Physician Advisor Basics

Ronald Hirsch, MD, FACP, CHCQM-PHYADV
Vice President, R1 RCM Inc.
Advisory Board Member, ACPA
What’s Your Role as Physician Advisor?

- Level of care determinations
- Utilization Review Committee member/chair
- Peer to peer calls
- Denial management
- Denial prevention
- Medical necessity reviews
- Length of stay management
  - Multidisciplinary rounds
- Resource utilization
- Clinical quality
- Clinical Documentation Integrity
- Revenue integrity
- Compliance/fraud
- Patient engagement/complaints
Watch one, Do one, Teach one

As a Physician Advisor, you will need to critique practice styles that you may have had in the past. (I did!)

• Using brand name drugs on release
• Keeping patients too long
• Ordering defensive tests
• Documenting poorly
• Not knowing the coding rules
• Hating administrators
• Thinking my patients are sicker
The Physician Advisor’s Role in the Quadruple Aim

- Medical Necessity of Services
- Provider Satisfaction and Burden Reduction
- Right Setting

Patient Engagement

The best care
For the whole population
At the lowest cost

- Improve individual experience
- Control inflation of per capita costs

The Institute for Healthcare Improvement

The Triple Aim

- Improve population health
What is The Right Care to All Patients?

Are we providing “evidence-based” care?

- Proper use of protocols
- Cognitive offloading
- Timely care
  - Bylaws v. good care
- Antibiotic stewardship
- Proper use of consultants
- Effective communication with patient and family
- Rational medication use
- Appropriate medication reconciliation
Evidence changes!

- NICE-SUGAR – tight DM control – good then bad
- Blood transfusions – what’s your trigger?
- Kyphoplasty – failed conservative trial?
- Zetia – Good? Worthless?
- What happened to Xigris?
- ORBITA for stable angina
- Lariat/Watchman/Impella
- Vitamin C for sepsis?
ENDING MEDICAL REVERSAL
IMPROVING OUTCOMES, SAVING LIVES
VINAYAK K. PRASAD, MD, MPH
ADAM S. CIFU, MD
Revascularization versus Medical Therapy for Renal-Artery Stenosis

The ASTRAL Investigators

A First Renal Event

<table>
<thead>
<tr>
<th>No. at Risk</th>
<th>Years since Randomization</th>
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<tbody>
<tr>
<td>Revascularization</td>
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<td>Medical therapy</td>
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B First Cardiovascular Event

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<th>Years since Randomization</th>
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<tbody>
<tr>
<td>Revascularization</td>
<td>403</td>
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<tr>
<td>Medical therapy</td>
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Stenting and Medical Therapy for Atherosclerotic Renal-Artery Stenosis

Niacin, Fenofibrate
Steroid injection for spinal stenosis
Their Study

A Decade of Reversal: An Analysis of 146 Contradicted Medical Practices

Vinay Prasad, MD; Andrae Vandross, MD; Caitlin Toomey, MD; Michael Cheung, MD; Jason Rho, MD; Steven Quinn, MD; Satish Jacob Chacko, MD; Durga Borkar, MD; Victor Gall, MD; Senthil Selvaraj, MD; Nancy Ho, MD; and Adam Cifu, MD

Abstract

Objective: To identify medical practices that offer no net benefits.

Methods: We reviewed all original articles published in 10 years (2001-2010) in one high-impact journal. Articles were classified on the basis of whether they addressed a medical practice, whether they tested a new or existing therapy, and whether results were positive or negative. Articles were then classified as 1 of 4 types: replacement, when a new practice surpasses standard of care; back to the drawing board, when a new practice is no better than current practice; reaffirmation, when an existing practice is found to be better than a lesser standard; and reversal, when an existing practice is found to be no better than a lesser therapy. This study was conducted from August 1, 2011, through October 31, 2012.

Results: We reviewed 2044 original articles, 1344 of which concerned a medical practice. Of these, 981 articles (73.0%) examined a new medical practice, whereas 363 (27.0%) tested an established practice. A total of 947 studies (70.5%) had positive findings, whereas 397 (29.5%) reached a negative conclusion. A total of 756 articles addressing a medical practice constituted replacement, 163 were back to the drawing board, 146 were medical reversals, 138 were reaffirmations, and 139 were inconclusive. Of the 363 articles testing standard of care, 146 (40.2%) reversed that practice, whereas 138 (38.0%) reaffirmed it.

Conclusion: The reversal of established medical practice is common and occurs across all classes of medical practice. This investigation sheds light on low-value practices and patterns of medical research.
FIGURE 1. A breakdown of articles concerning a medical practice.
Networking with Colleagues

• RAC Relief user group
  • Opinionated, intelligent, diverse, smart!

• ACPA
  • Authoritative information
  • I welcome all articles! (OK, begging for articles)

• NPAC conference

• Twitter
  • @AmerCollPhyAdv
  • @signaturedoc
  • @DrVelvetHammer
Know the Payer

- Medicare fee for service, traditional
  - Part A – Inpatient care – Hospital, Inpatient Rehab Facility, Long Term Acute Care Hospital, Inpatient Psychiatric Facility
  - Part B – Outpatient care – Office, hospital, Ambulatory Surgery Center – Facility and all professional fees
    - Can buy supplemental plans – Medigap
  - Part D – Prescription drug benefit – Prescription Benefit Managers
  - Federal laws

- Medicare Advantage
  - Part C – Replaces A and B completely
  - Must offer same care as A and B but can limit providers and payment is contractual
  - Consider it a commercial payer
  - If provider out-of-network, plan must follow Medicare rules
• Medicaid  
  • State plan – State makes rules

• Managed Medicaid  
  • Commercial insurer manages care as with Medicare Advantage

• Commercial Plans  
  • Anything goes  
  • What’s in your contract?
Some Need-to-Know Basics

Only two patient status options

• Inpatient – Patient who is formally admitted subsequent to an order for admission from qualified practitioner with admitting privileges

• Outpatient – Patient registered to receive services who has not been admitted as inpatient
How Medicare Pays Hospitals

- **Inpatient care – Diagnosis Related Grouping (DRG)**
- **Generally triads**
  - Primary diagnosis determines group
  - Secondary diagnoses determine which DRG in group

### TABLE 5. — LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS,

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>FY 2019 FINAL Post-Acute DRG</th>
<th>FY 2019 FINAL Special Pay DRG</th>
<th>MDC</th>
<th>TYPE</th>
<th>MS-DRG Title</th>
<th>Weights</th>
<th>Geometric mean LOS</th>
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<tr>
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<td>No</td>
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<td>MED</td>
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### FY 2019 Inpatient Prospective Payment (IPPS) Payment Results

**Claim Return Code:** 14 - Paid normal DRG payment with period days = or > GM ALOS.

**Provider #:** 110010  
**PSR Record Eff Date:** 10/01/2016  
**Provider Type:** 00  
**GEO/STD CBSA:** 12060 /  
**Reclass CBSA:**

#### PROVIDER DETAILS

**Patient Id:**  
**DRG:** 190  
**Discharge Date:** 10/04/2018  
**Length of Stay:** 3 Days  
**Charges:** $0.00

#### CLAIM DETAILS

**PPS FACTORS & ADJUSTMENTS**

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<th>FACTOR VALUE</th>
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#### CAPITAL AMOUNTS

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#### OPERATING AMOUNTS

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<td>New Tech</td>
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#### OTHER PPS AMOUNTS

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**TOTAL PAYMENT**  
$11,515.80
# Provider Details

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<tr>
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# Claim Details

| Patient Id: | |
| DRG: | 190 |
| Discharge Date: | 04/10/2018 |
| Length of Stay: | 3 Days |
| Charges: | $0.00 |

# Capital Amounts

| C-FSP: | $522.41 |
| C-Outlier: | $0.00 |
| C-DSH: | $0.00 |
| C-JME: | $0.00 |

# Operating Amounts

| O-FSP: | $6,451.86 |
| O-HSP: | $0.00 |
| O-Outlier: | $0.00 |
| O-DSH: | $193.56 |
| O-JME: | $0.00 |
| Uncomp Care: | $1,430.34 |
| Readmissions Adj.: | $42.56CR |
| VBP Adjustment: | $1.83 |
| New Tech: | $0.00 |

# Capital Factors & Adjustments

| OP/CAP CCR: | 2920 / 0.0380 |
| OP/CAP DSH: | 1200 / 0.0000 |
| Operating IME: | 0.0000000000000000 |
| Capital IME: | 0.0000000000000000 |
| Nat Labor/Non-Labor %: | 5200 / 0.3800 |
| Nat Labor: | 3500.57 |
| Nat Non-Labor: | 2145.51 |
| Inp Wage Index: | 0.9350 |
| Inp PR Wage Index: | 0.000000 |
| Inp DRG Weight: | 0.1907 |
| Inp DRG GM ALOS: | 0.38 |
| Transfer Adj. Factor: | 0.0000 |
| Readmissions Adj. Factor: | 0.9334 |
| VBP Adj. Factor: | 1.0028437770 |
| Bundle %: | 0.0000 |
| EHR Reduction Indicator: | |
| HAC Reduction Indicator: | Y |
| Cost Outlier Threshold: | $0.00 |

* TOTAL PAYMENT *

$8,743.50
## PROVIDER DETAILS

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## CLAIM DETAILS

| Patient Id: |
| DRG: 190 |
| Discharge Date: 10/04/2018 |
| Length of Stay: 3 Days |
| Charges: $40,000.00 |

## CAPITAL AMOUNTS

| C-FSP: $794.65 |
| C-Outlier: $0.00 |
| C-DSH: $82.25 |
| C-IME: $204.22 |

## OPERATING AMOUNTS

| O-FSP: $10,052.20 |
| O-HSP: $0.00 |
| O-Outlier: $0.00 |
| O-DSH: $737.58 |
| O-IME: $2,987.83 |
| Uncomp Care: $1,239.35 |
| Readmissions Adj.: $15,083.90 |
| VBP Adjustment: $39.18 |
| New Tech: $0.00 |

## OTHER PPS AMOUNTS

| HAC Adj.: $161.22CR |
| Low Volume: $0.00 |
| Pass Thru + Misc: $1,439.58 |
| Islet Add on: $0.00 |
| EHR Adj.: $0.00 |
| Bundle Adj.: $0.00 |
| MA-HSP: $0.00 |

## PPS FACTORS & ADJUSTMENTS

| OP/CAP CCR: 0.2020 / 0.0140 |
| OP/CAP DSH: 0.2935 / 0.1035 |
| Operating IME: 000000.297231592 |
| Capital IME: 000000.2569959851 |
| Nat Labor/Non-Labor %: 0.6830 / 0.3170 |
| Nat Labor: 03856.27 |
| Nat Non-Labor: 01780.81 |
| Inp Wage Index: 01.7251 |
| Inp PR Wage Index: 00.0000 |
| Inp DRG Weight: 01.1907 |
| Inp DRG GM ALOS: 03.8 |
| Transfer Adj. Factor: 0.0000 |
| Readmissions Adj. Factor: 0.9985 |
| VBP Adj. Factor: 1.00389790420 |
| Bundle %: 0.00 |
| EHR Reduction Indicator: |
| HAC Reduction Indicator: Y |
| Cost Outlier Threshold: $0.00 |

* TOTAL PAYMENT *

$17,400.54
Emory University Colon Resection no CC or MCC

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<tr>
<th>PROVIDER DETAILS</th>
<th>CLAIM DETAILS</th>
<th>PPS FACTORS &amp; ADJUSTMENTS</th>
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<td>Patient Id:</td>
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<td>Provider Type: 00</td>
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<td>GEO/STD CBSA: 12060</td>
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<td>Charges: $40,000.00</td>
<td>Nat Labor/Non-Labor %: 0.6200 / 0.3800</td>
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<th>CAPITAL AMOUNTS</th>
<th>OPERATING AMOUNTS</th>
<th>OTHER PPS AMOUNTS</th>
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<td>C-DSH: $26.77</td>
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* TOTAL PAYMENT *

$15,254.67
## Provider Details

- **Provider #:** 110010
- **PSF Record Eff Date:** 10/01/2018
- **Provider Type:** 00
- **GEO/STD CBSA:** 12060 /
- **Reclass CBSA:**

## Claim Details

- **Patient Id:**
- **DRG:** 329
- **Discharge Date:** 10/04/2018
- **Length of Stay:** 3 Days
- **Charges:** $40,000.00

## Capital Amounts

- **C-FSP:** $2,190.50
- **C-Outlier:** $0.00
- **C-DSH:** $78.66
- **C-IME:** $451.44

## Operating Amounts

- **O-FSP:** $27,053.16
- **O-HSP:** $0.00
- **O-Outlier:** $0.00
- **O-DSH:** $277.97
- **O-IME:** $7,264.84
- **Uncomp Care:** $780.23
- **Readmissions Adj.:** $29.76CR
- **VBP Adjustment:** $125.00
- **New Tech:** $0.00

## Other PPS Amounts

- **HAC Adj.:** $381.92CR
- **Low Volume:** $0.00
- **Pass Thru + Misc:** $1,910.28
- **Islet Add-on:** $0.00
- **EHR Adj.:** $0.00
- **Bundle Adj.:** $0.00
- **MA-HSP:** $0.00

## Total Payment

- **Total Payment:** $39,720.60

## PPS Factors & Adjustments

- **OP/CAP CCR:** 0.2930 / 0.0280
- **OP/CAP DSH:** 0.0411 / 0.0350
- **Operating IME:** 00000.268539548
- **Capital IME:** 00000.206687986
- **Nat Labor/Non-Labor %:** 0.6200 / 0.3800
- **Nat Labor:** 03500.57
- **Nat Non-Labor:** 02145.51
- **Inp Wage Index:** 00.9350
- **Inp PR Wage Index:** 00.0000
- **Inp DRG Weight:** 04.9927
- **Inp DRG GM ALOS:** 10.8
- **Transfer Adj. Factor:** 0.0030
- **Readmissions Adj. Factor:** 0.9989
- **VBP Adj. Factor:** 1.00452070550
- **Bundle %:** 0.00
- **EHR Reduction Indicator:**
- **HAC Reduction Indicator:** Y
- **Cost Outlier Threshold:** $0.00
Don’t Forget Effect on LOS
Simple Pneumonia – Indiana Community Hospital

- 190 – $7,528 – 3.8 days
- 191 – $5,899 – 3.1 days
- 192 – $4,782 – 2.5 days
Colon Resection

• 329 – $29,898 – 10.8 days
• 330 – $15,368 – 6.2 days
• 331 – $10,493 – 3.7 days
Be Wary of Benchmarks!

• There is no benchmark length of stay (LOS)
  • How is it measured?
    - Day of admit order or day of start of care
    - Medical? Surgical? All? Peds? OB?

• What is your Case Mix Index?
  • Medical?
  • Surgical?
  • Combined?

• What is the cost per case?
• What is the payment per case?
• How are you going to attribute it?
• What if there are payer/hospital delays?
3-Day Payment Window

• Services provided by hospital or hospital-owned entity in the 3 calendar days (not 72 hrs) prior to the date of inpatient admission are not paid separately but are included on the inpatient claim
  • All diagnostic services
  • All related non-diagnostic services

• Payment window closes at moment of discharge services provided after discharge are separately payable (unless intentional unbundling)
Patient Liability for Inpatient Care

- Part A deductible – $1,364 on first day of care
- Resets every 60 days without any Part A care
How Medicare Pays Hospitals

- Outpatient care – Ambulatory Payment Classification (APC)
- Groups like cost items together
- Pays based on (incomprehensible) hierarchy
  - Item is paid unless provided with another item then bundled item never paid
  - Item always paid separately

<table>
<thead>
<tr>
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How Medicare Pays Hospitals

• Outpatient care – Ambulatory Payment Classification (APC) – procedure payment
• Single payment that covers all care during encounter – Comprehensive APC – Status Indicator J1

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APC Adjustment

• Each APC is adjusted to the hospital’s wage index

• Payment = (APC*0.4) + (APC*wage index*0.6)

• 1.7922 – Santa Cruz, CA to 0.684 – Ashland, AL

• Total Knee Arthroplasty
  • Santa Cruz – $15,807
  • Ashland – $8,683
Comprehensive APC

• It’s a mini-DRG

• Additional tests = additional cost with no additional revenue

• Also lost opportunity to provide service as outpatient and get revenue

• Do the surgery and nothing else!
So What is Observation?

• A service provided to outpatients to determine if inpatient admission is necessary or the patient can be safely discharged to a lesser setting

• But, you can call Observation a status
  • “Place in Observation” = Place in outpatient status with observation services
  • “Admit to Observation” = Place in Observation – but stop saying this!
  • “Admit for Observation” = ??? Get clarification
How is Observation Paid? C-APC 8011

• Observation hours counted
• Subtract “carve out” hours where patient received other monitoring – MRI, stress test, transfusion, etc
• If total = 8 or more, all care paid as single C-APC
• One fee for all services – ED to discharge
• Current approved amount – $2,387
  but...
• If patient has status T or J1 procedure, no Obs payment
• Then other hierarchy kicks in
How is Observation Paid? C-APC 8011

• ED visit, 6 hrs Obs, discharge = ~$500
  • Outpt Part B, <8 hrs Obs so no payment
  • Pay for ED, other tests

• ED visit, 10 hrs Obs, discharge = $2,387
  • Outpt Part B, C-APC 8011, bundled

• ED visit, 42 hrs Obs discharge = $2,387
  • Outpt Part B, C-APC 8011, bundled

• ED visit, 8+ hrs Obs, EGD, discharge = ~$1,250
  • Outpt Part B, EGD is SI=T so no pay for Obs
  • Pay for ED, EGD, other tests
How is Observation Paid? C-APC 8011

• ED visit, any Obs, lap chol’y, D/C < 2 MN = ~$4,600
  • C-APC for surgery, no pay for ED or Obs

• Scheduled Lap chol’y = ~$4,600
  • C-APC for surgery

• ED visit, Obs over 1 MN, lap chol’y, D/C > 2 MN = DRG $12,000
  • DRG for inpt admission for surgery

• Outpt lap chol’y then 2 MN due to complication = DRG $25,000 – $40,000
  • DRG for inpt admission for complication with surgery
How Long Can Observation Last?

“For example, if the beneficiary has already passed 1 midnight as an outpatient observation patient or in routine recovery following outpatient surgery, the physician should consider the 2 midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. This means that the decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in medically necessary hospitalizations should not pass a second midnight prior to the admission order being written.”
How Long Can Observation Last?

• Does the patient require continuing hospital care past the second midnight?
  • Documented rational, medically logical reason to keep the patient in the hospital

• Were there any delays for convenience – patient, physician, or hospital?
  • Don’t count these midnights

• If care will pass that second midnight, admit as inpatient
Be Wary of Benchmarks!

• There is no benchmark Observation Rate
  • How is it measured?
    - What numerator/denominator?
    - Medical? Surgical? OB? All?
    - Medicare? Medicare Advantage plans? Commercial?
    - What about ED patients who should have gone home?
    - Does the 10 hr Obs patient have the same effect on finances as a 40 hr patient?
Patient Liability for Part B Care

• $185 Part B deductible every year

• 20% of allowed charges

• Single line item max – $1,364

• No yearly maximum
Outlier Status

• Outpatient = (Cost – (APC payment x 1.75))/2 if greater than $4,600

• Inpatient = (.80) x [(charges x cost/charge ratio – (DRG + IME + DSH + $25,769)]
Who Is Watching Over Us?

• BFCC-QIO – Beneficiary and Family Centered Care Quality Improvement Organization
  • Appeals, quality of care concerns, short stay audits

• MAC – Medicare Administrative Contractor
  • Pays claims, targeted probe and educate audits, develops local coverage determinations

• RAC – Recovery Audit Contractor
  • Contingency-based auditor, targets per CMS

• CERT – Comprehensive Error Rate Testing
  • Randomly looking at error rates
Who Is Watching Over Us?

• SMRC – Supplemental Medical Review Contractor
  • Special projects from CMS

• UPIC – Unified Program Integrity Contractor
  • Fraud and waste

• OIG – Office of Inspector General of Health and Human Services
  • Oversees everything – oig.hhs.gov- subscribe!

• DOJ – Department of Justice
  • Criminal actions
Patient Notices

- CMS loves requiring forms for patients
- Improper form delivery is a compliance issue
- Improper form completion can jeopardize your payment
- No one reads the forms until there’s a problem
Important Message From Medicare

• Any patient formally admitted as inpatient must get the IM (or IMM)

• Result of lawsuit Weichardt v Levitt 2003

• Informs patient of right to immediate appeal if they feel discharge is inappropriate
Important Message From Medicare

• First copy must be given within 2 calendar days of admission

• Follow up copy must be given within 2 calendar days of discharge, unless first copy was given in that time frame

• Can give follow up copy on day of discharge but must offer patient 4 hours to consider appealing discharge
Shifting Liability to Patient

• HINN notices – Hospital Issued Notice of Non-coverage
  • For inpatients

• ABN – Advance Beneficiary Notice
  • For outpatients

• Use the right form, fill it out completely and legibly, don’t use abbreviations
Discharged but Won’t Go

• If physician has determined patient stable for discharge to lower level of care – cannot give for lateral transfer to acute care – LTACH, IRF, IPF

• Inform patient of discharge

• Be sure follow up Important Message (IM) has been given within 2 calendar days

• If not, give one and leave; come back in 4 hours
Discharged but Won’t Go

• Ask patient if they plan to appeal

• If yes, instruct them to call Quality Improvement Organization (QIO) listed on form and then you call QIO to confirm

• QIO will ask for records and tell you to give Detailed Notice of Discharge (DND) to patient
Discharged but Won’t Go

• Wait for QIO to decide
  • Not obligated to give unnecessary care!

• QIO agrees with you
  • Ask patient if they are leaving
    • If so, discharge them
    • If not leaving, give HINN 12 – liability begins noon next day

• QIO disagrees with you
  • Keep treating patient
Discharged but Won’t Go

• If patient not appealing,
  • Give HINN 12 – liability at midnight

• If patient won’t tell you, call QIO to inquire and issue HINN 12
Stable but Attending Won’t Discharge

• Pretty rare – covering doctor, belligerent doctor

• Be sure you reviewed case carefully

• HINN 10 – Hospital Requested Review
  • Asks QIO to decide if patient stable for discharge

• If they agree with you, give HINN 12, patient liable at noon the next day or can contact doc to get order
• If they disagree, patient stays
Pre-Admission HINN (HINN 1 to Oldsters)

• Inpatient admission ordered

• Inpatient qualifications not met
  • Should be outpatient with Observation or should be outpatient surgery
  • Should not be in hospital at all – social admit

• Patient will be responsible for full cost of care
  • Chargemaster prices, not approved fee (ugly!)
• Non-medically necessary service during necessary inpatient stay
  • Scheduling ICD implantation with EF > 35% in patient with acute HF
  • Scheduling cardiac cath for high cholesterol in patient with cellulitis of leg

• Cannot be given for “while you are here” or “incidentaloma” tests – those tests are medically necessary but in wrong setting – no way to shift liability to patient
Outpatient Notices

• Medicare Outpatient Observation Notice – MOON
  • Required for all Medicare eligible patients who receive over 24 hours of Observation
  • Must be given by hour 36 or discharge or admission
  • Can be given to all Observation patients
  • Should not be given to patients who are not getting observation – routine post-op surgery
  • Must indicate “why not inpatient”
  • Requires oral explanation of content
  • Lots wrong with this form but we have to give it
Advance Beneficiary Notice – ABN

• Notice for any outpatient service that it may not be covered and patient accepts liability
• Must not be given prior to EMTALA exam
• Patient must be given time to consider decision

• Commonly used for labs, x-rays, skin tag removal
• Can be used for Obs patient who won’t leave
  - Service – “Observation” cost $200/hr
• Can be used for statutory non-covered services like cosmetic surgery but not required
Inpatient Admission Decision

• Two Midnight Rule – 2 MN Rule – CMS-1599-R – 2014 IPPS Final Rule

• Two questions:
  • Does patient require hospital care?
    - If not, no inpatient admission
  • How long total hospital time needed starting with symptom-related care?
    - Under two MN – Outpatient +/- observation
    - Over two MN – Inpatient
    - Inpatient only surgery, unexpected vent, documented case-by-case high risk – Inpatient
Case-by-Case Exception

• Expectation of ONE Midnight!!!!

• High Perioperative Risk for planned procedure
  • Total Knee Arthroplasty
  • Will discuss in Reg Update

• High risk of significant morbidity or mortality in that one midnight time frame
  • CVA, DKA, SDH, 3° Heart block, angioedema

• Prefer documentation of conscious decision to admit as inpatient due to high risk
Zero – One Day Inpatient Stays

• Did patient leave AMA, die, elect hospice, transfer?
  • Leave inpatient
• Did patient improve unexpectedly rapidly?
  • Leave inpatient
• Did patient spend one or two midnights as outpatient in ED, Surgery, Obs, routine recovery and one Inpt?
  • Leave inpatient
Zero – One Day Inpatient Stays

• If patient has under two inpatient midnights but spent a total of two midnights in your or another facility, apply occurrence span code 72 to claim.

• Tells CMS that 2 midnight benchmark was met even though didn’t have two inpatient midnights.
Zero – One Day Inpatient Stays

• If none of those apply, then choice of inpatient was wrong. Patient should have remained outpatient.

• Two Options
  • Still in hospital – do condition code 44 process
  • Already discharged – self-deny and rebill
    - Condition code W2 process
Condition Code 44

Someone discovers inpatient was wrong from the start – no second guessing!

- Need attending to agree to change to outpatient
- Need a UR doctor to agree change appropriate
- Need to give patient written notification of change
  - They got the IM and are losing appeal right
- Need order to change status
  - Every CC44 is Inpatient to Outpatient
  - Some patients still need Obs services
  - OK just get order to change status to Obs
  - UR doctor name must be in notes, but no note from UR doctor needed
Condition Code 44

Payment for CC44

- Whole stay coded and billed as outpatient Part B 131 claim. Condition code 44 put on claim
- If 8+ hours obs from change to discharge, then get Obs C-APC payment – $2,387
- If <8 hours obs, get paid for ED visit, labs, imaging, etc – $1,000 – $1,400
- One claim filed, payment in weeks
Self-Denial

Find mistake after discharge or attending won’t concur

- Still requires UR doctor review and agreement
- Attending must be contacted and given opportunity
  - If no response, can proceed
  - If disagree, second UR doc can overrule to rebill
- Must notify patient in writing within 2 days of determination
Self-Denial

Claim processing

• Hospital codes admission as inpatient Part A claim
• Submits 110 no pay claim with M1 span code
• Waits for claim to show up as processed
• Once clears, bill services prior to admit order as outpatient part B 131- ED visit, ED tests with W2 and
• Bills services after admit order as inpatient part B-121- tests done on floor with W2
• Payment – $1,000 – $1,400 in couple months
CC44 v CCW2

• CC 44 is less coding work and gets claim paid faster
• Potential to get Obs C-APC
• Must get attending agreement
• Time sensitive

• CC W2 is more work and delayed payment
• But can override attending
• More controlled process
A Day in Your Life

• The physician lounge is your best place to hang out

• Visit your staff on the floors regularly

• Review the daily census
Long LOS Rounds

• Referred by UR staff?

• Based on some arbitrary LOS?

• Based on Geometric Mean LOS?
Look at Observation List

- Length of stay in hours
- Diagnoses
- Doctors
- Location
Multidisciplinary Rounds

- Many models to follow
  - Bedside, sitting, daily, M/W/F
  - With/without attending

- All or targeted units?

- Critical care or not?
Review Target Doctor’s Census

- Great doctors
- Good doctors
- “How did they become a doctor?” doctors
Denials, Appeals, Peer to Peers

• Who does the Peer To Peer?

• Who reviews the appeals?
  • Appeal all or be selective?

• Who writes the appeals?
  • RN, doctor, outsourced?

• Short and sweet or overwhelm with filler?

• Track and report your appeal data
While You are Here, WIGS

• Do you have a way to know when incidental workups happen?

• Are doctors following standard of care on common diagnoses?

• Recruit spies all over hospital
Communicating with your Doctors

• In the hallway

• “Cup of Coffee” conversations

• FYI letters

• Meetings with CMO
Order your PICC early

Discharge Planning begins at Admission

As we all work to provide more efficient care, the PICC team has analyzed their data and found that a substantial number of PICCs are requested late in the day, after hours, and on patients without valid indications. Placing a catheter into the central circulation is not something that should be taken lightly; the acquisition of a central line associated blood stream infection can be devastating.

There are a few keys to being sure PICCs are used appropriately.

1. Identify candidates for PICC's early. Patients requiring long term antibiotics, home antibiotics, or TPN, and patients with sepsis and other complex conditions should be PICC'd earlier rather than later.

2. Use IV ports for peripherally IV placement. If an IV is only needed for a short time, a peripheral placed by a specialist can eliminate the need to call in the PICC team after hours.

3. Discuss the PICC with the patient prior to ordering. Hard to believe but several patients have refused once the PICC nurse arrived!

“Crazy” Expensive!

Diabetes costs US $50 billion per year

Hospitalized patients are thrown into a new environment full of beeps and rings and machines, stuck with tubes and needles, asked the same questions over and over again, walked at night to be sure they are sleeping well and all too often they get confused. Once confused, they then get a new set of blood tests, strapped to a table for an MRI that ultimately shows nothing new and shot full of sedatives. Then comes the nonessential UTI, the bed sore, aspiration pneumonia and transfer to the nursing home, never to be the same again.

Wouldn’t it be better to prevent delirium? Here’s a bunch of simple measures from the National Institute for Health and Clinical Excellence that are evidence-based, easy to perform and actually work.

Avoid Foley catheters: Orient your patient frequently, ensure adequate hydration, assess for dysautonomia, encourage mobility—sit up for meals and walk the halls; discontinue unnecessary medications, ensure adequate nutrition; and promote good sleep by minimizing disturbances.

Speaking of Medications...

Are you sure your patient needs all of this???

An 85-year-old male was recently admitted to the hospital from his local nursing home for treatment of a urinary tract infection with possible sepsis. The patient had dementia and was fed by a G-tube. He was bedbound and was chronically confused. He had diabetes, hypertension and an old CVA and MI. His list of medications from the nursing home included Ismopril, Metformin, Insulin, Metoprolol, Leptadren, Lipitor, Arimidex, and Namenda along with several vitamin supplements.

While one can see the value of treating the blood pressure and blood sugar, is there any benefit to treating his dementia or high cholesterol at this stage in his disease process? Is Leptadren still needed? Most likely these medications were started years ago when the patient had a better functional status but “clinical inertia” led them to be continued way past their usefulness and effectiveness, not to mention the cost to the patient, family or insurer and potential side effects and interactions with other medications.

Next time you reconcile your patient’s medications, look at each medication on the list with a critical eye: What is the benefit? What are the risks? Are there medications that can be tapered or stopped? Many times discontinuing a medication is the best thing you can do for a patient.
Drs. Kapoor and Khurana;

You both cared for Mary C (MR#218769) in Mid-June when she was hospitalized with pneumonia. She was found to have a very mild incidental iron deficiency anemia. Dr Kapoor consulted Dr. Khurana who performed a colonoscopy while the patient was in house.

This incidental workup extended her hospital stay approximately 3 days. The hospital will receive the DRG payment for community-acquired pneumonia of approximately $6,000 from Medicare to cover all expenses associated with the stay and the hospital gets no additional reimbursement for the extra days or for the added costs of performing the colonoscopy.

If Sherman is to survive health reform, we must all work to keep costs down and efficiency up. To this end, I would ask that you defer “incidental” workups on hospitalized patients to the outpatient setting. You can mitigate risk by discussing your recommendations with the patient and documenting that discussion. The Case Managers can also assist you in scheduling the needed tests to be done as an outpatient.

Thanks for your cooperation.

Sincerely,

Ronald Hirsch, MD
Medical Director, Case Management
Going Outside your Comfort Zone

• Attend all department meetings
  • Provide updates, audit targets, documentation tips

• Be active on Ethics Committee

• Get involved with Revenue Cycle/Integrity
Further Your Knowledge

• RAC Relief user group

• RACmonitor.com

• CMS
  • Open Door Forums
  • Publications

• MAC list servs, education
Also Doing CDI and Quality?

• Network while you are here

• I don’t know CDI well but I do know patients with sepsis are sick and have more than 2 SIRS
Proving Your Worth

- LOS improvement
- Cost/charges per case
- CMI improvement
- HCAHPS scores
- Number denials
- Overturned denials
- Complaints to CMO about you
What have I forgotten?

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