EHR®
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company™

Successful Strategies for Physician Engagement

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PEER REVIEWED by HFMA*

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Featured Speaker:
Robert R. Corrato, MD, MBA

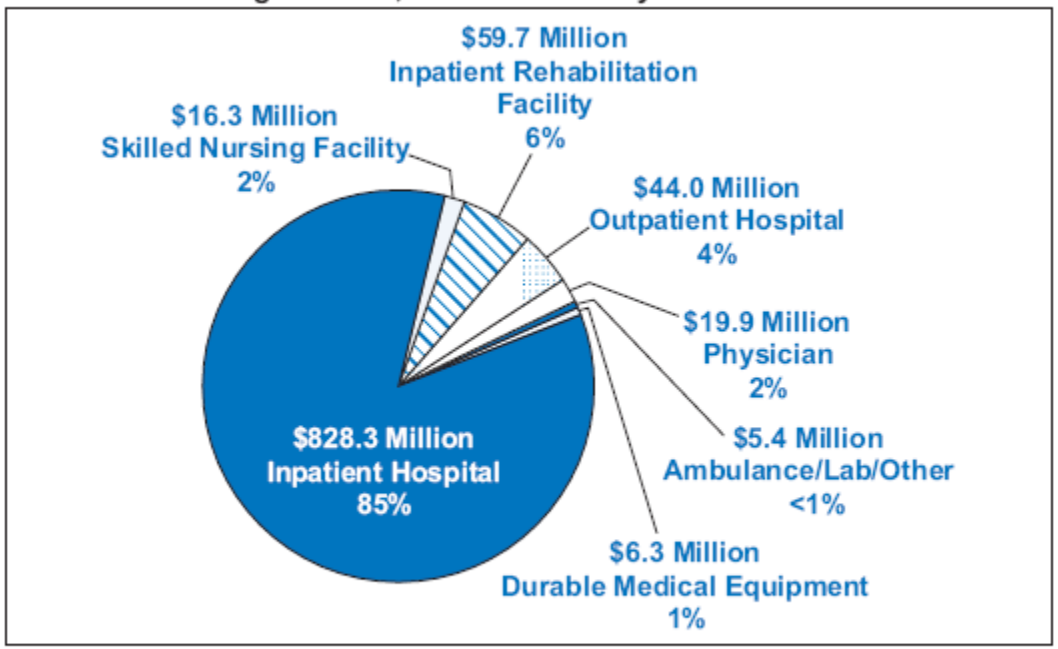
President & Chief Executive Officer
Executive Health Resources

Dr. Corrato founded EHR in 1997 and has since served as EHR's President and Chief Executive Officer. At present, more than 700 hospital and healthcare organizations in 48 states are using EHR's solutions. Since the start of the Recovery Audit Contractor (RAC) demonstration project, Dr. Corrato has amassed extensive experience with all stages of the RAC review and appeal process. He has engaged in thousands of RAC denial appeals and hundreds of Administrative Law Judge hearings, and has achieved unmatched success in obtaining the reversal of admissions inappropriately denied by RACs.

Prior to founding EHR, Dr. Corrato held the post of deputy director of the Office of Health Policy and Clinical Outcomes at Thomas Jefferson University in Philadelphia. An internist with extensive outpatient, inpatient, academic and community-based clinical practice experience, he is one of only six physicians in the U.S. to have completed medical fellowship training in managed care/administrative medicine. Dr. Corrato earned his master of business administration degree from the Wharton School of Business at the University of Pennsylvania and received his medical degree from the Medical College of Pennsylvania.

$828M in RAC Denials to Inpatient Hospitals – 2% of Dollars Came from Physicians

Figure 5. Overpayments Collected by Provider Type: Cumulative Through 3/27/08, Claim RACs Only



Note: These data are *not* net of appeals.
Source: RAC invoice files and RAC Data Warehouse (ratios needed to calculate Physician percentages from Ambulance/Lab/Other data were self-reported by the Claim RACs).

Over $152M of the $391M in Inpatient Hospital Medical Necessity Denials Related To Surgical Procedures

Table G1. Top Services With RAC-Initiated Overpayment Collections (Net of Appeals): Cumulative Through 3/27/08, Claim RACs Only

Type of Provider	Description of Item or Service	Amount Collected Less Cases Overturned on Appeal (Million Dollars)	Number of Claims With Overpayments Less Cases Overturned on Appeal	Location of Problem
Inpatient Hospital	Surgical procedures in wrong setting (medically unnecessary)	88.0	5,421	NY
	Excisional debridement (incorrectly coded)	66.8	6,092	NY, FL, CA
	Cardiac defibrillator implant in wrong setting (medically unnecessary)	64.7	2,216	FL
	Treatment for heart failure and shock in wrong setting (medically unnecessary)	33.1	6,144	NY, FL, CA
	Respiratory system diagnoses with ventilator support (incorrectly coded)	31.6	2,102	NY, FL, CA

Why is Getting Patient Status Correct Such An Important Issue?

- Incorrect overuse of Inpatient
  - Recovery Audit Contractors
  - Potential False Claims issue if no compliant process is in place
  - Eventual loss of revenue on audit and loss of opportunity for appropriate OBS APC and ancillary charge payment
- Incorrect overuse of Observation
  - Revenue integrity issue for hospitals and physicians
  - Length of stay artificially elevated
  - Mortality data artificially elevated
  - Market share data artificially lowered
  - Cost of inpatient care data artificially elevated
  - Transfer DRG payment impact
  - Qualified stay impact on patient skilled care benefit
  - Unexpected patient financial responsibility
    - E.g.- self administered medication charges, co-pay
    - It is about getting it right!

Only A Doctor Can Legally Admit Patients To A Hospital

- 42 CFR 482.12(c)(2)
  - "Patients are admitted to the hospital *only on a recommendation of a licensed practitioner permitted by the State to admit patients to a hospital."*
- Medicare State Operations Manual
  - "In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate."

Your Hospital's UR Plan is the Standard by Which Physicians Will Be Judged to Be In (or Out of) Compliance with Medicare Part B

- "The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by **members of the medical staff** to patients entitled to benefits under the Medicare and Medicaid programs."

- 42CFR482.30(c)(1) *Standard: Scope and frequency of review.*
  - "The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of—
    - (i) **Admissions** to the institution;
    - (ii) The duration of stays; and
    - (iii) **Professional services** furnished, including drugs and biologicals."

Regulatory Guidance for How the UR Committee Can Best Carry Out Its Mandate

Best Practices for Admission & Continued Stay Review (HPMP Compliance Workbook)

- "Because it is not reasonable to expect that physicians can screen all admissions, continued stays, etc. for appropriateness, screening criteria must be adopted by physicians that can be used by the UM staff to screen admissions, length of stay, etc. The criteria used should screen both the severity of illness (condition) and the intensity of service (treatment). There are numerous commercial screening criteria available. In addition, some QIOs have developed their own criteria for screening medical necessity of admissions and procedures. CMS does not endorse any one type of screening criteria."
- "Cases that fail the criteria should be referred to physicians for review. For your UM program to screen medical necessity appropriately, the decision to admit, retain, or discharge a patient should be **made by a physician**, either through the use of physician approved or developed criteria, **or through a physician advisor**."

The Law Mandates That The Treating Physician Be Involved In The UR Committee Function

42CFR482.30(d) *Standard: Determination regarding admissions or continued stays.*

- "(1) The determination that an admission or continued stay is not medically necessary—
  - ✓(i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient…concur with the determination or fail to present their views when afforded the opportunity; and
  - ✓(ii) Must be made by at least two members of the UR committee in all other cases.

- (2) Before making a determination that an admission or continued stay is not medically necessary, the **UR committee must consult the practitioner or practitioners responsible for the care of the patient**… and afford the practitioner or practitioners the opportunity to present their views.

- (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the **practitioner or practitioners responsible for the care of the patient**…

Regulatory Definition of “Inpatient”

“…However, the decision to admit a patient is a ***complex medical judgment…*** Factors to be considered when making the decision to admit include such things as:

- The ***severity*** of the signs and symptoms exhibited by the patient;
- The ***medical predictability*** of something adverse happening to the patient;
- The ***need for diagnostic studies*** that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The ***availability of diagnostic procedures*** at the time when and at the location where the patient presents.

It’s all about the physician!!!!!

Admissions of particular patients are ***not covered or non covered solely on the basis of the length of time*** the patient actually spends in the hospital.”

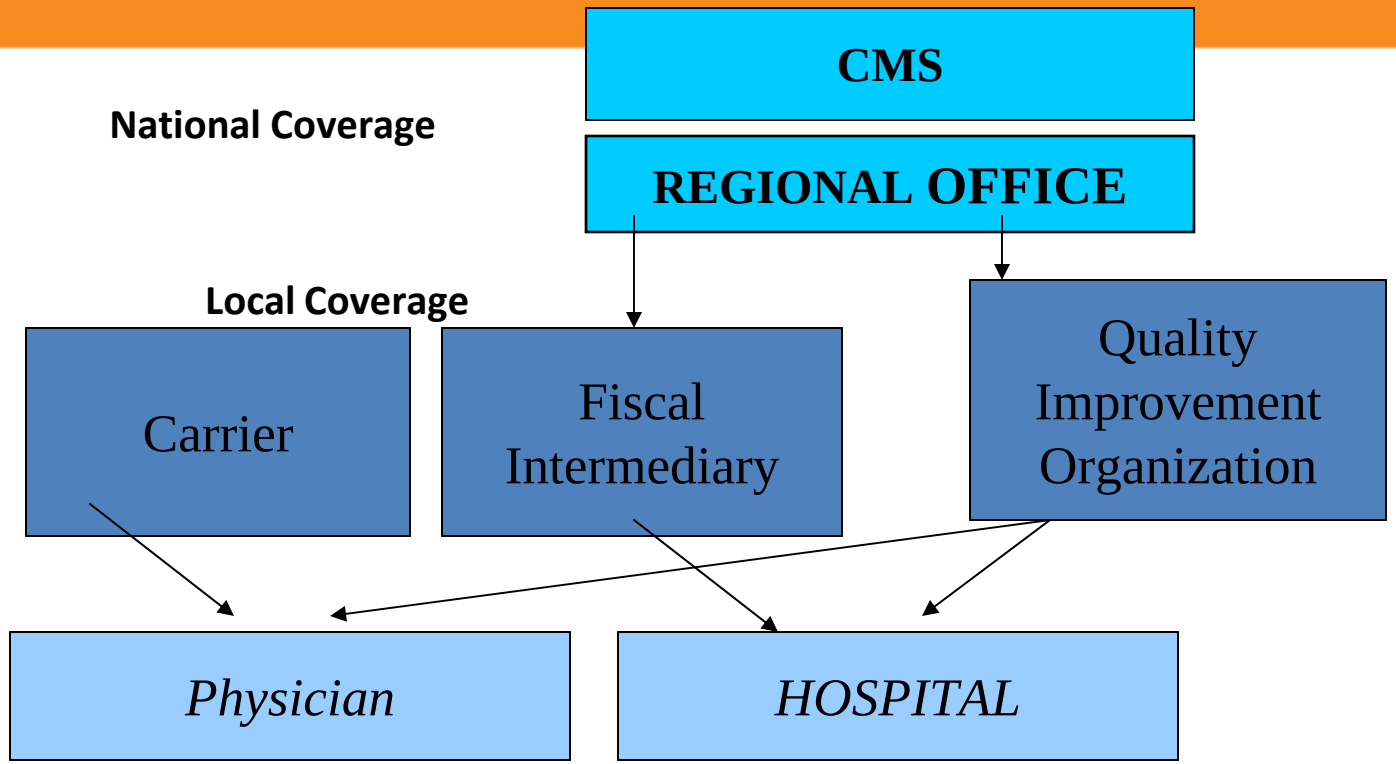
Why Should the Physician Care About Change in Medicare Claim Status?

- **Most physicians:**
  - Have **no idea** what observation means
    - Medicare vs. Managed Care vs. Medicaid!
    - Frequently leads to overuse of Observation Status
  - Aren't usually concerned about or don't understand the impact on the **hospital**
  - Are concerned that it means different financial responsibility for their **patients**
  - Are concerned that it may affect their **reimbursement and/or compliance exposure**

Does CMS Have an Evidence Basis To Assume that Physicians Don't Know How to Certify Claim Status?

- OIG track record of claims, suits, settlements and arrests
- Lee et al; Arch of IM; 2-11-08
  - "Many higher-risk patients are not being referred" [for cardiac catheterization] "because of the perception that they are not high enough risk."

Getting Your Medical Staff "On Board"



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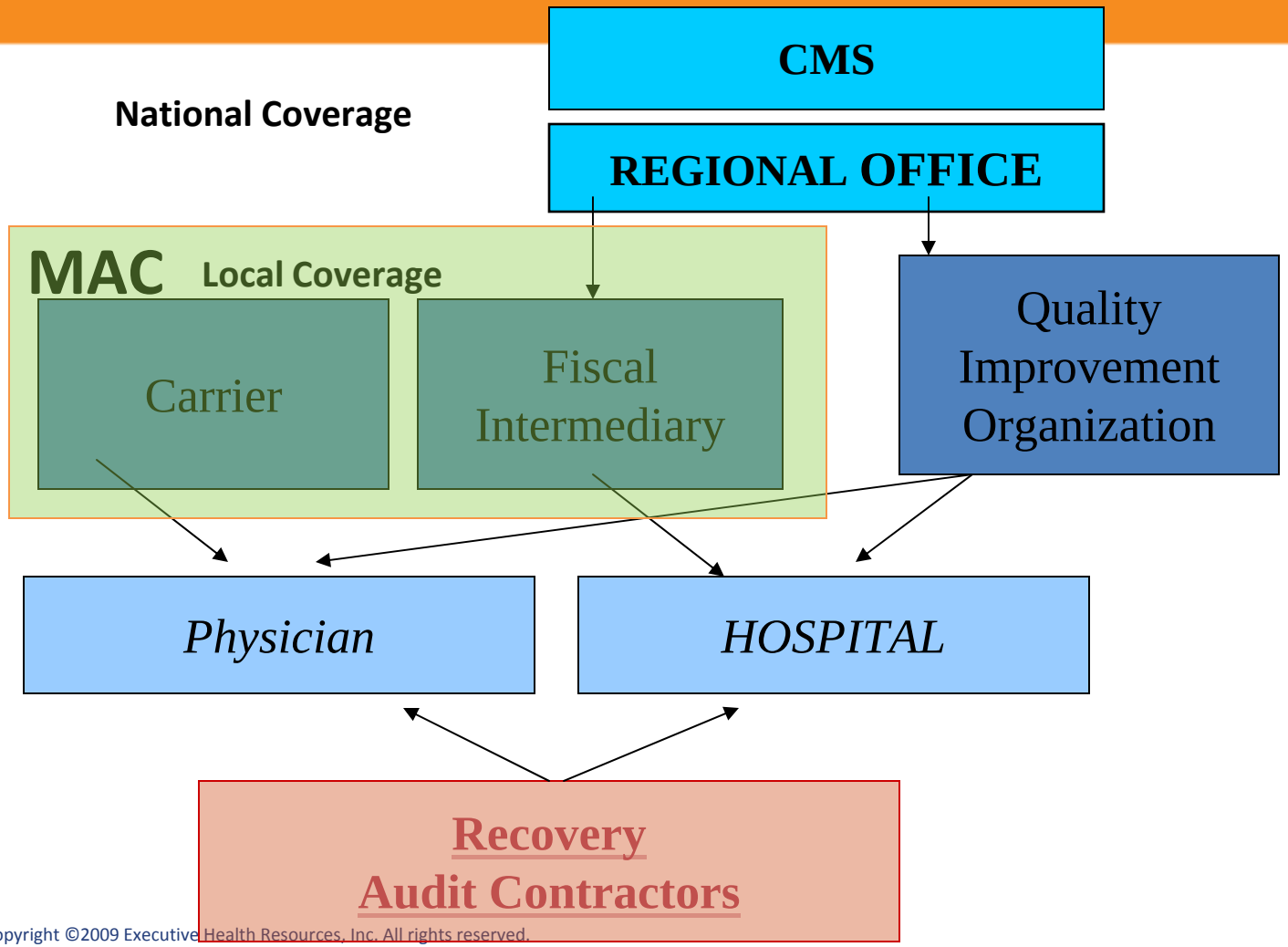

Concordance:
How are Hospitals and Doctors Affected?

The components of concordance:

1. The Hospital UR decision
2. The Treating Physician Order
3. The Hospital Claim (Part A services)
4. The Physician Claim (Part B services)

Getting Your Medical Staff "On Board"

Physician *Error*?...

Hospital UR Determination	Physician Order	Hospital Claim (Part A)	Physician Claim (Part B)	Physician Impact
OBS	IP	None	IP	VERY BAD

...Or Worse?

Claim Concordance Will Impact Physician Compliance & Revenue Integrity

- Updated RAC SOW FAQs (11/07) state that E&M Codes WILL be audited in the future
- Hospital-Physician Claim Concordance will be an upcoming OIG investigative target
- MAC edits have been created to identify lack of claim concordance
- No automatic denial of claims associated with a full inpatient denial, but they are subject to individual review/adjustment

Physician Admission Order Format Questions

- How should the order for admission status be written?
- Does the term “admit” = inpatient status?
- When does the tern “observe” = observation services?
- Ambiguous orders:
  - “Admit to Observation”
  - “Admit for Observation”
  - “Admit to Floor”
  - “Place Patient Under Close Observation”
  - “Observe Patient in the ICU”

Physician Order/Timing vs. Physician Intent

- Patient placed in hosp bed at 8pm on Day 1
- Physician admission order is ambiguous
- UR screening criteria review by UR staff occurs at 9am on Day 2
- At 10am on Day 2, UR staff determine that IP screening criteria were met based upon info obtained from the time of initial physician eval and placement in hosp bed on Day 1
- At 11am on Day 2, UR staff asks physician to clarify admission order for inpatient. Physician agrees and writes inpatient order at 11am
- At 11:15am on Day 2, physician notes dramatic improvement of patient status and writes order for patient discharge after lunch if patient can tolerate oral intake.
- Application of UR screening criteria at the time of physician inpatient order on Day 2 finds that inpatient status is no longer being met.

- What claim status is appropriate?
  - On Day 1? On Day 2?

OBS Order Timing Condition Code 44

- Observation is an outpatient service, not a “status”
- According to the CMS Claims Processing Manual, “Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time *that observation care is initiated* in accordance with a physician’s order.”
- What happens when the time of a physician’s *order* for observation services does not coincide with the time of the initiation of the services themselves?
- Example: A physician mistakenly orders an inpatient admission for a patient who only requires outpatient observation services. Prior to discharge, the hospital and physician agree that an inpatient admission was not medically necessary, and the decision is made to convert the admission to an outpatient service by means of Condition Code 44.
  - Can observation services be billed?
  - If so, at what time can billing for observation services be started?
    - From the time of the order for inpatient admission?
    - From the time of the order for Condition Code 44?

Ensuring ALL are Aware of Admission Status

- Treating Physician (42 CFR 482.12(c)(2))
  - Physician order and intent
- Hospital (42CFR482.30(c)(1))
  - Claim submitted is consistent with admission status determination
- Beneficiary (CMS- 4105-F)
  - Delivery of message detailing admission status, impact on beneficiary financial responsibility, and options regarding where and when beneficiary may receive services
  - BEFORE DISCHARGE from hospital bed

QUESTIONS?

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About Executive Health Resources

EHR® received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of Medicare and Medicaid Compliance Services,including Medical Necessity Certification, Continued Stay Review and Denial Review and Appeal.

The American Hospital Association has exclusively endorsedExecutive Health Resources' Medicare ComplianceManagement, Length of Stay Management, RetrospectiveClinical Denials and Concurrent Clinical Denials Programs.

EHR has been recognized as one of the "Best Places to Work" in the Philadelphia region by Philadelphia Business Journal.

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