** The MAC performs pre or post–payment review/recoupment of the admitting physician’s and/or Surgeon’s Part B services.

- For services related to inpt admissions that are denied, the MAC reviews the hospital records and if the physician services were reasonable and necessary, the service will be re–coded to the appropriate outpt E&M.

- 540/changed– HOLD – For services where the H&P, physician progress notes or other hospital record documentation does not support for medical necessity of the procedure, post payment recoupment will occur for the Part B service.
If Documentation associated with one claim can be used to validate another claim, those claims may be considered related.

Upon CMS approval, the MAC shall post the intent to conduct ‘related’ claims reviews on their website.

If ‘related’ claims are denied automatically– shall be an ‘automated’ review. If ‘related’ claims are denied after manual intervention, MACs shall count these as denials as routine review.

The RAC shall utilize the review approval process as outlined in their Statement of work when performing reviews of ‘related’ claims. (Note: New RACs = new SOW. Pending)

Contractors shall process appeals of the ‘related’ claims separately.

**And more update – Transfers**

- **Transfer update:** During MedLearn call (2-26-14) CMS updated: receiving hospital CAN count time at a sending hospital toward their own 2 MN benchmark.

- **Q2.2:** How should providers calculate the 2-midnight benchmark when the beneficiary has been transferred from another hospital?
  
  **A2.2:** The receiving hospital is allowed to take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, the **start clock for transfers begins when the care begins in the initial hospital.** Any excessive wait times or times spent in the hospital for non-medically necessary services shall be excluded from the physician's admission decision.

- Sending hospital – if there is knowledge that the pt is being transferred/next day, the pt is obs as only 1 MN is appropriate in the sending hospital

- Use Occurrence Code Span 72/field to identify the date of the 1st MN/sending hospital.

- Place the date on the Inpt UB that may only have 1 additional MN for the receiving hospital.

- 2 MN Benchmark is now present on the 1 MN UB from the receiving hospital.

- Reference: SE1117revised MLNMatters “Correct provider billing of admission date and statement covers period.”
Expanded education on 2 MN & Probe update – Phase 2 has started

- Jan 30, 2014
  - CMS updates: “Hospital inpatient Admission Order and Certification”
  - Lots of clarity on signatures, verbal, etc.

- Jan 31, 2014
  - “Extension of the probe and educate period.”
  - All elements of no RAC auditing remains/MAC only
  - MACS will continue to select claims for review with admission dates between March 31 and Sept 30, 2014 (Now: thru Mar 2015)
  - They will continue to deny if found not in compliance.
  - Hold educational sessions/MAC specific
More audit guidance – RAC

- “CMS will not permit RAC to conduct pt status reviews on inpt claims with dates of admission between Oct 1, 2013–March 31, 2015. These reviews will be disallowed PERMANENTLY, that is, the RAC will never be allowed to conduct pt status reviews for claims with DOS during that time period. “
- But they can audit all other areas – just not 2 MN.

- “In addition, CMS will not permit RAC to review inpt admissions of LESS than 2 MNs after formal inpt admission that occur between Oct 1–March 31, 2014. (now 3–15)“
<table>
<thead>
<tr>
<th>Action</th>
<th>No or Minor Concerns</th>
<th>Moderate to Significant Concerns</th>
<th>Major Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
<td>0-1*</td>
<td>2-6*</td>
<td>7 or more*</td>
</tr>
<tr>
<td>1. Deny non-compliant claims</td>
<td></td>
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<tr>
<td>2. Send summary letter to providers indicating:</td>
<td></td>
<td>2. Send detailed review results letters explaining each denial</td>
<td></td>
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<tr>
<td>- What claims were denied and the reason for the denials</td>
<td></td>
<td>3. Send summary letter that:</td>
<td></td>
</tr>
<tr>
<td>- That no more reviews will be conducted under the Probe &amp; Educate process.</td>
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<td>- Offers the provider a 1:1 phone call to discuss</td>
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<tr>
<td>- That the provider will be subjected to the normal data analysis and review process</td>
<td></td>
<td>- Indicates the review contractor will REPEAT Probe &amp; Educate process with 10 or 25 claims</td>
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</tr>
<tr>
<td>3. Await further instruction from CMS</td>
<td></td>
<td>4. Repeat Probe &amp; Educate of 10 or 25 claims with dates of admission January – March 2014</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>5. If problem continues, Repeat Probe &amp; Educate with increased claim volume of 100 – 250 claims</td>
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</tr>
<tr>
<td>For each provider with no or minor concerns, CMS will direct the MAC to:</td>
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<tr>
<td>1. Deny non-compliant claims</td>
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<td>2. Send detailed review results letters explaining each denial</td>
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<td></td>
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<tr>
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</table>
What is a Medicare Inpt?

- Per WPS–MAC/Medicare claims processor/auditor (July 23, 2014)

“If there is one place I would recommend beefing up the documentation, it is the plan. There are many patients who present in very acute, life threatening ways, who do not require 2 MNs of care. (think CHF) The plan, along with the diagnosis/clinical data on the claim are the 2 biggest supporters of the physician’s reasonable expectation especially if that expectation isn’t met. If all you have is ‘monitor overnight and check in the morning’ – you are going to have a hard time supporting a part A/inpt payment, regardless of the symptomology. You could also add an unexpected recovery note at the end of the record, if they get well faster than the doctor thought at the time of the inpt order and expectation of 2 MN. But in this ex, you’ll have to explain what you expected and what actually happened. It would be less charting if you actually just had a good plan up front.”
Only “0” and 1 midnight stay were targeted for audit in the 1st round of Probe and Educate. All hospitals are audited who meet the above. *(Hint: Use Occurrence Code 72 on 1 MN out/1 MN inpt)*

CMS shut down round 1 in April with very short notice. Not all hospitals had their 10 identified.

**Round 2 will begin in Aug** – All hospitals will have a round 2 if there were ‘at risk ‘ findings or 10 were not audited in round 2. (Or 25) Usually 45 days after ‘educate’ call/must be requested.

Inpt only CPT still being picked up. Coded by staff and determine if CPT is on the list. (working on edits)

Excluded: CAH, AMA, 2 MNs
Is Your Organization Seeing P&E Activity?

A) Yes, claims were deemed payable
B) Yes, we were denied, but not subject to additional probes
C) Yes, we were denied, and subject to additional probes
D) No, we have not seen probe and educate activity
E) Don’t Know / Not Applicable
Feedback from attendees at Compliance 360 Webinar (6-14) Phase 1/ended 4-14. Phase 2/started 8-14.

![Probe & Educate Activity](chart)

- No, we have not yet seen Probe and Educate activity: 32%
- Yes, claims were deemed payable: 8%
- Yes, we were denied and subject to more probe audits: 52%
- Yes, we were denied, but not subject to more probe audits: 8%
Probe and Educate: Probe 1 Results (Shared at RAC/MAC Summit 9, Nov, 2014)
WPS /MAC
## Probe 1 – WPS data

<table>
<thead>
<tr>
<th></th>
<th>J5</th>
<th>J8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A Hospital Provider Count</strong></td>
<td>800*</td>
<td>300*</td>
</tr>
<tr>
<td><strong># of Providers Sampled</strong></td>
<td>412</td>
<td>151</td>
</tr>
<tr>
<td><strong># of Claims Reviewed</strong></td>
<td>3,625</td>
<td>1,328</td>
</tr>
</tbody>
</table>

- Approximate number
- J5- NE, IA, KS, MO
- J8- MI, IN
Overall Denial Rate – WPS

J5 27%

J8 26%
Denials by Type – WPS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>5PC01</td>
<td>Documentation does not support services medically reasonable/necessary</td>
</tr>
<tr>
<td>5PC02</td>
<td>Insufficient documentation</td>
</tr>
<tr>
<td>5PC12</td>
<td>Order missing</td>
</tr>
<tr>
<td>5PC13</td>
<td>Order unsigned</td>
</tr>
<tr>
<td>5PC15</td>
<td>Certification not present</td>
</tr>
<tr>
<td>5PC17</td>
<td>No documentation of 2–midnight expectation</td>
</tr>
</tbody>
</table>
Probe 2 Estimated Timeline

- **August 2014**: Start of ADRs for Phase II
- **December 30, 2014**: Deadline for Providers to Send Records
- **March 31, 2015**: Last day for Provider Education
- **November 15, 2014**: Last Day for MACs to send Phase II ADRs
- **January 30, 2015**: Phase II Reviews Complete
## Probe 2 – WPS (Failed or not 10 in first sweep or had 1/0 now)

<table>
<thead>
<tr>
<th>Part A Hospital Provider Count</th>
<th>J5</th>
<th>J8</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Claims Completed</td>
<td>32%</td>
<td>35%</td>
</tr>
<tr>
<td>Top Denial Code</td>
<td>5PC01</td>
<td>5PC01</td>
</tr>
</tbody>
</table>

**New in Probe 2**
- 5PC11 - Procedure not reasonable and necessary
Tips – WPS

- Verify your procedures for inclusion on the inpatient-only list
- Include the signed admission order
- Compare physician notes to orders
- Document changes in expected patient care

NOTE: If the site ‘failed 2nd round’ – MAC will continue to audit 10–25 until 3–15/revised 11–14.
Per WPS’s Ask the Contractor 7–14
4 top reasons for denials with P&E

1) **Missed or flawed orders.** (EX: a) Order states observe and discharge in the am. Billed as inpt.  b) multiple ‘check boxes’ to pick from. Pick “obs”, billed inpt.

2) **Surgery not on inpt only list.** (EX: a)multiple outpt surgeries does not equal an inpt/spinal  b) MAC has to flag for audit/CPT code the file and confirm if on the list.

3) **Uncertain Course.** (EX: a)symptoms/no dx  b) no plan for why 2 MN.

4) **Attestation/Certification process.** (EX: Box marked without a reason/”I certify’ …what the regulation stated with no further justification. Does use H&P but needs tied to why the 2 MN . (Eliminated 1–1–15)

**REMEMBER** – the 1\textsuperscript{st} MN as an outpt does not count toward the 3 MN for SNF or Swing bed coverage.
## Novitas – Probe and Educate Medical Reviews – First Round

**JH**: CO, NM, OK, TX, AR, LA, MS  
**JL**: PA, NJ, MD, DE, Dist of Co  
PRESENTED TO THE RAC SUMMIT 11–14

<table>
<thead>
<tr>
<th></th>
<th># Providers</th>
<th># Claims Reviewed</th>
<th># Claims Denied</th>
<th>% Claims Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>JH</td>
<td>1004</td>
<td>3794</td>
<td>2206</td>
<td>58%</td>
</tr>
<tr>
<td>JL</td>
<td>586</td>
<td>2712</td>
<td>1720</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td># Claims Reviewed</td>
<td># Claims Denied</td>
<td>% Claims Denied</td>
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<td>----------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>JH</td>
<td>3028</td>
<td>1666</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>JL</td>
<td>1501</td>
<td>901</td>
<td>60%</td>
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</table>

* To date
### Top Reasons for Denial – Novitas– First Round

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>% Denials JH</th>
<th>% Denials JL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation did not support two midnight expectation (did not support physician certification of inpatient order)</td>
<td>50%</td>
<td>51%</td>
</tr>
<tr>
<td>No Records Received</td>
<td>29%</td>
<td>28%</td>
</tr>
<tr>
<td>Documentation did not support unforeseen circumstances interrupting stay</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>No inpatient admission order</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Admission order not validated/signed</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>
# Top Reasons for Denial – Second Round

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>% Denials JH</th>
<th>% Denials JL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation did not support two midnight expectation (did not support physician certification of inpatient order)</td>
<td>56%</td>
<td>53%</td>
</tr>
<tr>
<td>No Records Received</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Documentation did not support unforeseen circumstances interrupting stay</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>No inpatient admission order</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>Admission order not validated/signed</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>1%</td>
</tr>
</tbody>
</table>
Problematic Clinical Situations—NOVITAS

- Inadequate historical detail to understand symptoms of unknown significance in patients with underlying diseases
- Unstated or unclear impressions and treatment plans
- Admissions for management based on clinical guidelines and algorithms then not following those guidelines
- Variations in descriptions of patient condition by different physicians without explanation or reason
- Disconnects (and disagreements) between admitting physician and attending physician and between attending physician and specialist physicians
- Unforeseen circumstance vs. incorrect admitting diagnosis and treatment plan
Examples – Novitas

- Transient Cerebral Ischemia
- Vague neurologic changes, altered mentation, uncomplicated syncope
- Gastrointestinal bleeding
- Cardiac arrhythmias (atrial fibrillation)
- Tube replacements
- Volume depletion
- Same day outpatient procedures
- Psychiatric problems, suicidal ideation, patient non-compliance, alcohol inebriation
What’s Missing?

- Solid documentation of the nature of an illness, the physician's impression (differential diagnoses), and a clear statement of diagnostic/therapeutic choices along with their stated or implied rationale
Selective approach to participation
- Prior to 2014 participating in 1–2% of available cases
- Now participating in 15–20% of available cases
- Majority of available cases are Part A

2014 statistics demonstrate effectiveness of our participation
- Confirmation of denial in 80% of cases in which we participated
- Confirmation of denial in 40% of cases in which we did not participate
In addition to Medicare RAC audits, which audits are you seeing an increase in activity?

A) MAC
B) Medicaid RAC/MIC
C) ZPIC
D) Commercial Payor Audits
E) Other
Results from Feb 14 Compliance 360 Free Webinar – Attacking the 2 MN rule – All payers are auditing

In addition to Medicare RAC, which audits have you seen the greatest increase in activity?

- **MAC**: 57% (Feb-13), 51% (Oct-13), 48% (Dec-13), 46% (Feb-14), 51% (Jun-14)
- **Medicaid RAC/MIC**: 22% (Feb-13), 24% (Oct-13), 22% (Dec-13), 23% (Feb-14), 67% (Jun-14)
- **ZPIC**: 2% (Feb-13), 3% (Oct-13), 2% (Dec-13), 4% (Feb-14), 16% (Jun-14)
- **Commercial Payor Audits/Denials**: 51% (Feb-13), 54% (Oct-13), 51% (Dec-13), 67% (Feb-14), 10% (Jun-14)
- **Other**: 16% (Feb-13), 9% (Oct-13), 6% (Dec-13), 16% (Feb-14), 10% (Jun-14)
Every payer is looking for – why an inpt?

- Enhanced documentation at the beginning of care – ER/direct admit. First point of contact.
- Admit to inpt with the dx and the reason for inpt admission…
- ALL payers, every time.
- Embedded in the EMR ‘que’ questions to prompt the provider.
- Medicare – add the 2 MN or 1/1 MN question
HOT AS A PISTOL – New Inpt ruling PLUS Billing for denied hospital inpt claims

MLN Matters SE1333, effective 10–13


FEAR OF AUDIT IS NOT JUSTIFICATION TO VIOLATE BENEFICARIES RIGHTS OR DEPRIVE THE HOSPITAL OF COMPLIANTLY EARNED REIMBURSEMENT. (Physician advisors on RAC RELIEF 11–13)
“No Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness of injury or to improve the functioning of a malformed body member.”
Title XVIII of the Social Security Act, Section 1862 (a) (1) (A)

“Observation services must also be reasonable and necessary to be covered by Medicare.” (Medicare claims processing manual, Chapter 4, 290.1) Obs did not change.

“The factors that lead a physician to admit a particular patient based on the physician’s clinical expectation are significant clinical considerations and must be clearly and completely documented in the medical record.” (IPPS CMS 1559–F, p 50944)

Only a physician can direct care …and…Patient Status….
Key elements of new inpt regulations – 2 methods

- **2midnight presumption**
  “Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.

- **Benchmark of 2 midnights/NEW INPTS**
  “the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt’s total expected LOS.
EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under the expectation the pt will require medically necessary hospital services for an additional midnight. Pt is discharged on 12-3 at 8am.

Impacts ER, Observation and Outpt Surgery.

1 MN out + 1 MN inpt expectations = 2 MN benchmark inpt.

Ex) Pt is an outpt surgical encounter at 6 pm on 12-21-13 is still in the outpt encounter at 1 min past midnight on 12-22-13 and continues as a outpt until admission. Pt is admitted as an inpt on 12-22 at 1am under the expectation that the pt will required medically necessary hospital services for an additional midnight. Pt is discharged on 12-23-13 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.
“Meeting Criteria” – means?

- It never has and never will mean – “meeting clinical guidelines” (Interqual or Milliman)
- It has always meant – the physician’s documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet Criteria – this means: Doctor cannot certify/attest to a medically appropriate 2 midnight stay – right?
- 11/1/2013 Section 3, E. Note: “It is not necessary for a beneficiary to meet an inpatient "level of care" by screening tool, in order for Part A payment to be appropriate“
- Hint: 1st test: Can attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers… but the physician’s order with ROA – trumps criteria.
More Med Learn Updates

- National UB committee – **Occurrence code 72 MLN CR 8586, effective 12–13**
  First /last visit dates
- **The from/through dates of outpt services. For use on outpt bills where the entire billing record is not represented by the actual from/through services dates of Form Locator 06 (statement covers period) …… AND**
- **On inpt bills to denote contiguous outpt hospital services that preceded the inpatient admission. (See NUBC minutes 11–20–13)**
- **Per George Argus, AHA, a redefining of the existing code will allow it to be used Dec 1, 2013. CMS info should be forthcoming.**

**MLM SE1117 REVISED: Correct provider billing of admission date and statement covers period.**

**DOS after 10–11, admission date (FL 12) is the date the pt was admitted as an inpt to the facility. It is reported on all inpt claims regardless of whether it is an initial, int. Of final bill.**

**The statement covers period (from and thru dates/FL 6) identifies the span of service dates included in a particular bill. The ‘from’ date is the earliest date of service on the bill.**
### Complex Denials/Setting By Dollar

64% of denials = wrong setting – FIX: ask the 2 MN question

#### % of Complex Denials for Lack of Medical Necessity for Admission – thru 3rd Q 2013/4th Q 2011- by $$ Impacted

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Q1 2013</th>
<th>Q2 2013</th>
<th>Q3 2013</th>
<th>Q4 2013</th>
<th>Q1 2014</th>
<th>Q2 2014</th>
<th>Q3 2014</th>
<th>Q4 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syncope and collapse (MS-DRG 312)</td>
<td>15</td>
<td>14</td>
<td>18</td>
<td>14</td>
<td>17</td>
<td>25</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Percutaneous Cardiovascular Procedure (PCI) w drug-eluting stent w/o MCC (MS-DRG 247)</td>
<td>19</td>
<td>17%</td>
<td>19</td>
<td>21</td>
<td>23</td>
<td>24</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>T.I.A. (MS-DRG 69)</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Chest pain (MS-DRG 313)</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>9%</td>
<td>/8%</td>
<td></td>
</tr>
<tr>
<td>Esophagitis, gastroent &amp; misc digest disorders w/o MSS (392)</td>
<td>11</td>
<td>13</td>
<td>16</td>
<td>13</td>
<td>10</td>
<td>3%</td>
<td>/0%</td>
<td></td>
</tr>
<tr>
<td>Back &amp; Neck Proc exc spinal fusion w/o CC/MCC (DRG 491)</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5%</td>
<td>/</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AHA RACTracc
Let’s get started—new language Certification process— It is the ‘why..because”

- Lots of ‘chatter’ but evaluate this process flow.
- **1st question:** Can the pt go home safely from the ER? Assess the reasons the provider (ER doc consults with the provider directing care) and document same. (Risk factors, history of like condition with outcome, presenting factors, plan )
- **2nd question:** Can the ER physician (after consulting with the admitting) attest/certify that the pt needs to ‘be in the hospital’ for an estimated 2 midnights to resolve the condition?
- **3rd question:** If no, move to OBS and evaluate closely. If yes, move to inpt with other elements of the inpt certification.
Where do the patients come from? Two hot spots for referrals into “a bed”

- **ER & Inpt surgery** (& Direct Admits?)
- Attack these places with a pro–pt status focus, not placing and chasing.
- Develop internal flows to attack:
  - **ER** – how much UR coverage? 24/7? or utilize ER lead RNs or house supervisors. No pt is given a bed without pt status ‘blessed.’ Integrated CDI program will help with cross training.
  - **Inpt surgery** – all daily inpt surgery schedules are reviewed by UR to review outpt being scheduled as outpt.
  - **Direct** – House supervisors or/& UR clarify PRIOR to placement.
  - Involve the internal UR leaders and PA for patterns.
  - Sr leadership will have to be prepared to push thru the regulation with any problematic providers.
Case: ER doctor admits the pt on Sat am. Facility is not using a certification form/tool. The ER doc does not have admitting privileges, so bridge/transitional. Did not document conversation with the admitting or hospitalist.

Mon am UR comes in. Determines the case does not meet clinical guidelines/Interqual. Asks Admitting to convert back to Obs. Pt was discharged home prior to having the UR provider agree. What is broken?
Still struggling with 2 MN Benchmark

- EX) Pt came to ER on Fri night/1900. ER provider, after discussing with the hospitalist, determines the pt is not safe to go home.
- They agree that the pt does not need 2 MN at this time, and places in obs.
- No UR coverage in the ER or weekends.

- 1st MN/ER
- 2nd MN/Sat – does the pt need additional services / care to resolve the condition?
- UR discusses with admitting provider and converts to INPT with the PLAN clearly outlined in the Reason for Admit for the 2 MN.
- NO dedicated Ambulatory Outpt Unit RAC 2014
Inpt only – scheduling gets CPT code/HIM codes, researches, notifies UR if problems.

Outpt surgeries being scheduled as inpt – scheduling notifies UR of a potential problem. Surgeon is immediately contacted.

PATTERNS – UR tracks and trends concerns/non-compliant surgeons.

Physician advisor – involved as needed for peer to peer intervention, education, etc.

UR committee – patterns are presented with assistance/intervention requested.
At risk examples – outpt procedures

- **Outpt surgery.**
  - After routine recovery (up to 4–6 hrs), doctor orders the pt to ‘stay the night.’
  - What did the doctor really want? Who is reviewing every ‘pt in a bed’ after the 4–6 hrs of RR? Why still in house?

- **Cath Lab**
  - Doctor has routinely had the patient the pt stay overnight. Historically billed a 1 day inpt stay.
  - Explore options – inpt, outpt or obs.
Bad habits – Attack them

- After an uneventful, but late outpt invasive procedure, physician orders to ‘stay the night’. This is a FREE service as the pt has no medical reason to be in a bed. Time to discharge.
- Liability risk for having a non billable pt in the hospital.

- Have the pt stay the night and do the test in the am or Mon/wkd.
- What is the clinical reason to ‘stay the night?’ If not an unplanned event leading to OBS, a FREE service.
- Is there another clinical reason to be in a bed? Document it well with correct status...
**INPATIENT ADMISSION CERTIFICATION (Medicare only)**

Must be completed by provider for Inpatient Admission

**Date of Service:**

**Check appropriate box for patient status:**

- Midnights (MN) Inpatient
- 1 MN Outpatient (ER or Obs) and 1 MN Inpatient

**For Initial Certification (CAH only):**

- Expect the Length of Stay to Not Exceed 96 hrs

**For Re-Certification**

- The Length of Stay is Exceeding 96 hrs

**Plans for Post-Hospital Care:**

- See Discharge Summary

**Supportive Findings to Primary Diagnosis:**

- Co-morbidities, abnormal findings, diagnostic abnormalities, exacerbations, new onset of disease with______(co-morbidities)

**SAMPLE “CLARIFICATION OF ORDER” FORM (Form is not required)**

Use for both OBS and Inpt – clarification of order and intent

And remember – it is not just a ‘form’ but the beginning of the pt story.

**Key elements:** Reason for admit/what is the plan for the estimated 2 MN stay or 1 additional MN after 1 outpt MN.
If it doesn’t tell the reason for admit, why the dx will take an estimated 2 MN/presumption or a 2\textsuperscript{nd} MN /benchmark.

If it doesn’t outline the plan for treatment with the treatment done and wrapped up in the discharge note.

Medically necessary? If it isn’t addressed thru the Reason for Admit/Plan, action attached to the RFA, then clinical guidelines won’t ‘bail’ out the inpt.

SO….It is all about the story told by the provider–beginning, middle, end with a beautiful wrap up.
More on decision making – Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)

- Note: presumption = 2 midnights AFTER obs. 1 midnight after 1 midnight OBS = at risk for inpt audit

- ..the judgment of the physician and the physician’s order for inpt admission should be based on the expectation of care surpassing the 2 midnights with BOTH the expectation of time and the underlying need for medical care supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs and the risk of an adverse event. Pg 50944
And the ‘what if’s’

- 412.3 (e) (2) (see p. 50965 of Final Rule) – “If an unforeseen circumstance, such as a beneficiary’s death or transfer, results in a shorter beneficiary stay than the physician’s expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and hospital inpatient payment may be made under Medicare Part A.” (Thx, Accretive)

- Can 1 day stay inpts still occur?
  - YES - but as the regs clearly state, anticipate an audit as it should be a highly uncommon occurrence.
  - 1 MN as outpt or OBS and 1 MN as inpt = inpt
  - Just because a patient dies, is transferred for tertiary care, or leaves AMA, (paraphrased from LCD L27548) it does not change the presentation of clinical factors/criteria that went into the physician’s complex medical decision to admit to an inpatient status. (Thx, Appeals Masters)
With unusual cases... Rare and unusual = ordered as a 1 day stay

- Lots of discussion on: “My patient is very sick, at risk but I don’t think they will need 2 midnights. I checked with Interqual/UR and it meets their definition of an inpt. I am admitting and highly anticipate they will only need 1 midnight.” (nope, not an inpt/obs and monitor closely)

- CMS has stated: Rare and unusual. 2 outlined definitions at this time: inpt only surgeries and initiation of mechanical ventilator with 1 midnight. They are still working on how to address transfers out & hospice referral.. (RAC Summit/12–13)

- DIFFICULT to prove –but part of P&E concerns.
More examples of coverage

**CAH:** must use the 2 MN presumption/benchmark PLUS certification to reasonably expect the pt to transfer or discharge within 96 hrs. If longer, re-do but should be unusual cases. (Watch HR 3991/slim chance to pass.)

Ex) What if the surgery was delayed because the surgeon was only at the hospital 1 day a week? Is there another hospital where the surgery could occur without the delay?

EX) Is the stay beyond 96 hrs within the scope of the CAH?

**Long obs:** Pt in in Obs for 2 midnights. 1\(^{st}\) Q: did the pt have 48+ hrs of billable obs or just hrs in a bed?

2\(^{nd}\) Q: Was the regulation for OBS met? (OBS is: Active physician involvement/ongoing assessment.)

If MET– then the pt was eligible to convert to INP after the first midnight with the physician ‘attesting’ of the need for medically appropriate care –2\(^{nd}\) MN

96 hr CAH requirement/CMS Physician certification, Jan 31, 2014 (still required/OPPS 1–15)

and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, 42 CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

d. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.

e. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Time as an outpatient at the CAH does not count towards the 96 hours requirement. The clock for the 96 hours only begins once the individual is admitted to the CAH as an inpatient.

If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH and something unforeseen occurs that causes the individual to stay longer at the CAH, there would not be a problem with regards to the CAH designation as long as that individual’s stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual’s inpatient stay.

f. Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

2. Timing: Certification begins with the order for inpatient admission. The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. With regard to the time of discharge, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the physician as having to occur prior to discharge (e.g., “discharge after supper” or “discharge after voids”). So discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the physician’s order for discharge is effectuated.

3. Authorization to sign the certification: The certification or recertification may be signed only by one of the following:
Delays in the Provision of Care: FAQ 12–23–13 CMS

Q3.1: If a Part A claim is selected for Medical review and it is determined that the beneficiary remained in the hospital for 2 or more MN but was expected to be discharged before 2 MN absent a delay in a provision of care, such as when a certain test or procedure is not available on the weekend, will this claim be considered appropriate for payment under Medicare Part A as an inpt under the 2 MN benchmark?

A3.1: Section 1862 a 1 A of the SS Act statutory limits Medicare payment to the provision of services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body. As such CMS' longstanding instruction has been and continues to be that hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment. Accordingly, CMS expects Medicare review contractors will exclude excessive delays in the provision of medically necessary services from the 2 MN benchmark. Medicare review contractors will only count the time in which the beneficiary received medically necessary hospital services.
Key areas to support documentation for pt status

- Admitting physician ‘starts the pt story’ thru use of the certification process – including REASON FOR ADMIT.
- Internal Physician Advisor – trainer/champion, works closely with UR and all providers to ensure understanding/compliance.
- Nursing continues with the care/assessments/interventions relative to the reason for admit.
- UR works with the treating/admitting physician to expand/clarify the documentation at the beginning and conclusion of the patient’s stay. Additionally UR closely monitors completion of the certification for ALL payers.
- Integrated CDI continually interacts with providers/nursing to ensure all elements are clear /complete. 1 voice of ongoing education…
WINS with the 2 midnight rule—Don’t be afraid of your inpt...

- Clarification of order form – always. Consistently start and clarify the pt story.
- UR in the ER – always involved prior to placement.
- Hospitalist – always see the pt rapidly/less than 2 hrs from referral to inpt.
- Integrated CDI program – one ongoing audit, one voice for ed
- Dedicated beds for OBS. OBS hasn’t changed at all. UR assigned to closely monitor every OBS that exceeds the first midnight.
- Grow an internal physician advisor—NOW! Ongoing education, UR support/intervention = effective change
- Actively involve nursing as the eyes of the pt story 24/7.
- Actively involve surgery scheduling to ‘spot’ any common outpt surgeries being scheduled as inpt.
- Beef up the UR committee
- Beef up the UR ‘s role, separate from case mgt.
- Front end…
‘What Ifs’ Not Addressed

- Services unavailable
- Weekends & Holidays
- Patient safety

Consultants unavailable
Equipment down
Patient & family issue

(Thanks, Dr Salvador, DE hospital & PA/UR bootcamp faculty)
1) Embed questions from the optional certification form within the electronic orders or use the manual form.

2) Empower UR staff to assist with compliance.

3) Know which procedures are riskiest, such as cath lab procedures and outpt surgeries that ‘stay the night’.

4) Target physicians in the ED.

5) Hire internal physician advisors to assist with education.

6) Understand the implications for transfers.

7) Use internal audits to identify problem areas.

8) Learn from the probes and hammer the message home.
Day Egusquiza, President
AR Systems, Inc
Box 2521
Twin Falls, Id  83303
208 423 9036
daylee1@mindspring.com

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