The First Talk of the Day

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Keynote Address: Roles & Responsibilities of a Physician Advisor: Observations & Experiences from the Field

Ronald Hirsch, MD, FACP
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AccretiveHealth, Chicago, IL

Abstract:
With the ever increasing array of hospital and physician by an ever increasing number of agencies, the case manager’s role in the hospital is finally being appreciated. In this session, the presenter will provide insight to help your manager perform more efficiently, more collaboratively, more completely and with higher job satisfaction.

Learning Objectives:
1. Understand techniques for effective physician communications and collaboration
2. Identify effective case reviews
3. Improve the hospital’s compliance with rules and regulations

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Case Management Hors D’oeuvres – Tasty Bites for the Mind

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Objectives of both talks

1. Understand techniques for effective physician interactions and collaboration
2. Perform effective case reviews
3. Improve the hospital’s compliance with rules and regulations

Before I get started...

JOIN THE ACMA!!!!!

then sign up for Learning Link

On Feb 8, 2013, at 9:06 AM, "Kimberly Mallory" <Kimberly.Mallory@CHHI.ORG> wrote:

We need so help. We have a patient in-house who is over 700lbs and in need of a skilled facility. We have exhausted our resources – calling over 200 facilities in multiple states.

Does anyone have a suggestion?

Kimberly D. Mallory, RN, MSN, MBA
Director of Clinical Resource Management
Cabell Huntington Hospital
Hi Kim
I recall a facility near Columbus, Ohio who was taking these type of patient—Bariatrics was all they did.

Chris Whetsell
Sent from my iPhone

On Feb 8, 2013, at 12:27 PM, "Marcia Whittaker" <MWHITTAK@HIGHLANDSHOSPITAL.ORG> wrote:

Kim,
We had a similar patient and some Bariatric facilities would not accept patients over 450. We did find one in Smithport, PA that would accept patients up to 700 lbs.

Marcia Whittaker, RN-BC, ACM
Director of Case Management
Highlands Hospital
Connellsville, Pa 15425

On Fri, Feb 8, 2013 at 4:16 PM, Howard, Pam <PHoward@seton.org> wrote:

Try Windsor Care Center in Ohio tel:419-637-2104

Sent from my iPhone
As a result, MAC’s are looking at doctors

National Government Services will be conducting service-specific prepayment audits on the following current procedural terminology (CPT) codes, targeting specific physician specialties for jurisdiction 1, New York and Commercial Part B providers:

- 99223 - Initial hospital care, per day for the Evaluation and Management (E&M) of a patient billed by physician specialty 02 (General Surgery);
- 99225 - Subsequent hospital care, per day, for the E&M of a patient billed by physician specialties 00 (Gastroenterology) and 10 (Gastroenterology) and;
- 99156 - Office or other outpatient visit for the E&M of an established patient billed by physician specialty 83 (Hematology/Oncology)

Doctors behaving badly

- Leading Oncology Practice To Pay $4.1 Million To Settle False Claims Act Investigation
- Georgia Cancer Specialists Overbilled Medicare for Evaluation and Management Services

Here, the U.S. Attorney’s Office alleged that Georgia Cancer Specialists applied modifier -25 to claims that did not qualify for its use, leading to overpayments by Medicare.
Florida dermatologist fined $26 million

- The dermatologist had an arrangement with the pathology lab
  - He sends slides
  - They read slides
  - He signs interpretations
  - He bills Medicare

- Also performed unnecessary Moh’s surgery and flap surgery to bill higher amount

- Whistleblower- employed pathologist at lab- $4 mil reward (guess who won’t be in front of a microscope any more?)

OIG 2013 Work Plan targets cloning

Evaluation and Management Services—Potentially Inappropriate Payments in 2010

- We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported.
**Quality in Health Care**

- "If the MDs don’t develop quality measures, the MBA’s will.”
- "If we don’t do it ourselves, Congress will make a law forcing us to do it.”
  - Ian Jones, MD, VPMA, Sherman Hospital, Elgin, IL
- We have not been good guardians of the Medicare Trust Fund so they had to mandate:
  - Core measures
  - Joint Commission Patient Safety Goals
  - Never Events
  - And now the RAC, Prepayment reviews, OIG audits, VBP

**Value Based Purchasing**

- First hospitals
  - Began October 2012 based on performance in 2009-2011
  - Processes of care
  - Outcomes of care
  - Patient satisfaction (don’t get me started on Press Ganey)

- Physicians to start 2015
  - Large physician groups first then smaller groups
  - Outcomes of care
  - Cost of care
What Quality Measures will be Used for Quality-Tiering?

- Measures reported through the PQRS system
- Three outcome measures:
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (chronic obstructive pulmonary disease, heart failure, diabetes)

What Cost Measures will be Used for Quality-Tiering?

- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with four chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
  - All cost measures are payment standardized and risk adjusted

Use your Physician Advisor as your CM advisor

- Their job is not all just secondary review
  - Long LOS cases
  - Ethics type cases
  - PITA doctors
  - Soft admit cases
  - Long Observation cases
  - CC 44 patients
  - Disruptive drug seekers
So what to tell docs?

- There is something “in it” for them- money
- They are “being watched” at all time- MAC’s, RAC’s, OIG, colleagues, hospital workers, patients
- Case Managers are here to help, not to kick their patients out- you are their best friend!

Inpatient v. Observation

- “Observation is a well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”
  Medicare Benefit Policy Manual, Pub 100-04, Chapter 4, Section 290

- “An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.
  Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed…”
  Medicare Benefit Policy Manual, Pub 100-2, Chapter 1, Section 10

- Thanks a lot CMS!

Overuse Observation

- Higher patient payment
- OIG audit target
- Hospital losing out on compliant reimbursement $800 v $5,000
- Patients lose potential SNF qualifying days

Overuse Inpatient

- Risk MAC and RAC audits
- Hospitals get $0 for denied cases
- Inpatients have immediate appeal rights not available on Observation
- Patients may be responsible for SNF costs if Inpatient stay denied
The Retrospectoscope is 20/20

"...[Reviewers should] consider only the medical evidence which was available to the physician at the time an admission decision had to be made, and do not take into account other information (e.g., test results) which became available only after admission."

Medicare Benefit Policy Manual, Chapter 1, section 10

- So shouldn't we be able to send the RAC only the notes before the patient is admitted??

Physician's Decision to Admit

"The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors:

- 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."

Medicare Benefit Policy Manual – Chapter 1, Section 10

Physician documentation of severity of illness and risk stratification

"CMS reminds providers that the medical record must contain sufficient documentation to demonstrate that the beneficiary’s signs and/or symptoms were severe enough to warrant the need for inpatient medical care."

CMS, MLN Matters, SE10T2, 11/12/2010
Medicare Requires Screening of Admissions

• “…screening criteria must be…used by the UM staff to screen admissions…
• The criteria used should screen both severity of illness (condition) and intensity of service (treatment).
• Cases that fail the criteria [for admission] should be referred to physicians for review.”

Medicare Hospital Payment Monitoring Program

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So how to decide?

• What did the doctor document?
  - Remind doctors the auditors are disgruntled nurses and therapists who get paid to deny. We need to spoon feed them the information.

• What is the patient’s risk?
  - Don’t be fooled by your patient population- look at the data
  - If you’ve seen one patient, you’ve seen one patient

• What are the plans for the patient?
  - ASA, stress test- probably Observation
  - Heparin, Nitro, cardiology consult- probably Inpatient

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What cases to refer?

• Patients that fail Interqual review
  - IQ and Milliman both say at that approx 30% of cases that fail criteria warrant inpatient

• Patients that meet Observation
  - To determine if physician judgment can upgrade them to Inpatient
Medicare defines three types of surgery

- Outpatient surgery that can be performed in ACS
- Outpatient surgery that must be performed in a hospital
- Inpatient Only surgery

“The fact that the procedure is in an APC* group… should not be construed to mean that the procedure may only be performed in an outpatient setting… We (CMS) expect that when these (APC list procedures) are performed in the outpatient setting, they will be only the simplest, least intense cases.”

Federal Register, Sept 8 1998 and Apr 7, 2000

*APC = Ambulatory Payment Classification, used to pay hospitals for bundled outpatient services

Elective Surgery Status Rules

- Surgery on Inpatient Only list- must have Inpatient order prior to incision
- Not on Inpatient Only list
  - Low risk patient- perform as Outpatient
  - High risk patient- admit as Inpatient prior to surgery (good note)
    - Do not let the docs say “Clear for surgery”
  - Needs more monitoring after recovery- place in Observation
  - Major intra-op complication- admit as Inpatient post-op
What Is an Outpatient Surgery or Procedure?

“When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of:

- the hour they came to the hospital,
- whether they used a bed, and
- whether they remained in the hospital past midnight.”

Medicare Benefit Policy Manual, Chapter 1

My mother-in-law said she was visiting for a “few days.”

Standard Recovery Period

- Normal recovery may be determined by PACU protocol (e.g., based on time and clinical indicators).
- The surgeon may determine normal recovery by post op orders. (Ex.: “Discharge pt after voiding following Foley catheter removal.”)
- Care ordered for all patients having a particular procedure would be “routine recovery” (Ex.: CBI)
- Normal recovery may be overnight in an outpatient bed without admitting or ordering observation
- Use of observation is not determined solely by duration of recovery or by the services ordered
Post op Observation

“Hospitals should not report as observation care services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours).”

Medicare Claims Processing Manual, Chap 4, Section 290.2.2

Medical Necessity for Post op Observation

“There must be medical necessity for observation beyond the usual recovery period, as hours of the usual recovery time associated with the procedure are already reimbursed with the procedure.”

Local Coverage Determination Policy (LCD#1281) issued by Blue Cross, Blue Shield of Tennessee (Riverbend Government Benefits Administrator)

(If this is true, then why don’t hospitals get paid for observation after a surgery?)

Post op/ Post procedure Observation

“…when a patient has a significant adverse reaction (beyond the usual and expected response) as a result of the test that requires further monitoring, outpatient observation or inpatient hospital services may be reasonable and necessary.”

WPS Medicare, Final Comments, LCD 32222
What about the surgery itself?

- Section 1862(a)(1)(A) of the Social Security Act states that Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

(Why does CMS have to use double negatives? Oh, yeah, they’re a government agency…) 

NCD’s and LCD’s available for many procedures
- Pacemakers, ICD’s, total joint replacement, cataract extraction

If no NCD/LCD, “acceptable standard of practice” applies
- Medicare contractors, in determining what “acceptable standards of practice” exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts
- By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine.

What is not included as “acceptable”?

- I’ve always done it this way.
- But the patient insists I do it.
- The device rep said that it works well for this.
- But I have to do something.
Is this an issue?

- FCSO- Total Joint audit 2011- 93% denial rate
  - As of 2103, recouping physician fees (whoohoo!!!)

- Palmetto- cataract extraction- 85% denial rate

- Pacemakers
  - Wholesale denials of dual chamber pacemakers

- Routine Pre-op lab testing
  - CBC, CXR, EKG, PT/PTT

- MAC anesthesia for minor procedures

Gaming the system

- How do you avoid a non-coverage rule? Lie!

- Minimally invasive lumbar diskectomy- mild® CPT 0275T
  - Not covered by CMS or Blue Cross

- The bait and switch
  - Doctor schedules as 60303- traditional discectomy
  - Vertos rep shows up in OR with mild equipment
  - Doctor performs 0275T
  - Doctor bills 63030, gets paid
  - Hospital forced to bill compliantly- 0275T, gets denied
  - Vertos still sends bill to hospital for hardware

What is your hospital’s new service evaluation procedure?

- Do you look at…
  - FDA/CMS/Insurance approvals?
  - Medical Necessity Guidelines?
  - Equipment costs- fixed and per procedure?
  - Staff training?
  - Reimbursement- DRG / APC?
  - Precertification requirements?
  - Expertise of physicians?

- Just because you can offer a new service does not mean that you have to offer it. (Gotta wonder…who is going to be patient #1 and do they know it?)
The Role of the CM in Surgery

- Be everywhere!
- In surgery scheduling
  - Proper level of care pre-op based on CPT
  - Documentation of medical necessity
  - Possibly patient education on expected LOS, post-discharge planning
- In the OR
  - Proper post-op level of care
  - Upgrades in the OR from surgery changes, complications

Outpatient Chemo - the final frontier

- Huge opportunity for CMS to recoup billions
- CMS covers drugs and biologics for anti-cancer therapy chemotherapy if they are used as per FDA-approved indications. CMS also pays for off-label, medically accepted indications if they are supported in either one or more of the compendia (4) or in peer-reviewed medical literature (26 journals) specified in the Medicare Benefit Policy Manual Chapter 15.

Kyprolis™ (carfilzomib)

- Approved for the treatment of patients with multiple myeloma who have received at least two prior therapies, including bortezomib and an immunomodulatory agent, and have demonstrated disease progression on or within 60 days of completion of the last therapy.
- The medical record must clearly document the patient’s prior chemotherapy regimens, disease progression and body surface area.
- $9,550 for a typical cycle of six vials, cycle every 28 days
- Currently, no data are available that demonstrate an improvement in progression-free survival or overall survival.
In your outpatient infusion/onc center

- Does someone review the records to see if the right drug is being given in the right order?

- Just because it is not covered, does not mean it cannot be given
  - ABN for outpatient
  - HINN 11 for inpatient

Readmissions

- Why 30 days?
  - Why not 23 days? 17 days? 8 days?

- Only 35% of readmissions are related to previous admission

- If your mortality rate is higher, your readmission rate is lower since you can’t readmit a dead HF patient

Post-Hospital Syndrome

- NEJM January 10, 2013
  - Readmission cause same as index admission only ~35% of time
    - deprived of sleep,
    - experience disruption of normal circadian rhythms,
    - are nourished poorly,
    - have pain and discomfort,
    - confront a baffling array of mentally challenging situations, receive medications that can alter cognition and physical function, and
    - become deconditioned by bed rest or inactivity.

- Get patients out of bed and out of the hospital!
Successful strategies

- Schedule outpatient appt for patient before they leave the hospital
- Pharmacist active involvement in medication reconciliation
- Community partnering
  - SNF’s, home care agencies, social service organizations work together
  - OIG 2013 Work Plan includes readmissions from SNF
  - Sounds great but then there is patient choice and physician steering to “their” SNF or agency of choice

Medicine Changes!

- Calcium and women
  - 60,000 women age 39-73
  - 19 year follow-up
  - Women who consumed 1,300 mg a day or more by diet and/or supplement as compared to those under 1,000 mg
    - 40% higher mortality
    - 51% higher CV mortality
    - 100% higher ischemic heart disease mortality
    - Those who took supplements had 2.57x higher risk of mortality than those who did not
      - BMJ 2013;346:f228

- Tight Glucose control in ICU
  - “Landmark” study found reduced risk of death with tighter control
  - NICE-SUGAR: larger population, better oversight: higher mortality
  - Tight diabetes control
    - For years – “The lower the HbA1c, the better”
    - 2011- three trials- ACCORD, ADVANCE, VADT done
      - Established diabetes in middle aged and older patients
      - Tight control led to increased death, increased MI
      - No improvement in any end organ measure: some reduction in degree of microalbuminuria but no effect on ESRD rates (do you care what your microalbumin level is?)
Patient Oriented Evidence that Matters

- Surrogate end points mean nothing if it does not correlate with a patient-oriented outcome
- HbA1c - surrogate marker for diabetes control
  - Evidence that lowering it prevents blindness, MI, CVA, ESRD is lacking for all drugs except metformin and real low = higher risk
- LDL - surrogate marker for CAD risk
  - Statins have evidence that they lower CAD risk
  - It is independent of LDL lowering - no benefit to Crestor over Simvastatin
  - No evidence that adding Niacin, fish oil, fibrates, Welchol reduces risk any further, but the LDL and HDL look better

Condition Code 44

- Any inpatient that is changed back to outpatient/observation prior to discharge must have a CC44 process performed…unless the order has not left the doctor’s hand.
- Yes, that means that even if the attending doctor knows inpatient is incorrect and wants to change it, you still must do a CC44.
- Can be done any time prior to formal discharge, even if doctor has written discharge order

How to do it

- Depends on who asks for it
  - Attending asks for change
    - CM calls UR MD, gets ok, writes order from attending
  - CM discovers error
    - CM calls UR MD, gets opinion, either one calls attending to get concurrence, writes order from attending
  - "Change patient to outpatient observation; does not require inpatient care; discussed with Dr Smith- UR Committee MD, TORB Dr Jones by R. Berg, RN"
Then what?

- Notify patient, hospital and physician
  - No specified format
  - No immediate patient appeal rights
- If attending disagrees, second UR doc reviews case and tries to convince attending. If still disagrees, no CC44, stay inpatient. Hospital bills as provider liable and can bill ancillaries only.
  - These inpatient days are not considered medically necessary and do not count to the three days needed for SNF part A benefit. If patient/doctor insist on SNF transfer (“admit for placement” case), tell SNF that you are billing provider liable.

Payment for CC44 patients

- Hospital bills
  - Hours from Inpatient order to switch with revenue code 0762
  - Hours from Observation order to discharge with revenue code 0762 and HCPCS G0378
  - If patient is switched to observation and then discharged right away, there will be no observation hours
- Patient liability same as pure outpatient -20% copay, med costs, etc.

What about after discharge?

- Cannot change patient status after discharge
- If determined that admission was medically unnecessary, hospital bills inpatient-provider liable and then bills ancillaries, still have to notify patient.
Are you full (of information) yet?

- Questions?
- Answers?
- rhirsch@accreteivehealth.com
- See you on Learning Link