Pt Status and OBS

The Challenges of Coverage and Compliance for Critical Access Hospitals in 2010

Special Olympic’s Oath:

Let me win,
But if I can not win,
Let me be brave in the attempt.
Critical Access Hospitals....

- Are paid for each submitted hour on the UB 04
- Are paid regardless...as Medicare will not know if medical necessity for each billable hr has been met in the medical record
- Higher exposure for compliance than APC hospitals -as marginal $ for them.

Outline of Training

- Updates to Obs
- Patient Status
- Billable hrs
From the pt: AARP Jan-Feb 2010 issue

- “Hospital Stays are Under Observation”
- Ruth Way fell, was admitted to the hospital for a 6 day stay and then to a SNF for rehab for 6 weeks.
- She is back living indptly but with more than $10,000 in nursing home charges.
- The reason: the hospital says she was never formally admitted as an inpt. A Medicare review board determined that her stay was merely for OBS.
- The decision meant Medicare was off the hook for paying for the SNF as a 3 day inpt stay is required.
- Advocate indicates they hear more of multi-day stays being deemed as OBS, sometime retroactively. Fearful of denial.
- Son: This is gross dereliction of the responsibilities that Medicare should have for our aging citizens.
- CMS Notice: www.medicare.gov/publications/pubs/pdf/11435.pdf - “Are you a hospital inpt or outpt? If you have Medicare - ASK!”

Transmittal 1745/1760 July 2009

- Meant to clarify OBS language on pt status. However, nothing changed regarding “active physician involvement, assessment and reassessment to determine if the pt needs admitted or safely discharged home” = billable hr.
Editorial change to remove references to “admission” and “observation status” in relation to outpt observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term ‘admission’ is typically used to denote an inpt admission and inpt hospital services. For payment purposes, there is no payment status called “observation”, observation care is an outpt service, ordered by a physician and billed with a HCPC code.

- Revenue code 762 or 760 is acceptable.
- Rounding of hrs. Hospitals should round to the nearest hr. (EX 3:03 to 9:45 = 7 hrs)
- Standing orders for obs services following outpt surgery are not recognized. Recovery room services billed separately (4-6 hrs)

References: 290.1; 290.2.1; 290.2.2/ Transmittal 1745
Medicare Claims Processing Manual Chpt 4, 290; Pub 100-02 Medicare Benefit Policy Manual Chpt 6, 29.6

Continuous Monitoring: May a hospital report drug adm furnished during the time period when obs services are being reported? CMS FAQ 1-27-10

- "Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g. colonoscopy, chemotherapy). " In situations where such a procedure interrupts observation services and results in two or more distinct periods of obs services, hospitals should record for each period of obs services the beginning and ending times during the hospital outpt encounter. Hospitals should add the length of time for the periods of obs services together to determine the total number of units reported on the claims for the hourly obs services under HCPCS code G0378 (hospital obs service, per hr.)
- Continuous monitoring = billed 1st, then 'earn' OBS hrs
- Medicare Claims Processing Manual, Pub 100-4, Chpt 6, Section 290.2.2
More on continuous monitoring

CMS 1-27-10, FAQ

A: The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for future information.

If the hospital determined that active monitoring is part of a drug adm service furnished to a particular patient and separately reported, then OBS services should not be reported with HCPCS G0378 for that portion of the drug adm time when active monitoring is provided.

Good News - Hydration

FAQ9974

"It is an unacceptable practice to automatically place a patient in observation for the sole purpose of providing Chemotherapy, or other therapeutic intravenous infusions. If any complex therapeutic intravenous infusions are given during a patient’s observation hours these service hours must also be deducted. Hydration is not considered as therapeutic active monitoring." An example: "a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring." (Source: FAQ 9974 active monitoring and drug administration.htm)
New 2011 Physician Supervision – 3 types of supervision outlined

- The final rule exempts CAHs & small, rural w/100 beds or less from this rule thru calendar year 2011. However, CAHs are expected to make the necessary adjustments to comply with the rule in calendar year 2012.
- **Direct supervision** – immediately available to furnish assistance and direction throughout the procedure. Does not mean in the room; but CMS makes it clear must be physically present. Available thru phone does not meet the requirement. In a clinic within close proximity, is considered to be immediately available.
- **General supervision** – services are furnished under the overall direction and control of the physician but his presence is not required during the procedure.
- **Personal supervision** – physician is present in the room when procedure is performed.

More on 2011 Physician supervision

- For a limited set of nonsurgical extended duration therapeutic services (all types of drug adm, OBS hrs), CMS allows direct supervision followed by general supervision. For those services, direct supervision is required at the initiation of the services; general supervision is required once the attending practitioner deems it safe to move to general supervision.
- Some revision to Direct Supervision. CMS makes it clear that the practitioner must be ‘physically present.’ The doc must be located close enough they can immediately step in. An ER doc WOULD qualify as long as they are not so busy they cannot be interrupted. A physician, available thru phone or telemedicine, is NOT currently considered immediately available. A physician in a clinic with close proximity to where the outpt therapeutic services is being performed DOES qualify as direct supervision.
Office of Inspector General/OIG’s 2011 Work Plan

We will review Medicare payments for OBS services provided during outpatient visits in hospitals. Provides for Part B coverage of hospital outpatient services and reimbursement for such services under the hospital OPPS. CMS’s Medicare Claims Processing Manual, pub 100-04, Ch 4, provides the billing requirements. We will assess whether and to what extent hospitals’ use of observation services affect the care Medicare beneficiaries receive and their ability to pay out-of-pocket expenses for health care services.”

Inpatient vs Observation Making it Easier
What if the payer wants an inpt billed as observation?

Why?
- Some non-Medicare payers certify for observation even when the doctor orders inpt.
- Some payers have regulations that indicate a patient must stay a minimum number of hours.
- Some payers do not honor physician orders; internal adjudicators change.

Fight the Decision or never, ever change the order

Create: “Variation from order for non-Medicare payers”

SAMPLE: According to Medicaid’s regulations—“(insert actual regulations), this account will be billed as an observation even though the physician ordered inpt.”

Document signed by leadership, in med record
Bus off converts from inpt to obs, revises billing.
Stats will change: loss of inpt day, possible productivity impact to nursing unit
Drug adm is billable; but is time charted?
RAC HealthDataInsights licenses Milliman Care guidelines

"HDI has signed a 5 year license with Milliman Care Guidelines. HCI will use the care guidelines content and software to review Medicare claims.

HDI will use the annually updated evidence based care guidelines products.

The Care Guidelines promote healthcare quality by providing clinical guidelines based on the best available clinical evidence."

CMS does not mandate or endorse any specific guidelines or criteria for utilization review."

Feb 25, 2009 “Evidence-based care guidelines will be used to combat waste in Medicare program.”

Medicare’s Inpt definition

Medicare benefit policy manual chpt 1 10

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 even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

"However, 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, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. 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..."
What does Severity look like?

- What brought the pt to the hospital?
- Has the pt failed outpt treatment?
- Does the pt’s condition require admission to an acute setting?
- Is the pt sick enough to require hospital level of care NOW?

What does intensity of service look like?

- Clinical documentation tied to the severity of the condition the pt was admitted for.
- What is currently being done for this patient?
- Does this treatment require an inpt level of care?
- Applies to each separate day. (all care givers)
Two focus points for OBS:

- **Pt status** - understanding what is OBS? (Ownership: UR and providers)
- **Billable hrs** - understanding what constitutes billable hrs vs hrs in a bed. (Ownership: Nursing and providers)
- **If only signs and symptoms are present but no confirmed course of tx/dx - think OBS.**

**GOAL OF OBSERVATION** -

- Where would the patient rather be - in a hospital (gappy gown, no one to watch cat, care for family issues, etc) or home?
- **Reason for Observation** - to allow the physician time to make a decision and then RAPIDLY move the patient to the most appropriate setting.
- Observation is not a holding zone
Patient Status/Level of Care

Who is the owner of pt status: Inpt, outpt receiving care in a bed, observation?

Provider, Case Management/Utilization Review

- Only a physician/provider can direct pt care
- UR Committee Membership Requirements
- Who can make the determination that a patient’s status should be changed?
- Consultation with ordering physician
- Notification of patient and physician

Medicare Guidelines

APC regulation (FR 11/30/01, pg 59881)

“Observation is an active treatment to determine if a patient’s condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged.”

Medicare Hospital Manual (Section 455)

“Observation services are those services furnished on a hospital premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible as an inpatient.”
Expanded 2006 Fed Reg Info

**Observation** is a well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, before a decision can be made regarding whether a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.

**Note: No significant 2007, 08, 09, 10, 11 reg changes**

Observation-Time Guidelines

- Obs time must be documented in the medical records
- A beneficiary's time in observation begins with the bene's admission to an obs bed (or when order is written if the doc is in the care area).
- Time ends when all clinical or medical intervention has been completed, including f/up care that may occur after the physician has ordered the pt be released. (Pg 68692 Fed Reg 11-10-05)

New Transmittal with 7-09 OPPS update, Transmittal 1745/1760, CR 6492

Clarify a hospital begins billing for observation services at the clock time documented in the pt's medical record which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.

HUGE IMPACT TO Condition Code 44: Bill OBS from point of order
Observation is an **Outpatient**

- Observation is an outpatient in a bed
- It is billed hourly to the payers
- Each hr must be medically necessary with active physician involvement—as appropriate for each billable hr
- Non-billable hrs occur when—order is up, no new orders, social admit, gaps between orders and physician contact, no transportation, ancillary delays, physician delays, family convenience, not medically necessary, late cases.
- Build in the CDM and track and trend = patterns

Three types of OBS audits

**focus areas**

- **ER to OBS**
  - Many hrs are lost while the pt is being held in ER pending bed placement. ER is an outpatient treatment area. Once the OBS order has been activated by nursing, discontinue the ER documentation and begin OBS documentation. Once the placement has been completed, floor nursing continues the ER/OBS documentation including drug adm.

- **PP to recovery to OBS**
  - This is the most problematic of the 3.
  - Bad habits exist where providers are ordering OBS at the same time a procedure is ordered. Can’t have an unplanned event BEFORE a scheduled surgery.
  - Routine recovery is up to 4-6 hrs anywhere in the hospital—all hrs billable in an outpatient setting. (Exception Appendix G—conscious sedation). Recovery must occur/pause prior to movement to a more acute level—OBS or inpt with an updated order.

- **Direct to OBS**
  - Majority of these are simply outpts receiving services in an inpt bed.
  - Facilities should incorporate a pt status’ midnight census to help reinforce correct pt status that is documented and ordered.
  - Look for very short LOS as well as outpatient procedures/transfusions. No OBS unless there is an adverse event.

Hey, who is inputting OBS charges when the pt is in an inpt unit?
More 2006 Regulations

Observation status is commonly assigned to pts with unexpectedly prolonged recovery after surgery and to pts who present to the emergency dept and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. (Fed Reg, 11-10-05, pg 68688)

More on Post procedure to OBS

Q30. We have standing orders for observation after surgery; we do not have the patient sign an ABN but bill observation hours knowing that Medicare will not pay, is this accurate?

A30. Per IOM 100-04, Chapter 4 Section 290.2.2: "General standing orders for observation services following all outpatient surgery are not recognized. 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), which should be billed as recovery room services." If a patient needs observation beyond the standard recovery period because of patient status or a complication, a specific order for observation must be written at that time. If no specific order was written, any observation hours on the claim must be billed as non-covered. (Noridian, Q&A, Feb 2010)
Another MAC weights in

- Trailblazer/MAC "Inappropriate Hospital Admission Versus Outpt Observation" 8-30-10
- Obs or monitoring is a type of service. Planned admission following an elective outpt procedure may be denied for lack of medical necessity when the pt's condition does not warrant an acute inpt stay. The admission must be related to the pt's condition and documentation must provide a rationale for the medical decision to place the pt in an inpt status. In addition, monitoring and observation services following an outpt procedure are not obs services; the recovery, monitoring and medications following the procedures are an inclusive part of the procedure.

Surgical/Interventional Procedures - Tough Environment

- Each patient individually assessed
- After 4-6 hrs routine recovery
- Decide: Safe to go home?
- If not, evaluate:
  - Is it an unplanned outcome?
  - Is it an exacerbation of a condition?
- If not, explore extended recovery.
- If yes, eligible for observation.

Uglies:
- Observation can not be ordered 'before' the procedure
- No standing orders for observation.
Services Not Covered as Obs

Services that are covered under Part A, such as a medically appropriate inpt admission or as part of another Part B service, such as postoperative monitoring during a standard recovery period (4-6 hrs) which should be billed as recovery room services. Similarly, in the case of pts who under diagnostic testing in a hospital outpt dept, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those dx services. Obs should not be billed concurrently with therapeutic services such as chemotherapy. (Pub 100-02, Ch 6, Sec 70.4)

And then there was Recovery...

- **Routine** - Immediate post procedure up to 4-6 hrs. Not billing for a room, but the service.
- Floor nursing can bill for recovery, extended recovery, as well as observation.
- Explore creating **timed phases**:
  - Phase 1 - immediate post procedure - PACU
  - Phase 2 - less than 1-1 nursing-up to 4-6 hrs-outside PACU
  - Extended recovery - not safe after 4-6 hrs -outside PACU/phase 3
  - Create a R&B choice for: obs, semi, private, extended
Operational Issues with Observation

After up to 4-6 hrs of routine recovery, the physician should expect a call to ask the following:

- Not safe to go home - need updated orders for extended recovery or observation or inpt.
- Active physician involvement will still be necessary to move the pt to the most appropriate setting.
- Extended recovery option - orders, medically necessary but no unplanned event.
- Unplanned event severe enough to warrant admit to acute level of care?
Decision Tree Additions

- At any point, the pt's status may deteriorate and an inpt admit is ordered – in recovery, extended recovery or observation.
- At any point, the pt's status may change while in extended, the physician orders observation and the decision-making moves to observation.

Unplanned Outcome

- Interqual's example of unplanned outcome:
  - IV administration for pain and/or nausea management.
  - Lab work that is outside the norm
  - Inability to void at end of routine recovery
  - Unusual bleeding=move to an obs bed and begin all other obs guidelines
It is all about understanding Pt Status and/or Level of Care

- Daily reconciliation of midnight status - 150 pts in a bed; what are they? Recovery, outpt, inpt, OBS, non-covered, extended recovery.
- Just because a pt is in a bed, does not mean they are a) OBS or b) Inpt.
- Ongoing communication with bedside nursing on their ‘pt status’ is essential.

Attacking Billable Hours vs Hours in a Bed
**Expanded 2006 Fed Reg Info**

- **Observation** is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, before a decision can be made regarding whether a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.

  - **Note**: No significant 2007, 08, 09, 10, 11 reg changes

**Physician 2006 Additions**

- **Pt must** be under the care of a physician...as documented in the medical record by admission, discharge and other appropriate progress notes that are timed, written and signed by the physician.

- The medical record must include documentation that the **physician explicitly assessed** patient risk to determine that the beneficiary would benefit from observation care. (pg 68694)
Key Elements for Covered Observation Stays

- Physician order to place/referral in observation
- Intent in the order
- Medical Necessity for ea billable hr
- Active physician involvement/ongoing assessment and reassessment
- Rapidly move to appropriate setting - home or inpt.

Deduction from hours

- “Gaps between orders’
- Condition code 44 not done correctly
- Beside monitoring/drug adm and no other separate, unique documentation is present = continuous monitoring
- Left the unit
**Condition code 44/CMS**

- Original transmittal 81 (effective 4-1-04) Updated transmittal 299, dated 9-10-04. (FL 24-30)
- Further clarity on physician review:
  - Q&A, March 2006
- Use 'when the physician ordered inpt, but upon UR review performed before the claim was originally submitted, the hospital determined that the service did not meet it's inpt criteria.'
- New MLN Matters Q&A - 'UR must consult with the practitioners responsible for the care of the pt and allow them to present their views BEFORE making the determination’
- Review and final decision must be made while the pt is still in the facility.

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**More CMS clarity on CC 44**

FAQ (questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_aip)

- Q: May a hospital change a patient’s status using CC 44 when a physician changes the patient’s status without UR committee involvement?
- A: No, the policy for changing a patient’s status using CC 44 requires that the determination to change a pt’s status be made by the UR committee with physician concurrence. The hospital may not change a pt’s status from inpt to outpt/OBS without UR committee involvement. The conditions for use of CC 44 require physician concurrence with the UR committee decision. For CC 44 decisions, in accordance with 42 CFR 482.30 (d 1), one physician member of the UR committee may make the determination for the committee that the inpt admission is not medically necessary. (cont)
More Clarity on CC 44 (cont)

* This physician member of the UR committee must be a different person than the concurring physician for CC 44 use who is the physician responsible for the care of the pt.

Noridan/MAC states in their FAQ:
Q37: If the attending physician AGREES with the status change from INPT to Outpt/OBS, do we need to involve the UR physician also? Or is it only required with the attending does not agree?
A37: In order to change the beneficiary’s status from inpt to outpt/OBS, the attending physician must concur with the UR committee.

More clarity on Condition Code 44 – Patient impact

* Palmetto/MAC, issued “Observation and CC 44 Discussion Items.” Power Q&A as a result from NC work group, 4th Q 2009.

Q: A Medicare pt is admitted as an inpt. Case Mgt/UR does not believe meets inpt/Interqual requirements. The physician agrees. The pt status is changed back to OBS; however, the hospital failed to inform the pt of the status change. How is this situation billed? Should the pt remain an inpt and not be charged OBS/

A: Should the pt’s status change at any time during the hospital stay, it is imperative that the pt be notified of this change in a timely manner (prior to discharge.). In this particular situation, this notification should have occurred at the point when the pt was identified as not being eligible..
More CC 44 news...

...for an inpt stay they could have been entitled to information regarding the change in status and impact to coinsurance. According to Medicare Claims Processing Manual, Publication 100-04, Chapter 30, Section 20: "When the beneficiary did not know or could not have reasonably expected to know that the items or services were not covered, but the provider knew or could have been expected to know, of the exclusion of the items or services, the liability for the charges for the denied items or services rests with the provider."

...Because the pt was not notified of his/her change in status, the provider will be required to bill the claim AS AN INPT type of bill (11x) in spite of the fact that the stay does not meet inpt criteria. The claim should be filed as a "no pay".

Final CC 44 Issues

...type of bill (110) with all days and charges as non-covered. Since the beneficiary was not given a notice of non-coverage before discharge, the stay should be billed as provider liability using a M1 occurrence span code in form locator 35 or 36. This will cause the claim to process in FISS as non-covered with no payment and no pt liability reports on the remittance advice or the beneficiary's Medicare Summary Notice (MSN).

...After the no pay claim (TOB 110) is processed, you may then file an inpt ancillary claim (TOB 12x) to seek payment for the eligible ancillary provided during the stay. The eligible ancillary services are outlined in Medicare Claims Processing Manual, publication 100-04, chapter 4, section 240.1.
WOW! Transmittal 1803, CR 6626 - billable hrs with CC 44

* Numerous MACs are submitting clarifications regarding billable hrs when changing from inpt to OBS under CC 44 provisions.

* Per Noridian/MAC - training update sent 9-24-09

"When a hospital has determined that it may submit an outpt claim according to CC 44, the entire episode should be billed as an outpt episode of care with outpt services that were ordered and furnished billed.

Because there was no order for obs at the time the pt was admitted, providers may not be counting obs hrs until such time as an order for obs is given.

EX) Pt A is admitted at noon on Sun. On Mon afternoon, it was determined that the pt didn't meet inpt criteria, the physician concurred, and the status was changed back to outpt OBS. The outpt status considered to have begun at noon on Sun. However, OBS hrs cannot be billed until the physician has written an order for obs. If the order is written at 2:00 pm on Mon, the hospital would begin the OBS hrs at that time. No obs hrs would be charged between noon on Sun and 2:00 pm on Mon."

RAC ISSUE: What did the physician bill? Inpt or Obs?

Urban Myth - 'get 24 hrs of OBS"

* www.rgbagov.com/publications/lcd/lcd-files/080-01a.html (gone!! Cahaba has taken over as the MAC)

* Guideline: If the physician 'believes' the condition will resolve itself within 24 hours - with results, indicators, etc. completed - order observation.

* Guideline: If the physician has doubt that the patient meets criteria for inpatient, then admit to observation, aggressively manage, move to inpatient or safely discharge home.

* Guideline: If the physician's original INTENT/order is inpatient, but the patient recovers soon (<24 hrs), inpatient is still billed.
Aggressive operational

"new thoughts"

- **Dedicated OBS bed or unit**: medical, post procedure, OB, Tele (ideas)
- Super trained nursing to 'actively move the pt” as well as “active physician involvement.”
- **New action oriented pre-printed physician order form**.
- **HINT**: Use for all outside PACU recovery, late case procedures, etc.
Floor 1: Making it Happen

- Physician must order ‘observation.’
- Order clearly indicates status: Inpatient versus Observation
- Initial order clearly indicates intent: why the patient needs assessed what is the goal for the care what are the ‘triggers’ that will indicate to the care team-order met, contact the physician.
Physician Order Sample—Action Oriented w/triggers

- Place in Observation
- Dx: "Dehydration"
- Treatment: "2 Liters IV fluid bolus over 2 hours followed by 150cc/hr"
- Monitor for "hypotension, diarrhea, vomiting, urine output, etc..."
- Notify physician when: Patient urinates or 3 liters have been infused

Each hour needs tied to the physician’s orders.

Billable time is finished when the orders are met.

Nursing develops internal ‘triggers’ to aggressively monitor all orders.
  - color coded observation charts
  - white board - room # w/trigger times
  - update new trigger times with updated orders
  - 24 hr board - use colors to identify OBS orders due/room
  - could also use for recovery phase 2 is done/6 hr mark
Physician and Nursing - Partners

- **Active physician involvement** = charting indicates condition update w/corresponding orders, changes documented with all timed and signed by the physician.
- **Who keeps the physician 'updated' so the above can occur?**

Idea to Explore and Resolve

- **ER:**
  - New space = observation unit
  - Physicians more actively involved with ongoing obs care/orders once moved to the floor
  - Internal changes to accomplish
Additional Opportunities

- **Hospitalist**
  - Role in assisting the primary physician in ongoing orders, interventions, after hrs, etc.
  - Financial impact
  - Coordination of pt care with the FPs and the surgeons

Charge Capture Ideas

- Explore *front loading the 1st hr*, where the majority of costs occur
- Explore different rate for different levels of acuity, i.e. care areas: medical, post procedure, OB, telemetry
- Each subsequent hr significantly less
- *Create non-billable CDM entries*
  - Non-billable not medically necessary
  - Non-billable community benefit
  - Stats only, but allows for tracking/trending
More Charge Capture Ideas

- Don’t forget to look for outpatient services being done in Observation
- **New Drug Administration CPTs** for infusion and injections/9xxx; blood tx/36430
- Outpatient procedures done (0-69999 CPTs)
- Nonbillable/$0 entries

Drug Administration Uglies

- Initial/primary reason for visit
- Use 9xxxx for all payers. Only 1 C/pump for Medicare
- Once determined, initial/primary visit code (hydration, therapeutic, chemo)- then use subsequent CPTs for additional services
- All outpt areas are impacted: ER, observation, Hospital based clinics
- May be unrealistic for nursing/care areas to chart and charge.
  - **IDEA:** Nursing takes ownership for charting ‘stop and stop’ times per CPT.
  - **IDEA:** Create charge Capture Analyst position
"Time" Charting Ideas

- Create a stamp for Drug adm start and stop times. (Could do recovery & O2 as they are timed charges)
- Use the stamp for billable time
- IV Hydration Infusion

  Start  Stop  Date  Dept  Initials  

  (multiple lines)

- IV Therapeutic Infusion

  Start  Stop  Date  Dept  Initials  

  (multiple lines)

Remember: time continues from ER to observation/outpt areas

Creating an Observation Attack Team

- If opportunities are found for improvement, create an internal, cross functional team to begin the rollout/improvement process.
- Follow the CQI: FOCUS PDA process.
- Find (F) an opportunity to improve.
- Organize (O) a team
- Clarify (C) the current process
- Understand (U) the variation
- Select (S) the process(es) to improve
- Plan, Do, Act
Working on the Process

- Observation Attack Team develops a rollout
  - 1st: pull hx data: by dx, by care area, by doctor, by payer + hrs
  - 2nd: perform a benchmark chart review-identifying 'broken processes'. Compile data
  - 3rd: perform financial review - identifying $ at risk, summarizing reasons for non-billable
  - 4th: develop training material - including findings from audit, new tools, interventions.
  - FOCUS: Observation made easy!!

An Observation Attack Team

- Team members: HIM, UR, case mgrs/care team leaders, PFS, Compliance, nursing
- Daily process:
  - Review observation charts, complete G code work paper, complete chart review form
  - Complete manual charge ticket: billable and non-billable
  - Using non-billable statistics, evaluate patterns, by dx, by physician, by care area
  - Continue to evaluate improvement to the process: ed, sharing of data, new tools, accountability
Internal Processes

- Daily the Observation Attack team reviews each record
- Complete an internal chart review form with the required elements for coverage: order, intent, medical necessity for each billable hr, charted times, non-billable time
- Manually, complete the charge ticket:
  - Example: 20 hr LOS
    - 55112 1st hr 1 unit $250
    - 55113 sub hrs 15 hrs $270
    - 55114 Non-billable-not medically necessary 4 hrs

Daily Charge Capture Process

- Daily, Observation Attack Team completes:
  - Audit of observation accounts
  - Determines non vs billable hours
  - Completes charge ticket with non & billable items
  - Billable divided into first hr, each subsequent hour
  - Drug administration &/or procedure chg
Observation Attack Team ......

Functions as **Charge Capture Analyst** for:

- Identifying billable vs non-billable hrs
- Identifying type of drug administration with start and stop times - include admits from ER as well as direct admits.
- Identifying bedside procedures and bill
- ER to OBS = complete drug adm charge ticket at OBS d/c; not in ER
- Reports non-billable items due to missing/incomplete documentation.
DAILY AUDIT TOOL SAMPLES
OBSERVATION CHART AUDIT TOOL

UR#____________ DR.____________ DOS________ Time______ (On face sheet)

MEDICARE REQUIREMENTS

Physician initial orders
➤ Dated __________________
➤ Timed _________________
➤ Clearly states: Observation (Chart Findings)

Intent in the physician order - Why did the physician want the patient in a bed? (Chart Findings)

➤ Orders for each hour? (Chart Findings)

Appropriate level of service to be in a bed continues to be met. (Chart Findings)

Active Physician Involvement - Is there documented communication between both the physician and nursing? (Chart Findings)

Patient arrival on unit (Nursing documentation)
Date
Time _________ (in a bed / nursing notes)

- Signature Y N (Circle One)

Other? (Chart Findings)

Was medical necessity met for each billable hour?
Hours billed equals _____________

Billable time__________ Non billable time _________

Summary of At Risk: (Chart Findings)
SAINT JOSEPH'S HOSPITAL OF ATLANTA
OBSERVATION CHART AUDIT TOOL

Patient Name

Patient Account Number

DOS

Dr.

Time (on face sheet)

PATIENT PROFILE (FROM H&P)

MEDICARE REQUIREMENTS

1. INITIAL PHYSICIAN ORDERS:
   - Clearly states: Observation (Chart Findings) Y / N (If No, complete 1 and proceed to 2)
   - Was the order consistent with CMS instructions to Physicians? Y / N
   - Dated: Y / N ________________
   - Timed: Y / N ________________

2. INTENT IN THE PHYSICIAN ORDER:
   - Why did the physician want the patient in Observation Status? (Chart Findings)
     - Orders for each hour? (Chart findings)
     - Is the level of service appropriate for Observation Status? (Chart findings)

3. ACTIVE PHYSICIAN INVOLVEMENT
   - Is there documented communication between both the physician and nursing? (Chart Findings)

4. OBS. TREATMENT INITIATION

   Location:
   
   Date:
   
   Time: (in Obs. / nursing notes)

   Nursing Signature: Y / N

   Others? (Chart Findings)

OBS. ENDING/DISCHARGE

   Location:
   
   Date:
   
   Time: (in Obs. / nursing notes)
Observation ATTACK Team
Charge Audit Tool

Date of Audit: ____________________________
Clinical Area of Observation Charges: ____________________________

Patient Name: ____________________________
Account Number: ____________________________
Date(s) of Service: ____________________________
Physician: ____________________________

Audit Performed By:
Clinical Area: ____________________________
Case Management: ____________________________
Business Office: ____________________________
HIM: ____________________________
Other: ____________________________

Total Hours in Observation Status: ____________________________

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<th>Billable Observation Hours</th>
<th>Original Amount Charged</th>
<th>New Amount Audit</th>
<th>Add Hours</th>
<th>Subtract Hours</th>
<th>Charge Code</th>
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<tr>
<td>Additional Hour of Observation</td>
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<td></td>
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<td>Direct Admit Observation Change</td>
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<th>New Amount Audit</th>
<th>Add Hours</th>
<th>Charge Code</th>
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<tr>
<td>Physician / Patient Convenience</td>
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<tr>
<td>Social Reason / Community Benefit</td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

Does Account Require Charges to be Adjusted?

- [ ] No
- [ ] Yes

Adjusted Charge Entry Information

Date of Charge Entry for Audited Results: ____________________________
Employee That Performed Charge Entry of Audited Results: ____________________________
Operational Ideas

- Can ancillary areas 'see' the order is for observation vs inpatient?
- Ensure there is a cost benefit of OT vs having the pt stay in non-billable hrs
- How does the nurse bed-side case manager 'see' the interprets are complete? How does the physician know they are ready to be acted on?

Celebrate the baby steps

- Determine objectives - compliance, revenue, patient satisfaction. (Where does the patient want to be??)
- Determine if current billing should continue or if a break during corrective action plan.
- Determine how to continue to share the message after the initial kick off plan.
- Celebrate as each area: nursing, physician, administration - live the message.
Roll out Key Elements

- Use 'real life' examples for ed.
- Determine timeline to start Attack Team
- Determine timelines for ed, daily process, ongoing process.

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Thanks for joining us!