



IMA Insights

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Observation, Admission, and RAC—The Next Perfect Storm?

To our Healthcare Clients and Friends:

In the March issue of *IMA Insights* we discussed a major compliance and revenue issue for 2008 and forward -- the combination of the complexity of managing and organizing the process in which a provider bills/documents observation services and how the Recovery Audit Contractors (“RAC”) will be focusing attention on your compliance to this complicated area. Recall that the importance of the topic from a financial perspective is that the difference in hospital payment between an “Observation Status” claim and an “Inpatient Status” claim has been estimated to range between \$4,400 and \$5,000 per case.

The RAC has created the “perfect storm” in hospitals due to the complexity of the documentation and billing requirements for the appropriate reimbursements for observation services. In this edition we will discuss the challenges that providers confront on a day-to-day basis in the management of this matter, and provide you with insights and techniques on how to remain compliant and protect your essential revenue.

BACKGROUND

CMS reimburses hospitals for services that are determined to be medically necessary. CMS defines medical necessity as the provision of services or supplies that are needed for the diagnosis or treatment of the patient’s medical condition. Medically necessary services are those that meet the standards of good medical practice and are not provided for the convenience of the patient or the physician. CMS only provides reimbursement to providers if the service is deemed to be medically necessary for the treatment of the patient’s medical condition. The Medicare Claims Processing Manual Section 290.1 identifies observation services as 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.

CMS guidelines for observation service billing present unique challenges to hospitals. You must prevent lost revenue from inappropriately billing for observation services when an admission is medically necessary or justified (under billing). At the same time you must be compliant with the regulations and insure that you are not billing for admissions, which are not medically necessary or justified (over billing). Evidence indicates from some of the early RAC initiatives that this area is a prime target of review. This information would lead many hospitals to accelerate the planning, budgeting and management oversight of their RAC initiatives.

To date, the RAC Program has been so successful in returning funds to the Medicare Trust Fund that Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires the Secretary to expand the

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program to all 50 states by no later than 2010. Whether this date is firm is yet to be determined and the source of discussion.

On November 4th, 2008 CMS imposed a temporary stay in the contract work of the four Recovery Audit Contractors as a result of a protest filed with the Government Accountability Office (GAO) by two unsuccessful bidders for the program contracts. This stay will stop work by the RAC program until a determination has been made. A decision is expected in early February 2009.

This delay does not speak to the integrity of the RAC program, but rather a requested legal review of the RAC vendor selection process. It should be emphasized that this delay is only temporary. Many have questioned the incentives CMS pays to hired contractors on a “contingency-fee basis”, given the Office of Inspector General’s common historical statements on the inappropriateness of Hospitals doing the same. This time delay provides the perfect opportunities for hospitals to accurately assess their potential risk to the forthcoming RAC data-mining initiative.

CHALLENGES

One of the first actions to take, after your institution realizes the risks associated with RAC, is to decide how to prepare. The best defense and easy answer is that if you have embraced the applicable billing regulations, and designed policies and processes to comply with them, then you should be doing this accurately already and should not have any concerns. Unfortunately with all of the external and internal challenges that hospital management and physicians face on a day-to-day basis perfection in this preparation is hard to achieve. Many good actions that have been taken to reasonably assure compliant billing and documentation with the observation/admission status are being declared insufficient by the RAC.

As recommended in the March, 2008 *IMA Insights* a process should be developed that includes extensive training on the selection of the appropriate patient status for the level of care provided to your patients. This training and education needs to be accomplished with all your staff involved in the determination of whether a patient is observation or admission.

It is also an important step to measure the retention of your training and education program. This is far too serious a matter to the financial health of your hospital to entrust the distribution of knowledge to a power point slide for staff to review or a computer-based education module to view in their “spare time.” Training needs to be a focused, interactive (the platform is “burning”) initiative such that all involved appreciate the risk to assure that behaviors are compliant to your policies.

As with any process, communication is also critical for success. Individuals need to be involved with all communications of your patient identification process, and the corresponding policies and procedures, which delineate the process. In addition, these individuals need to receive the focused education on these policies and process as discussed above. The individuals involved (which would vary per location) would include the emergency physician, the attending physician, fellows/residents, emergency department leadership and case managers. If your hospital has bed management or utilization staff responsible for monitoring the patient’s status they should also be included in education and training on observation status process, procedures and policies.

One area of concern that requires attention is in the Emergency Department. The daily demands of patient care

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responsibilities take the priority of these professionals. The Emergency Department is the primary access point for most patients entering into your hospital. Not all patients can be safely discharged and not all patients need to be admitted. Crowded emergency rooms and an aging population create a ripple effect on how to best meet the patient's needs for their condition without comprising quality of care or inappropriate hospital admissions. These factors coupled with reductions in payments for Emergency Department services lead to reduced staff and to issues, such as, the designation of a patient's observation or admitted status becoming less of a daily priority. The life or death day to day issues of running a hospital obviously take precedence for your staff. Unfortunately, lack of resources or attention to apply to "patient designation billing rules" will, in today's environment create increased risk to your hospital.

Discussions and policy development combined with education of the involved individuals will need to occur to protect your hospital against allegations of overpayments or pattern and practices of bad billings. If your leaders in Compliance, Medical Staff, and Emergency Department are not discussing this issue frequently they need to begin the dialogue. The RAC, like CMS or Office of Inspector General ("OIG") does not take into consideration "well you were too busy to do it properly" when they are calculating overpayments. If the regulations are not being followed you will be at risk.

As a proactive measure, many hospitals are developing a process to both clarify and verify the patient status for those patients coming through the emergency department. This process is often referred to as "throughput". Throughput helps to ensure that hospital beds are available for emergency room and direct admissions, and allows for better resource-utilization by staff and ancillary services. In order to ensure success, someone needs to be responsible for the throughput process.

In the vast majority of hospitals, the assignment of accountability is to the physician population since the physician's order is what begins the process of observation and/or admission. The ultimate responsibility for the patient status and how patients are identified and categorized in the hospital's system lies with the attending physician. The attending physician has the responsibility to write an order determining whether the patient status is a hospital inpatient admission or an outpatient in observation status. The physician order should be clear without any ambiguity. Of course, to assist the Physician in understanding the regulations, it is incumbent upon the hospital to provide their Physicians with the necessary education to assist them in making this determination/judgment. In addition, hospital leadership must be cognizant to educate based upon the guidelines, not financial impact. Today, few things could be more dangerous to a hospital in this environment than providing to admitting Physicians education or offer tools to "channel" cases to the admission category when they are not medically necessary or consistent with the regulations. This type of behavior if discovered will most likely be referred to investigators to review for potential fraudulent intent.

INSIGHTS

Who will monitor the throughput process to ensure success at your hospital? An individual or group of individuals needs to be identified. These individuals should review charts on a concurrent basis to identify that the patient status ordered by the physician is in fact correct as identified by the CMS defined criteria and documented by the physician in the patient's medical record. This review process should also include a review of any forms that are currently in place. Do they need to be updated or totally revised? One hospital we recently observed was developing a Utilization Review Committee, chaired and comprised primarily of members of the Medical Staff. One area that is prevalent in all areas of healthcare is conflicts of interest, this hospital addressed this concern in their hospital Utilization Review policy with a statement that includes, "no physician will be assigned responsibility to review or provide opinion for any case in which he/she is professionally involved."



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Two Christy Drive, Suite 219
Chadds Ford, PA 19317

Phone: 484.840.1984
Fax: 484.840.0124

Toll Free: 866.840.0151

Robert De Luca,
Partner

Kimberly Hollingsworth,
Partner

Mary Ann Holt,
Partner

Anthony J. Scarcelli, Jr.,
Partner

Robert D. Sutton,
Partner

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Your review committee (however it is structured) should be focused on cases that are admissions (may be reviewed before, during, or after hospital admission). Cases reviewed should be selected via a sample basis, except for reviews of extended stay cases (those that stand out as outliers). Your review committee should refer to the Medicare Conditions of Participation for guidance and at a minimum be responsible for the following types of reviews; extended length of stay - outliers, admissions to determine their medical necessity including applicable documentation, one day length of stays, review of professional services furnished, third Party Payor denials, and additional reviews as deemed to be necessary in your environment and high-profile risk areas.

SUMMARY

The complexity of observation status versus admission status coupled with the incentives the RAC has been provided by CMS has created a "Perfect Storm" for hospitals. As discussed, preparation including policies, focused education and review are critical to your facility surviving the storm.

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We are pleased to have had the opportunity to provide this information to you. If you have any questions or need assistance, please contact me at 484-844-3327.

Yours very truly,

Bret Bissey, FACHE, MBA

Director
IMA Consulting

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