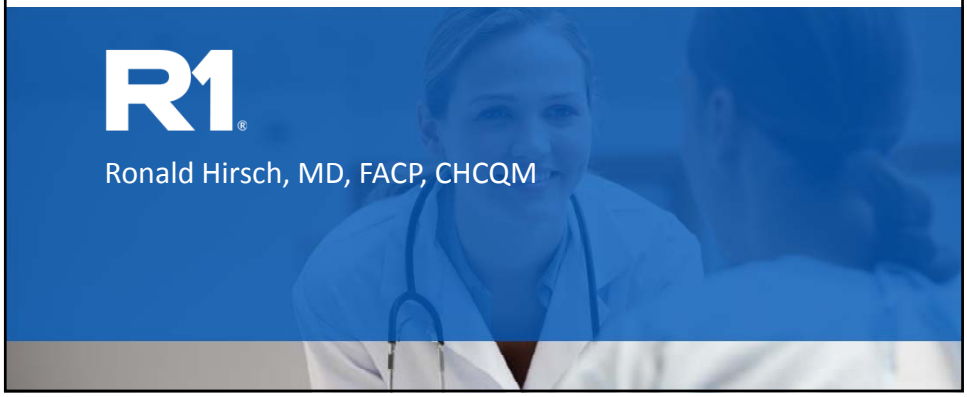
Medicare Update 2019



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What's New For 2019

- Lots of big Medicare fraud arrests
  - Florida $1.3 billion SNF owner
    - Bribed doctors to admit patients, order unnecessary services
    - Bribed state inspector to notify him of unplanned inspections
    - Bribed college official to get son into school
  - Nationwide $1.2 billion DME, telemedicine
    - Bribed docs to prescribe unnecessary items

GAO U.S. Government Accountability Office

Reports & Testimonies | Bid Protests & Appropriations Law | Key Issues

MEDICARE AND MEDICAID:

CMS Should Assess Documentation Necessary to Identify Improper Payments

GAO-19-277: Published: Mar 27, 2019. Publicly Released: Mar 27, 2019.

FAST FACTS | HIGHLIGHTS | RECOMMENDATIONS | VIEW REPORT (PDF, 60 PAGES)

Medicare and Medicaid review medical record documentation to ensure that they're only paying eligible doctors and hospitals for medically necessary, covered services. These reviews found an estimated $27.5 billion in payment errors due to insufficient documentation in FY 2017.

We found that Medicare and Medicaid have different documentation requirements for some of the same services, contributing to substantially different estimated error rates.

We **recommended** that the programs look into their documentation requirements, and more.

Both programs are on our **High Risk List**.

Clinical Validation Audits

- Documenting a diagnosis is not sufficient
- The clinical indicators must be present to support that diagnosis
- “Possible” diagnoses can be coded
- “Possible” diagnoses that are ruled out cannot be coded

Clinical /DRG Validation Audits

DRG	Description	CMI	GMLOS
870	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS OR ECMO	6.2953	12.4
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.8564	4.8
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0529	3.7
689	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.1116	3.9
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7941	3.0
193	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3167	4.2
194	SIMPLE PNEUMONIA & PLEURISY W CC	0.9002	3.3
195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.6868	2.6

DRG 871 $14,364

DRG 689 $8,838

DRG 194 $7,270

*St Joseph Burbank payment

Clinical Validation Audits – Why Care?

- You are being measured and tracked
- Your name is on every claim
- Quality programs use that data
  - SOI- Severity of Illness
  - ROM- Risk of Mortality
- One day someone will draw a line; you want to be above that line

Clinical Validation

- Document the diagnosis
- Support the diagnosis with exam or test findings
- Link the findings to the diagnosis

Clinical Validation

- Patient with dementia but has worsening mental status changes now with combativeness due to sepsis from e coli UTI.
- Cr up from 0.6 to 1.4- AKI due to sepsis from community acquired pneumonia

Clinical Validation

- Other clinical validation targets
  - AKI
  - Ac Resp Failure
  - Encephalopathy
  - Malnutrition
  - Hyponatremia

When can a diagnosis be coded?

- When they affect patient care requiring
  - Clinical evaluation; or
  - Therapeutic treatment; or
  - Diagnostic procedures; or
  - Extended the length of hospital stay; or
  - Increased nursing care and/or monitoring.

Clinical Validation

- Don't let your template/copy and paste kill your argument
  - Encephalopathic ≠ alert and oriented x 3

The Actual Admission Order

- Every admission requires an admission order
  - Payer's abnormal infatuation with those 3 words
- On extremely rare occasions, an admission can be billed if the intent to admit is established
- Always give the order but if one is missed, you may be asked to document your intent

The Future

- Appropriate Use Criteria for advanced imaging- 2020
  - Effect on in-hospital tests unclear
- E&M changes
  - Hospital care not being addressed yet
- Discharge Planning changes
  - May need discharge summary within 24 hours

Readmission Reduction Program

- Review medications
  - 24% of antipsychotics started for delirium were ordered on discharge; 15% of these still had delirium
  - Does patient need the PPI or H1 Blocker?
  - Did pharmacy do therapeutic substitution or was it a treatment “failure”?
  - Does someone need to do a medication debridement?
  - Be aware of cost and formulary issues

What's New with Two Midnight Rule?

- Cases continue to get audited
- Cases continue to be denied
- More auditors are waiting to audit cases
- Commercial and MA plans continue to make up their own rules

What Can You Do?

- Document your plans including duration
- Describe why the patient needs to stay in the hospital
- Discuss the risks of sending home

How Do You Count Midnights?

- Start of care in the ED
  - Chest pain- EKG
  - Abd pain- CBC, lipase
  - Asthma- nebulizer
  - Any care after triage based on presenting symptoms

Example

- Patient presents to ED at 11:25 pm with abdominal pain
- Triaged by RN, ED protocol states- order CBC, CMP, Lipase. Order entered at 11:55 pm- Clock Starts
- ED doc sees patient at 12:45 am, CT and Dilaudid ordered
- 3:15 am hospitalist called- still in pain

Example

- Hospitalist sees patient in ED at 4 am, reviews CT, labs, all normal, still in pain; determines need to hospitalize patient
- One midnight has already passed, pain may resolve by end of day so <2 MN so Observation ordered
- Endorses patient to partner at 7 am to monitor and discharge

Example

- Partner rounds at 5 pm, pt still getting Dilaudid every 4 hours, eating little, reports 8/10 pain
- Treatment continued, patient staying overnight
- Admit as inpatient since second midnight will pass

Case #2

- Patient placed Obs for nausea and vomiting on Monday
- Tuesday taking clear liquids, iv at 125 cc/hr
  - RN note- patient tolerating clears, no nausea, ambulating in halls
  - Labs from am- normal
  - Order- "Admit as inpatient due to persistent nausea, need for iv fluids"

vs.

  - "Although Cr is 1.0, patient baseline from office notes is 0.4. Hx AKI from similar episode. Cont iv fluids to supplement orals overnight to ensure adequate hydration, BMP in am"

The Big Question

- Why can't the patient go home and see a doctor in the am after getting labs done at hospital at 7 am?
- Your notes should explain why

Observation Measured in Hours not Days

- Monitor and reassess as often as clinically appropriate
- If patient with asthma placed obs at 2 am and H&P done, no reason they can't go home at 10 am or 2 pm or 8 pm if they get better
- Syncope patient presents at 9 pm. Placed on tele on 9:30 pm. Placed obs at 1 am. Testing done at 4 pm, all negative. Tell patient- "we will be monitoring you until 9:30 pm. If all is normal, you will be discharged at that time. Be sure you have a ride."

Midnights that Don't Count

- Convenience of hospital
  - No stress tests or MRI on Sundays
- Convenience of doctor
  - Orders GI workup for Hb = 11.8, asymptomatic
- Convenience of patient
  - Too late to go home, no ride, wants to stay

What about Commercial/MA plans?

- Some follow 2 MN Rule, some don't
- Many want to see intensity of service documented
- Many want to see "worsening" or "not improved"
- Ask for help if unsure
- Justify every day of every stay

Determining Status of Surgery Patients

- Commercial – Ask the payer- no rhyme or reason
- Medicare – Start with Medicare inpatient only list
  - If on the list, always inpatient
  - If not on the list, status depends on how long they will be in the hospital
  - Emergency simple appendectomy- outpatient
  - Appendectomy with perf- needs ATB x 48 hours- inpatient

Spending the Night After Outpatient Surgery

- Why are they staying?
  - Routine recovery? EHOP – no extra payment
    - Why are they staying overnight? Standard of care or physician preference?
  - Complication so could not discharge as expected? Observation or Inpatient depending on severity

Medical Necessity of the Care

- Three kinds-
  - Does the patient need what is being done to them?
    - Since doctors are well-shown to overestimate harms of disease (and risk factors) while underestimating harms of intervention, we often don't get a realistic picture of whether the harms of an intervention exceed the benefits.

Medical Necessity of the Care Itself

- Why a nuclear stress test and not plain?
- Why a CT scan and not a clinical exam and risk scoring?
- Why iv antibiotics and not oral?
- Why surgery and not conservative measures?

What's Not Medically Necessary?

- 66 yr old female with OA of knee. Tried Naprosyn with some relief. Xray with mod OA. Patient's daughter getting married, wants knee fixed now so she can dance at wedding. Schedule surgery.

Medical Necessity of the Care Location

- Does the patient need to be in the hospital?
  - Why not do the surgery in an ASC?
  - Why not do the procedure in the doctor's office?
- Why does the chemotherapy need to be done in the infusion center?
  - Why not in the doctor office?
- Why be seen in the ED?
  - Why not an urgent care center or doctor office?

Medical Necessity of the Status

- Why inpatient and not outpatient?
- As discussed earlier

Orthopedists are Special - Total Knee Replacement

- Previously inpatient only; now can be performed as outpatient or inpatient
- Most go home on post-op day 1 so default status = Outpt

- To be admitted as inpatient
  - High risk surgery due to surgical complexity
  - High risk due to comorbid conditions
  - Medical need to go to SNF after surgery
  - Expected to need longer in-hospital stay

- Applicable factors must be documented clearly
- Admission decision must be documented

Surgical Risk

- 75 yr old female with OA knee, failed conservative measures- PT for 3 months, RX NSAID, Synvisc. Pain limits walking and going out for activities. Xray with severe degenerative changes and osteopenia. Recent DEXA with significant osteoporosis. Schedule for surgery.
- Will admit as inpatient. Significant osteoporosis will make surgery technically difficult and more prolonged with higher risk of fracture. If goes well, expect home on Post-op day 1

Medical Risk

- 70 yr old Patient with tpe II DM requiring insulin with HbA1c of 7.8%, HTN On 3 meds with BP 150, and OSA warrants inpatient admission due to higher risk of surgery. At risk for hypo- and hyperglycemia, BP fluctuations, and apnea. Will require close peri-op monitoring and post-op glu, BP, and resp monitoring.
- Be sure to order glucose checks, basal/bolus insulin, resp monitoring, BP checks. Avoid "monitoring per protocol"
- One day stays are allowed for this surgery!

Needs SNF

- 85 yr old male with OA. Assessed in pre-hab class by PT and discovered widower, lives alone in split level home, no family. Will not be able to discharge home after surgery unless good mobility and able to access bathroom at house.
- POD#1- Ambulating 10 steps with full assist, no steps tolerated, cont in hospital PT
- POD#2- some progress with PT- did 3 steps but not steady, needed full assist. cont PT
- POD#3- more progress, unable to safely go home- send to SNF today

No Significant Risks

- 72 yr old male, s/p right TKA yesterday. This am confused, sees bugs on wall. PT unable to get patient to cooperate.
  - Admit as inpatient- review meds, order labs, hold opioids, ask family to remain at bedside.

- 72 yr old male s/p left TKA yesterday. Called to see patient with wheezing. Hx mild COPD, uses prn albuterol at home. Exam with sig wheezing.
  - Admit as inpatient- Get CXR, start nebs, consider ATB and steroids.

Oops, We Got Status Wrong

- Medicare one and two day inpatient admissions will be reviewed
  - Is there an order for admission?
  - Was order signed?
  - Was inpatient appropriate?
  - Does documentation support admission?

During the Stay

- If admission decision was incorrect, check payer
  - Commercial plans- change status with order
  - Medicare- requires review by UR committee doctor, agreement from attending, order for change, written notification to patient

After the Stay

- If admission decision was incorrect, check payer
  - Commercial plans- check payer policy
  - Medicare-
    - requires review by UR committee doctor
    - notification of attending
      - Agrees- self-deny and rebill
      - No answer- self-deny and rebill
      - Disagrees- go to tiebreaker with 2nd UR doc

What's Self-Deny and Rebill?

- Hospital notifies patient in writing by mail
- Hospital submits a no pay inpatient claim
- Hospital waits for that claim to process
- Hospital submits two more claims
  - 131- services before admission order
  - 121- services after admission order
- Physicians still bill inpatient admission
- SNF eligibility not affected unless "admit for SNF"

Questions?

