CBIZ KA Consulting Services, LLC

Issues Surrounding Hospital Inpatient Short Stays & Observation Services

Presented by:
Stacy A. Pereira, CPC
Executive Director
CBIZ KA Consulting Services, LLC
January 2015
Agenda

• Inpatient Admission Orders & Signatures
  o Audit Findings
  o Electronic & Written

• Top Reasons for Denials - Novitas Probe & Educate
  o Documentation Supporting 2 Midnight Expectation
  o Unforeseen Circumstances

• CMS Inpatient Only Procedures
  o Admission Orders

• Observation
  o Reminders
  o Current Trends
INPATIENT ADMISSION - ORDERS & SIGNATURES

Audit Findings
Audit Findings

Overall Findings Inpatient Admission - Order & Signatures

1. Unclear Orders (w, e)
   a. Admit to OBS (w)
   b. Admission: Retain for Observation (e)
   c. Admit to Same Day Surgery (w)
   d. Admit to Recovery Room (w)

2. Illegible Signatures (w)

3. Missing Signatures (w, e)

4. Signed After Discharge (w, e)

5. Backdated Order (w, e)

6. Absent Order (w, e)

w = written    e = electronic
Audit Findings

What is this?
Audit Findings

Inpatient Admission Order

• Medicare states that while they do not require specific language to be used on the inpatient admission order, it is in the interest of the hospital for admitting practitioner to use language that clearly expresses intent to admit the patient as inpatient.

  ✓ Examples include: Admit to Inpatient or Admit to Inpatient Care

• CMS will continue to treat orders that specify a typically outpatient or other limited service as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.

  X Examples include: Admit to Observation, Admit to Recovery, Admit to Outpatient Surgery, Admit to Same Day Surgery

Audit Findings

Inpatient Admission Order

Example - Missing or Flawed Order for Inpatient Admission:

Patient presented to ED with complaints of chest pain. The physician notes stated that the beneficiary was going to be worked-up, but it was unlikely the pain was cardiac-related. The physician order stated “admit to observation”. The patient was kept overnight and discharged the next day. The hospital submitted a claim for a 1-day inpatient stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record:

a. Failed to support an expectation of a 2-midnight stay; and,
b. Lacked an order to admit as an inpatient

Medicare Inpatient Probe and Educate Status Update February 24, 2014
Audit Findings

Inpatient Admission Order

Example – Flawed Order for Inpatient Admission:

*Actual Electronic Medical Record Order for Inpatient Admission*)

12/14/13  Retain for Admission / Diagnosis: CHF
Admit to: Doe, John, MD
Medical - Telemetry
Audit Findings

Inpatient Admission Order

12/14/13  Admit  12478 – 585  Rout  RTE  Smith, John  N  NPL  L

Patient Status: Admit to Inpatient
Certification: I anticipate the patient requires 2 or more midnights of care.
Attending: Doe, John
Attending Service: MED
Hospitalist Covered?: Y
Medical Resident Covered?: Y
Primary Diagnosis: CHF
Location: 6 Med Surg SD
Pt Condition Guarded

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>User</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/14/13</td>
<td>1530</td>
<td>MM</td>
<td>order entered into MDS by Saaashik Lurbooonk</td>
</tr>
<tr>
<td>12/14/13</td>
<td>1530</td>
<td>MM</td>
<td>order source provider – signature is necessary for entry</td>
</tr>
<tr>
<td>12/14/13</td>
<td>1530</td>
<td>MM</td>
<td>order E Signed by Saaashik Lurbooonk</td>
</tr>
<tr>
<td>12/14/13</td>
<td>1530</td>
<td>MM</td>
<td>order transmitted</td>
</tr>
</tbody>
</table>
Audit Findings

Audit Findings / Issues – Electronic Signatures

1. Using phrases such as:
   a. Assigned by Dr. Smith
   b. Dr. Smith (Nothing else)
   c. Noted by Dr. Smith
   d. Prepared by Dr. Smith

2. The electronic signature for Admission is buried somewhere within the medical record, not anywhere near the actual order, nor corresponding to the actual order. Very Difficult to Connect or NO Way to Connect the Signature with the Order!

3. The electronic signature for Admission is not a part of the same electronic record as the Order, but housed in another electronic system - that is not considered part of the Medical Record!
Audit Findings

ELECTRONIC SIGNATURES

What specific verbiage is acceptable for Electronic signatures?

- “Accepted By” with provider’s name
- “Electronically signed by” with provider’s name
- “Verified by” with provider’s name
- “Reviewed by” with provider’s name
- “Signed by” with provider’s name
- “Signed: John Smith, M.D.” with provider’s name
- This is an electronically verified reported by John Smith, M.D.
- Authenticated by John Smith, M.D.
- Authorized by: John Smith, M.D.
- Confirmed by with provider’s name
- Electronically approved by with provider’s name
Audit Findings

Audit Findings / Issues – Written Signatures

1. Illegible Signature
2. Missing Signature
3. Stamped Signature
4. Beeper or ID number next to Illegible signature
5. Telephone Order (Verbal Order) from RN not Co-signed
6. Incomplete Transcription from the Written order to the Electronic order
Audit Findings

WRITTEN SIGNATURES

What should hospitals do if signatures are illegible?

• A signature log is acceptable for illegible signatures. Ensure it includes a list of typed or printed names associated with initials or illegible signature along with credentials.

  – Definition of a Signature Log: Providers will sometimes include in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log may be included on the actual page where the initial or illegible signature is used or may be a separate document.

• Reviewers will consider all submitted signature logs regardless of the date they were created.

• A signature attestation is a statement that must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Novitas FAQ 10/20/2014 / MLM Matters Number MM6698 / CMS Medicare Program Integrity Manual (Pub. 100-8) Chapter 3, Section 3.3.2.4.C.
Audit Findings

SIGNATURE ATTESTATION STATEMENT

Example Only:

• “I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”
Medicare Program Integrity Manual  
Chapter 3 – 3.3.2.4  *(Rev. 543, 09-26-14)*

**Signature Requirement**

<table>
<thead>
<tr>
<th></th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Legible full signature</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Legible first initial and last name</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>Illegible signature over a typed or printed name</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory.</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation <strong>is accompanied</strong> by: a signature log, or an attestation statement</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation <strong>is unaccompanied</strong> by: a signature log, or an attestation statement</td>
<td>X</td>
</tr>
</tbody>
</table>
### Medicare Program Integrity Manual
**Chapter 3 – 3.3.2.4 (Rev. 543, 09-26-14)**

<table>
<thead>
<tr>
<th></th>
<th>Met</th>
<th>Not Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>7)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>8)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>9)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>10)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>12)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>13)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>14)</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

- **Initials over a typed or printed name**
- **Initials NOT over a typed/printed name but **accompanied** by: a signature log, or an attestation statement**
- **Initials NOT over a typed/printed name **unaccompanied** by: a signature log, or an attestation statement**
- **Unsigned typed note with provider’s typed name**
- **Unsigned typed note without provider’s typed/printed name**
- **Unsigned handwritten note, the only entry on the page**
- **Unsigned handwritten note where other entries on the same page in the same handwriting are signed**
- **“Signature on File”**

This is not all inclusive, refer to the CMS Medicare Program Integrity Manual for additional detailed information related to Signature requirements.
TOP REASONS FOR DENIALS

Phase I
Novitas Probe & Educate Program
Novitas Probe & Educate July 2014

Top Reasons for Denial – Region JL

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>Percentage of Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Documentation did not support two midnight expectation</td>
<td>46.7%</td>
</tr>
<tr>
<td>2. No records received</td>
<td>27.6%</td>
</tr>
<tr>
<td>3. Documentation did not support unforeseen circumstances interrupting stay</td>
<td>10.9%</td>
</tr>
<tr>
<td>4. Other</td>
<td>3.4%</td>
</tr>
<tr>
<td>5. Order missing</td>
<td>2.5%</td>
</tr>
<tr>
<td>6. Order not validated</td>
<td>2.4%</td>
</tr>
<tr>
<td>7. Certification not present</td>
<td>2.1%</td>
</tr>
<tr>
<td>8. Certification inadequate</td>
<td>1.9%</td>
</tr>
<tr>
<td>9. Order unsigned</td>
<td>1.6%</td>
</tr>
<tr>
<td>10. Procedure not reasonable and necessary</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Novitas Solutions Medicare Part A Presents: Two Midnight Rule Probe and Educate July 15, 2014
Top Three Errors

1. Documentation Did Not Support Two Midnight Expectation

2. No Records Received

3. Documentation Not Supporting Unforeseen Circumstances Interrupting Stay
TOP THREE ERRORS
(Phase I Novitas Probe & Educate)

1. **Documentation did not Support Two Midnight Expectation**

   - Represents *46.7% of Denials* under the Probe & Educate program for Novitas for Region JL New Jersey.
   
   - CMS reminds providers that attestation statements indicating the expected length of stay of 2 or more midnights are not adequate by themselves to support the expectation of a 2 midnight stay. Rather, *the expectation must be supported by the entirety of the medical record.*
TOP THREE ERRORS  
(Phase I Novitas Probe & Educate)

Example: Documentation did not Support Two Midnight Expectation

The physician’s order contained a checklist with pre-printed text stating:

✓ The patient is expected to require 2 or more midnights of hospital care.

➢ The physician’s plan of care, however, stated that the patient was to have diagnostics performed post-operatively, with a plan to discharge in the morning if stable.

➢ The patient was discharged the following day as planned, after a 1 midnight stay.

➢ Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a 2-midnight stay when the order was written.

Medicare Inpatient Hospital Probe & Educate Status Update February 24, 2014
TOP THREE ERRORS
(Phase I Novitas Probe & Educate)

2. **No Records Received**

   - Represents *27.6% of Denials* under the Probe & Educate program for Novitas for region JL New Jersey.
TOP THREE ERRORS
(Phase I Novitas Probe & Educate)

3. Documentation Not Supporting Unforeseen Circumstances

- The final rule explicitly states: That while we acknowledge that unforeseen circumstances might result in a shorter beneficiary stay than the original expectation of a two midnight stay, this must also be clearly documented and supported by the documentation in the medical record.
TOP THREE ERRORS
(Phase I Novitas Probe & Educate)

An **Unforeseen Circumstance** may result in a stay of less than two midnights despite the physician’s appropriate expectation of a two or more midnight stay at the time the inpatient order was written

- a) Death
- b) Transfer
- c) Departure Against Medical Advise (AMA)
- d) Clinical improvement where the patient stayed less than the expected two midnights (patient improves more rapidly than expected)
- e) Election of Hospice Care

- These claims may be considered **appropriate for hospital inpatient payment**;

- The medical record **documentation must clearly support** any unforeseen circumstances.
TOP THREE ERRORS
(Phase I Novitas Probe & Educate)

Unforeseen Circumstances – Clinical Improvement

Example: Unforeseen circumstance after formal admission. 63 year old male presents to the ED from home and is admitted by the attending physician for a diagnosis of sickle cell crises. Treatment plan includes IV hydration, IV pain management, labs, chest x ray, vital sign monitoring & blood transfusions.

• 6-14-14:
  – 10 PM - present to the ED at which time the admitting physician evaluates & orders diagnostic/therapeutic modalities.

• 6-15-14:
  – 3 AM – physician writes order to admit as inpatient. Patient is formally admitted with the expectation of medically necessary hospital level of care/services for 2 or more midnights.
  – 1 PM - pain controlled, labs within normal limits; x-rays normal; pain managed; patient is out of bed ambulating and much improved.
  – 4 PM - Discharged home with follow up-appointment with PMD in 2 days.
CMS INPATIENT ONLY PROCEDURES
CMS Inpatient Only Procedures

What You Need to Know

• CMS designates certain procedures as inpatient-only, meaning they will reimburse the facility only when the procedure is performed on an inpatient basis.

• The procedure and all related services will not be paid if performed on an outpatient basis.

• These procedures are an Exception to the Two-Midnight Rule; therefore a physician should order inpatient status prior to the procedure, regardless of the anticipated length of stay, e.g., less than a 2 midnight stay.
CMS Inpatient Only Procedures

The Published List

- Published in the Final Rule & on-line within the CMS website
- Over 1,700 procedures listed
- Published under Addendum E
  - Listed by CPT Code & Short Descriptor
  - Identified with Status Indicator C
- Also Published under Addendum B
  - Listed by CPT Code & Long Descriptor
  - Identified by Status Indicator C
- Reviewed & Updated Quarterly
  - Additions & Deletions
CMS Inpatient Only Procedures

What’s the Big Deal?
CMS Inpatient Only Procedures

Audit Findings / Issues - Admission Orders

ACCOUNTS AT RISK FOR NO PAYMENT

1. Admission order placed following the procedure

2. Admission order placed prior to the procedure, but reads “Admit Post-Operatively”

3. No Inpatient Admission Order and No Outpatient Observation Order
CMS Inpatient Only Procedures

How to Tackle the Issue?

• Assign a Gatekeeper.
• Involve several departments, e.g., Patient access, registration, pre-admission testing, case management and admitting should be informed of and involved with this list, its use and the hospital process.
• HIM department should assign a Coder to work with gatekeeper
• Surgeons and their office staff need to be involved.
• Create a list based on each Surgeon’s most commonly performed procedures.
• Hold regular meetings with all departments/personnel involved to identify issues and resolve them.
• Put in the time and resources needed up front to create an ongoing effective process
• Audit accounts regularly.
OBSERVATION

Reminders and Current Trends
Observation

Reminders

• As per Novitas LCD (L27548), outpatient observation is defined as “The use of a bed for physician periodic monitoring and active monitoring by the hospital’s nursing or other ancillary staff, for the patient care which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for an inpatient admission.”

• A physician’s order is required when placing a patient in observation – it should be clearly worded, such as “place patient in outpatient observation.”

• Observation services generally are not expected to exceed 24 hours and services greater than 48 hours are seen as rare and exceptions.

• Per CR 6492, “a hospital begins billing for observation services with HCPCS code G0378, at the clock time documented in the patient’s medical record, which coincides with the physician’s order for observation services.”
Observation

Reminders

• Medicare will cover up to 48 hours of observation services

• A patient in observation status is either:
  
  o Admitted as an inpatient based on the patient’s condition, or;
  
  o An outpatient released when the physician determines observation is no longer medically necessary.
Observation

Current Trends

• Since the implementation of the Two Midnight Rule, we have seen an increase in the overall number of observation cases.

• In particular, we see an increase in the number of cases reporting more than 37 hours.

• Case management should work closely with the ED physicians to see if these types of cases meet the two midnight requirements for an inpatient stay.
Thank you

CBIZ KA Consulting Services, LLC

Stacy A Pereira, CPC
spereira@cbiz.com
609-918-0990