
ACCRETIVE HEALTH
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ACMA Utah
Hot Topics in Compliance
Ronald Hirsch, MD, FACP
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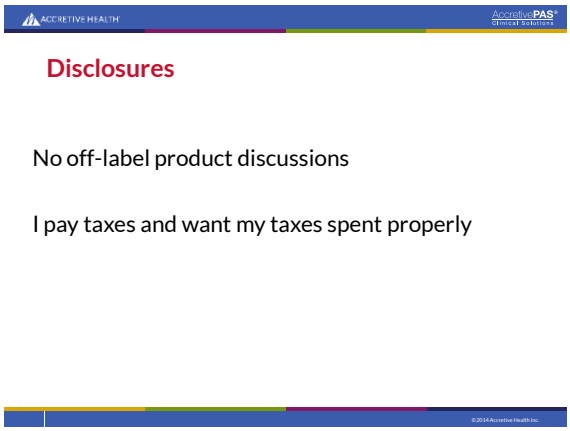
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Disclosures
No off-label product discussions
I pay taxes and want my taxes spent properly
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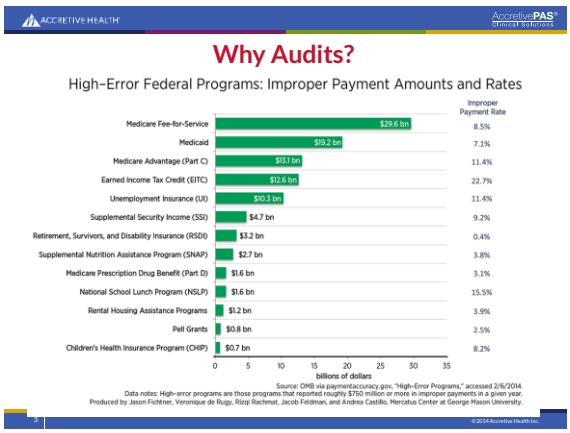
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Why Audits?
High-Error Federal Programs: Improper Payment Amounts and Rates
Improper Payment Rate
Medicare Fee-for-Service $29.6 bn 8.5%
Medicaid $19.2 bn 7.1%
Medicare Advantage (Part C) $13.1 bn 11.4%
Earned Income Tax Credit (EITC) $12.6 bn 22.7%
Unemployment Insurance (UI) $10.3 bn 11.4%
Supplemental Security Income (SSI) $4.7 bn 9.2%
Retirement, Survivors, and Disability Insurance (RSDI) $3.2 bn 0.4%
Supplemental Nutrition Assistance Program (SNAP) $2.7 bn 3.8%
Medicare Prescription Drug Benefit (Part D) $1.6 bn 3.1%
National School Lunch Program (NSLP) $1.6 bn 15.5%
Rental Housing Assistance Programs $1.2 bn 3.9%
Pell Grants $0.8 bn 2.5%
Children's Health Insurance Program (CHIP) $0.7 bn 8.2%
0 5 10 15 20 25 30 35
billions of dollars
Source: OMB via paymentaccuracy.gov, "High-Error Programs," accessed 2/6/2014.
Data notes: High-error programs are those programs that reported roughly $750 million or more in improper payments in a given year.
Produced by Jason Fichtner, Veronique de Rugy, Rizqi Rachmat, Jacob Feldman, and Andrea Castillo, Mercatus Center at George Mason University.
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Hematologist-oncologist Farid Fata, MD, of suburban Detroit now faces up to 175 years in prison after pleading guilty

- Falsified cancer diagnoses to justify chemotherapy
- Ordered maintenance doses of chemotherapy for patients whose cancer was in remission
- Ordered chemotherapy for patients with advanced cancer who would not benefit from it
- Ordered intravenous immunoglobulin for patients whose antibody levels did not warrant the treatment
- Administering intravenous iron to patients who were not iron deficient
- Ordering unnecessary PET Scans
  - http://goo.gl/GfGZ0o

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I can't believe I am still teaching 2 MN Rule

88 yr old female presents to ED with fever 103, BP 80/50, WBC 18,000, UA with WBC, altered mental status.

You screen by criteria and passes inpatient.

Doctor orders inpatient admission to ICU for "sepsis due to UTI."

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What is the 2 MN Rule?

Two step process

1- Does the patient require care that can only be safely provided in the hospital?

2- How many midnights is the patient expected to require in the hospital until able to safely move to a lower level of care (regardless of who is going to pay for that care)?

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When does the Midnight Clock Start?

When symptom-related treatment or diagnostic testing begins.

-Nebulizer for dyspnea, CBC for abd pain

These are provider-initiated tests based on protocols that will be signed by a doctor

Not when provider first sees patient

Not when triage starts

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What are the three clocks?

Midnight clock to decide inpatient or outpatient

-begins with symptom-related care

Observation clock to count hours to get paid

-begins with order for observation services

-can bill any # of hrs: Medicare pays >8

Inpatient admission clock to count 3 days for SNF

-begins with admission order, not retroactive

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Every day of every admission ask…

"The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care."

88 yr old male presents to ED with c/o syncope. Woke up at 3 am to urinate, recalls standing at toilet and feeling warm, wife heard him hit floor. No head injury, labs, EKG normal.

You screen by criteria and passes observation.

Doctor orders observation.

Sounds good; meets rule- needs a day on tele at most

88 yr old male presents to ED with c/o syncope. Woke up at 3 am to urinate, recalls standing at toilet and feeling warm, wife heard him hit floor. No head injury, labs, EKG normal.

You screen by criteria and passes observation.

Doctor orders inpatient admission.

Doesn't meet rule- needs a day at most

88 yr old male presents to ED with c/o dizziness. Ate potato salad at block party and has had diarrhea for 2 days, not able to drink. BUN 30/Cr 1.2. Gets 2 L in ED and still orthostatic. You screen by criteria and passes observation. Doctor orders observation.

Next day, less diarrhea, able to take sips, but labs unchanged, still weak. Doctor wants to keep one more day for hydration and orders inpatient. Should go home tomorrow. You screen and fails inpatient criteria but passes observation criteria.

Meet rule or not meet rule?

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The Rule says…

"…The decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in *necessary hospitalizations* should not pass a second midnight prior to the admission order being written."
IPPS Final Rule p 50946

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75 yr old presents with chest pain. EKG and troponin negative. Doctor places observation to rule out MI and get stress test.

You screen and passes observation.

Next day stress test negative and doctor orders GB ultrasound, GI consult for EGD and inpatient admission. You screen for inpatient admission and fails inpatient criteria, fails observation criteria and passes discharge screening.

Meet rule or not meet rule?

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So how do you use criteria?

If a patient passes Inpatient or Observation criteria, or fails discharge screening, that means they require hospital care. You then need to count midnights to determine correct status.

Pass Inpt- could be inpt or obs, dep on illness and plan

Pass Obs- could be obs or inpt dep on how many MN already spent

Fail discharge- In or obs dep on the day and the plan

Don't meet criteria at all- get a secondary review

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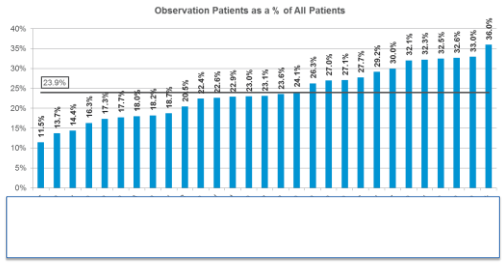
Speaking of Observation

What is the benchmark observation rate?



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The Right Answer? It depends…

- ED or direct "admit" patients who are expected to stay in the hospital under two midnights
- Post-procedure patients who need care past the normal recovery but under two midnights
- Post-procedure patients who need recovery after the recovery room time
- Late procedures who need recovery but recovery room closed
- Post-procedure patients who need to spend a night in the hospital
- Pre-procedure patients hospitalized the day prior for preparation or clearance
- Patients who are staying because they can't get a ride home

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The Hirsch Rule of Observation

If every patient is reviewed by CM for proper admission status, and every patient is placed in the right status, and observation is only ordered on the proper patients, and every patient goes home as soon as their need for hospital care has finished and every patient who requires a second midnight is admitted as inpatient, then your observation rate is at your benchmark.

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Symptoms without a Cause

If you don't know the cause, you can't know the course

Acute exacerbation of chronic pain
Abdominal pain
Resolved neurologic findings/ TIA
Acute back pain
Headache
Nausea and vomiting/dehydration
Syncope
Chest pain

They can always admit if not better after first MN

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Mild Exacerbation of Known Illness

Heart Failure
Asthma
COPD
Rapid A fib in pt with known A Fib

Mild Case of Potentially Serious Illness Will it bloom or will it fade?

Pneumonia
Pyelonephritis
Cellulitis
Acute Pancreatitis

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What is physician judgment?

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. MBPM Ch 1

"I expect two midnights" means nothing if that expectation is not clinically rational… **the physician's "order and certification regarding medical necessity" are not entitled to any "presumptive weight"** and are "evaluated in the context of the evidence in the medical record."

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Unexpectedly Rapid Recovery

The doctor correctly thought they'd need over 2 MN but they got better faster.

The 2 MN expectation must be clinically sound.

Their unexpected recovery should be explained.

This should happen infrequently.

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But who really does require hospital care?

"The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care."

The JAMA Network

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From: **Risk for Clinically Relevant Adverse Cardiac Events in Patients With Chest Pain at Hospital Admission**

JAMA Intern Med. Published online May 18, 2015. doi:10.1001/jamainternmed.2015.1674

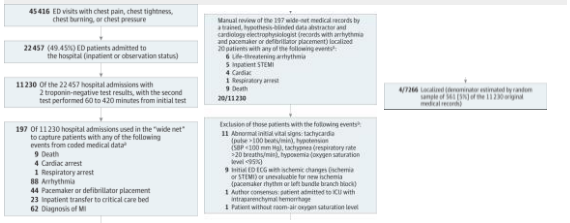

Figure Legend:

Algorithm for Determining Clinically Relevant Adverse Cardiac Events Includes patients admitted to the emergency department (ED) with chest pain and troponin-negative test results; this resulted in 4 patients of an estimated 7266. ECG indicates electrocardiographic; ICU, intensive care unit; MI, myocardial infarction; SBP, systolic blood pressure; and STEMI, ST-segment elevation MI.

[a]Some patients had more than 1 event.

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88 year old female tripped and fell at home. ED eval finds non-displaced fracture of pelvis. Pain moderate at rest, increased with standing, only able to walk two steps. Gets one dose morphine and pain improved.

Doctor consults ortho and physiatry and orders inpatient admission. Tells you patient will need SNF.

You screen and fails inpatient criteria.

Meets rule or doesn't meet rule?

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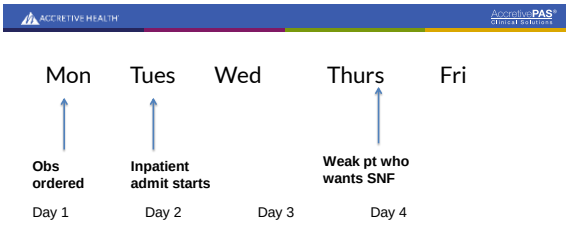
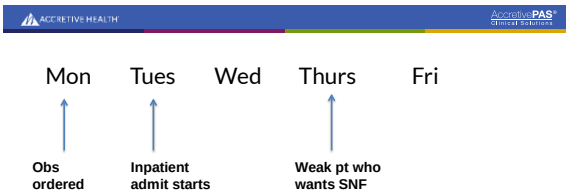
88 yr old male presents to ED with c/o near syncope. Ate potato salad at block party and has had diarrhea for 2 days, not able to drink. BUN 30/Cr 1.2. Gets 2 L in ED and still orthostatic. You screen by criteria and passes observation. Doctor orders observation.

Next day, less diarrhea, able to take sips, but labs unchanged, still weak. Doctor wants to keep one more day for hydration and orders inpatient. Next day, patient worse, labs worse, stays in hospital.

Day after patient better, labs better but now weak. Lost 8 lbs, unsteady on feet.



Can he go to a SNF on Thursday under his part A benefit?



42 CFR 409.30 Post-hospital SNF care
The beneficiary must have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge.

Does that mean…

The patient must have spent three medically necessary days in the hospital as inpatient

or

The patient must have had a medically necessary inpatient admission that lasted three days

In addition, the qualifying hospital stay must have been medically necessary. Medical necessity will generally be presumed to exist. When the facts that come to the intermediary's attention during the course of its normal claims review process indicate that the hospitalization may not have been medically necessary, it will fully develop the case, checking with the attending physician and the hospital, as appropriate. The intermediary will rule the stay unnecessary only when hospitalization for 3 days represents a substantial departure from normal medical practice.

MBPM Ch 8 section 20.1

My suggestion

Ensure inpatient admission was medically necessary and that all three days meet broad definition of medically necessary hospital care.

This also applies….

Patient admitted as inpatient, stays two days, discharged by physician but wants to stay a third day and go to SNF so appeals discharge.

Do the days during appeal process count to the SNF qualification?

Inpatient Only Surgery Order "Reprieve"

As of April 1, 2015, the inpatient admission order can be written any time during next three calendar days (the pre-admission window) of the hospital stay but…

Not applicable to CAH which have no payment window

Days do not count for SNF

Gives you no opportunity to check medical necessity and documentation

Why do patients get readmitted?

Mrs. Gomez 's Home Medications and her Inpatient Medications

Home Medications	Inpatient Medications
Lisinopril/HCTZ, 20/25 mg/d	Prinivil (lisinopril), 20 mg/d
Metoprolol, 50 mg BID	HCTZ, 25 mg/d
Lantus (insulin glargine), 20 units/d	Coreg (carvedilol), 25 mg BID
Metformin, 500 mg BID	Levemir (insulin detemir), 35 units/d
Aspirin, 325 mg/d	Ecotrin (aspirin), 325 mg/d
Pravastatin, 40 mg/d	Crestor (rosuvastatin), 10 mg/d
	Plavix (clopidogrel), 75 mg/d
	Nexium (esomeprazole), 20 mg/d
	N-acetyl cysteine, 600 mg BID for 1 day

BID = twice daily; HCTZ = hydrochlorothiazide.

My personal opinion on Readmissions

Make the hospitalists actually spend >30 minutes with patient on discharge

Sit down next to bed, on side away from the door

Do med rec themselves, looking at home meds carefully

Use generics- no fancy stuff that needs prior auth

Type out discharge instructions themselves in plain language

Call a family member on every discharge and explain course

Do the discharge summary on the day of discharge

Get a message to the PCP on hospital course and get patient appt

Follow up on pending tests after discharge

Watch early discharge programs (out by 10 am)– may incr readmissions

Condition Code 44

Determination that an inpatient admission should have been outpatient +/- observation

CC44 changes inpatient to outpatient, not to Obs!

Requires:
Concurrence of admitting/attending physician
Review by UR committee doctor
Completion before discharge
Written notification to patient

Not Allowed/Not Appropriate

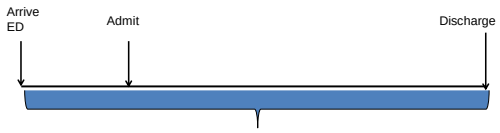
Attending changing their own admission to obs
No UR doctor involvement
Unexpected recovery, AMA, unexpected transfer
After discharge

Self-denial of Inpatient Admission

Patient inappropriately admitted as inpatient but not noted until after discharge (catch these by reviewing all one-day inpatient admissions)

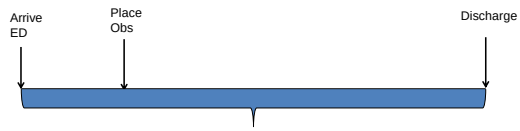
Requires:
Review by UR Committee doctor
Discussion with attending (and 2nd UR doc if attending disagrees)
Written notification of patient within 2 days
Billing as no pay claim then rebilled to Part B

Normal Inpatient Stay



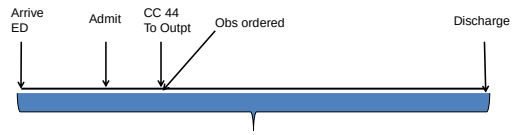
Inpatient Part A- DRG payment
Avg $4,000 to $8,000

Normal Outpatient/Observation Stay



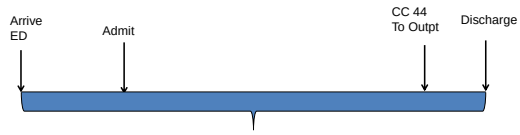
Outpatient Part B payment 13x- ~$800
(xrays, labs, diagnostic tests)
APC 8009 for Obs/ED visit 13x- $1,287
Total= $2,000

Condition Code 44 with > 8 hrs observation



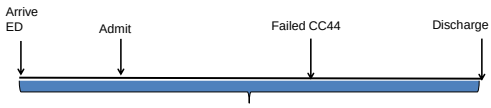
Outpatient Part B payment 13x- ~$800
(xrays, labs, diagnostic tests)
APC 8009 for Obs/ED visit 13x- $1,287
Total= $2,000

Condition Code 44 near discharge



Outpatient Part B payment 13x- ~$800
APC for ED visit 13x $294-$456
No pay for Obs since no Obs
Total= $1,100-$1,250

Attending does not concur- 3 claims



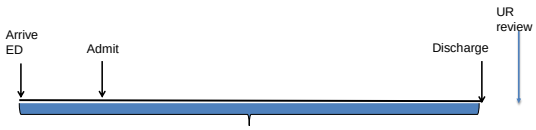
No pay inpatient 110 Claim
then

Outpatient Part B 13X ~$200, ED visit $294-$456

Inpatient Part B 12X ~$600

Total = $900-1,100

Rebilled Claim- self-denied after D/C



No pay inpatient 110 Claim
then

Outpatient Part B 13X ~$200, ED visit $294-$456

Inpatient Part B 12X ~$600

Total = $900-1,100

Medical Necessity- Two Types

Medically necessary of the setting-

Does the patient require care that can only safely be provided in the hospital/rehab/LTACH/SNF/home?

Medical necessity to provide the care itself-

Does the patient have medical necessity to have the service that is being planned for them?

Nuclear Stress Tests

Patient calls hospital to schedule test.
Do you have a written order from MD?

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Nuclear Stress Tests

Patient calls hospital to schedule test.
Do you have a written order from MD? ☑

What is the ICD-9 code? 786.50 ☑

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Nuclear Stress Tests

Patient calls hospital to schedule test.
Do you have a written order from MD? ☑

What is the ICD-9 code? 786.50 ☑

Is the order signed and dated by doctor? ☑

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Nuclear Stress Tests

Patient calls hospital to schedule test.
Do you have a written order from MD? ☑

What is the ICD-9 code? 786.50 ☑

Is the order signed and dated by doctor? ☑

Does anyone check to see if the patient actually needs a nuclear stress test? ☒

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Noridian LCD L33660

The patient has an abnormal ECG with a high likelihood of coronary artery disease (CAD) based on multiple risk factors or strongly suggestive symptoms

The patient takes medication that would make interpretation of a standard exercise test inaccurate

The patient had an abnormal standard stress test and further evaluation is medically necessary

The patient has a condition which would likely result in a non-diagnostic or inaccurate standard stress test

Keeping up with the literature

Evidence changes!

- NICE-SUGAR- tight DM control- good then bad
- Blood transfusions- what's your trigger?
- Kyphoplasty- failed conservative trial?
- Zetia- Good? Worthless?
- Surviving Sepsis
- Intervention for Stroke

How do you keep up with changing medical practice?

The (Un)Learning Process

Denial - We gravitate towards literature, dogma, experts, and practice patterns that reflect our own biases. Thus, we may not come into contact with the information prompting a change in our practice or, alternatively, we may outright dismiss the assertion or data without a solid look.

Remind ourselves that publications may lead us astray if we are not careful.

- The first study makes the biggest splash but the second (third, fourth, etc) are the most important - don't overlook these . After all, replication is the key to science, the foundation of medicine.
- Pay particular attention to "negative" studies, which are published far less frequently than positive studies.

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Anger - We tend to become defensive when our beliefs and practices come under scrutiny or are challenged - it can feel like we're being attacked.

Accept that we will do things that may, in hindsight, be called "wrong" even though this was not known at the time.

- This takes a certain level of intellectual and emotional vulnerability. Historically, this is not only an issue at the individual level, but also a barrier for institutions to unlearn a practice.
- Beware of zealotry for a medical intervention. If question over one of an intervention causes us unease, it may indicate that we are tied more to an idea than to patient care.

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Bargaining - We may engage in mental trade-offs with the evidence, using our own experiences/anecdotes or mental frameworks in an effort to trump the data driving the unlearning. We may utter something along the lines of, "But, I saw Drug X work, in front of my very eyes," despite data demonstrating lack of efficacy.

Recognize the cognitive biases we have developed, our heuristics and anecdotes that may cause us to anchor in our learned practice patterns, and attempt to set these aside while we examine the data. These cognitive short cuts and experiences certainly comprise part of one's clinical gestalt; yet, there may be times in which they act as a crutch.

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Depression - We may feel guilty or defeated by this unlearning process and assume that it translates into either a reflection on ourselves or demonstration of the futility of medicine, research, or evidence based medicine.

Recall that while we have a seemingly innate desire to intervene, sometimes even apparently harmless interventions carry risks.

Reinforce that this is part of the process of practicing medicine, which is a dynamic environment teeming with uncertainty.

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Acceptance - Once we acquiesce to the notion that it's necessary to unlearn a practice or thought process in medicine, we are at risk of becoming complacent and failing to unlearn yet again, resulting in a vicious cycle. Perhaps we should never be fully comfortable with the support for what we do, as that may allow us to become complacent and think that we understand when we don't. We may share in creating a dogma to replace the one we have just unlearned.

Given the changing landscape of medical practice, it's likely wise to regard all of our practices with a skeptical and curious eye. This may allow us the mental flexibility to alter our practice when warranted.

http://goo.gl/sFOjPJ The Short Coat Blog

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Questions?

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