Adapting Your Medical Necessity Compliance Program In An Evolving Regulatory Environment

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How will you ensure your hospital withholds auditor scrutiny in 2016 given the expected changes from Centers for Medicare & Medicaid Services (CMS) to address the persistently large improper payment rates in short-stay inpatient claims?

Hospitals should evaluate their current compliance programs regularly. With medical necessity changes CMS is proposing, the best way to defend against inappropriate denials is to ensure a compliant process for review and certification of admission status on every patient that enters the hospital.

With a renewed emphasis on physician judgment and medical necessity, not hospital level of care, providers must demonstrate a legitimate, defensible and consistent Utilization Review process to determine appropriate admission status. Hospitals across the country may struggle with this proposed shift, especially considering the time-based recommendations implemented in 2014. It is challenging to anticipate projected enforcement under the QIOs with their extensive referral possibilities.

This session will provide guidance on the implications of proposed changes from CMS and the potential impacts to your medical necessity admission review program.

Following this session, participants should be better able to:

- Interpret trends and lessons learned from Probe and Educate efforts
- Provide potential QIO enforcement ramifications and explain the extensive referral opportunities that could impact hospitals
- Evaluate policies and practices implemented under FY 2014 IPPS, related to the 2 midnight rule, and determine if current programs would align with a renewed emphasis on provider judgment and medical necessity for inpatient hospital admissions
- Understand the expanded rare and unusual circumstances that could qualify in 2016 for inpatient admissions without a 2 midnight expectation
The Past
“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.”
Continued...

• 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;
  – The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
  – The availability of diagnostic procedures at the time when and at the location where the patient presents.

• Admissions of particular patients are not covered or non covered solely on the basis of the length of time the patient actually spends in the hospital.”
Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

– Observation patients are outpatients
“Observation services are those services furnished by a hospital on the hospital’s premises, including use of a bed and at least periodic monitoring by a hospital’s nursing or other staff which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff by-laws to admit patients to the hospital or to order outpatient tests.”

“When a physician orders that a patient be placed under observation, the patient’s status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.

(See Pub. 100-02, Medicare Benefit Policy Manual, chapter 1, §10 “Covered Inpatient Hospital Services Covered Under Part A”).
Physician Chart Documentation is the backbone for verifying Medical Necessity

Remember the 5 key pieces of documentation:
1. Medical History
2. Current Medical needs
3. Severity of signs and symptoms
4. Facilities available for adequate care
5. Predictability of an adverse outcome

Think in INK!
The Present
“The estimated 2014 Medicare FFS improper payment rate – the percentage of Medicare dollars paid incorrectly – was **12.73 percent**. This means that Medicare paid an estimated **$45.8 billion** incorrectly between July 2012 and June 2013. For 2014, CMS adjusted the improper payment rate by 0.9 percentage points ($3.3 billion) from 13.6 percent to 12.7 percent to account for the effect of rebilling inpatient hospital claims denied under Medicare Part A (Part A to B rebilling). “

“It is important to note that the improper payment rate does not measure fraud. It estimates the payments that did not meet Medicare coverage, coding, and billing rules.”

“Once again, during the 2014 report period, the most common cause of improper payments (accounting for 60.1 percent of total improper payments) was lack of **documentation** to support the services or supplies billed to Medicare.”

- *From the 2014 Medicare Improper Payments Report*
The Age of Accountability

<table>
<thead>
<tr>
<th>Who</th>
<th>What</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAs</td>
<td>Recovery Auditors</td>
</tr>
<tr>
<td>MACs</td>
<td>Medicare Administrative Contractors</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>MIP</td>
<td>Medicaid Integrity Plan</td>
</tr>
<tr>
<td>MIG</td>
<td>CMS Medicaid Integrity Group</td>
</tr>
<tr>
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<td>Medicaid Integrity Contractors</td>
</tr>
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<td>Medicaid Inspector Generals</td>
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<td>Payment Error Rate Measurement</td>
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<td>Program Safeguard Contractors</td>
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<td>ZPICs</td>
<td>Zone Program Integrity Contractors</td>
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<td>Office of the Inspector General</td>
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<td>DOJ</td>
<td>Department of Justice</td>
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<td>QIO</td>
<td>Quality Improvement Organization</td>
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## CMS Recovery Amounts

(Through FY2014)

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<tr>
<th>Period</th>
<th>Total Corrections</th>
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<tr>
<td>October 2009 – September 2010</td>
<td>FY2010 $92.3</td>
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<tr>
<td>October 2010 – September 2011</td>
<td>FY2011 $939.3</td>
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<tr>
<td>October 2011 – September 2012</td>
<td>FY2012 $2,400.7</td>
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<td>October 2012 – September 2013</td>
<td>FY2013 $3,834.8</td>
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<td>October 2013 – September 2014</td>
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<tr>
<td><strong>Total National Program</strong></td>
<td><strong>$9,671.7</strong></td>
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Total corrections through FY 2014 ~ $9.67 billion
Approximately $8.925 billion in overpayments

Sources: [CMS website](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html)
# CMS Recovery Amounts

(Q4 FY2014 Only)

<table>
<thead>
<tr>
<th>Region</th>
<th>Overpayments Collected</th>
<th>Underpayments Returned</th>
<th>Total Quarter Corrections</th>
<th>FY To Date Corrections</th>
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<tbody>
<tr>
<td>Region A: Performant</td>
<td>$8.38</td>
<td>$9.33</td>
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<td>Region B: CGI</td>
<td>$9.47</td>
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<td>Region D: HDI</td>
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<td>Nationwide Totals</td>
<td>$145.45</td>
<td>$47.52</td>
<td>$192.97</td>
<td>$2,404.57</td>
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</table>

Medicare Fee for Service National Recovery Audit Program
Figures provided in millions (July 1, 2014 – September 30, 2014)
Quarterly Newsletter

2-Midnight Benchmark

• “Our proposed 2-midnight benchmark, which we now finalize, simply modifies our previous guidance to specify that the relevant 24 hours are those encompassed by 2 midnights.”

Page 50945, IPPS

• “We do not believe beneficiaries treated in an intensive care unit should be an exception to this standard, as our 2-midnight benchmark policy is not contingent on the level of care required, or the placement of the beneficiary within the hospital.”

Page 50946, IPPS
Benchmark vs. Presumption

• “Benchmark of 2 midnights”
  – “the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpatient service. In other words, if the physician makes the decision to admit after the beneficiary arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the beneficiary’s total expected length of stay.”

Page 50946, IPPS

• “Presumption of 2 midnights”
  – “Under the 2-midnight presumption, inpatient hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care…”

Page 50949, IPPS
“We note that it was not our intent to suggest that a 2-midnight stay was presumptive evidence that the stay at the hospital was necessary; rather, only that if the stay was necessary, it was appropriately provided as an inpatient stay. We have discussed in response to other comments that, in accordance with our statutory obligations, some medical review is always necessary to ensure that services provided are reasonable and necessary, and that we will continue to review these longer stays for the purposes of monitoring, determining correct coding, and evaluating the medical necessity for the beneficiary to remain at the hospital.”

2014 IPPS, Pg.50,951
“The decision to admit the beneficiary as an inpatient is a complex medical decision made by the physician in consideration of various factors, including the beneficiary’s age, disease processes, comorbidities, and the potential impact of sending the beneficiary home. It is up to the physician to make the complex medical determination of whether the beneficiary’s risk of morbidity or mortality dictates the need to remain at the hospital because the risk of an adverse event would otherwise be unacceptable under reasonable standards of care, or whether the beneficiary may be discharged.”
• “The Medicare review contractor will count only medically necessary services responsive to the beneficiary's clinical presentation as performed by medical personnel.”

• “…CMS expects Medicare review contractors will exclude extensive delays in the provision of medically necessary services from the 2 midnight benchmark. Medicare review contractors will only count the time in which the beneficiary received medically necessary hospital services.”
EXCEPTIONS to the 2MN Rule (CMS FAQs 12/23/13)

• CMS has identified the following exception to the 2-midnight rule: 
  Mechanical Ventilation Initiated During Present Visit.

• **NOTE:** This exception is not intended to apply to anticipated 
  intubations related to minor surgical procedures or other treatment.

• Medicare’s “Inpatient-Only” List

• “Rare and Unusual”
6 Reasons an Inpatient can stay < 2MN

1) Death
2) Transfer
3) AMA
4) Canceled Surgery
5) Hospice Transfer
6) *Unexpected Recovery* …
Question 1

Which of the following has CMS identified as an exception to the "2 midnight rule"?

A. Services not provided over a weekend
B. Medicare "Outpatient-Only" List Procedures
C. Beneficiary need for placement
D. Mechanical ventilation initiated during present visit
E. Beneficiary unable to obtain transport
Physician Order

- For payment of hospital inpatient services under Medicare Part A, the order must specify the admitting practitioner’s recommendation to admit “to inpatient,” “as an inpatient,” “for inpatient services,” or similar language specifying his or her recommendation for inpatient care.

Page 50942, IPPS

- “Admit to Tower 7” or “Admit to Dr. Smith” are no longer acceptable.
Certification October 1, 2013 through Dec 31, 2014

3 Additional Statements required in the record and SIGNED by the responsible physician prior to discharge:

• Reason for inpatient services: The reasons for either— (i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for cost outlier cases under the inpatient prospective payment system (IPPS)

• The estimated time the beneficiary requires or required in the hospital

• The plans for post-hospital care, if appropriate, and as provided in 42 CFR 424.13
Certification Beginning Jan 1, 2015

• Inpatient Admission Order required as a condition of payment
• 2 Midnight Rule UNCHANGED: “Our proposed policy change regarding the physician certification requirements does not change unrelated requirements implemented in the FY 2014 IPPS/LTCH PPS final rule such as the requirements related to the 2-midnight policy.”
• “The order must be supported by objective medical information for purposes of the Part A payment determinations. Thus, the physician order must be present in the medical record and be supported by the physician admission and progress notes in order for the hospital to be paid for hospital inpatient services.”
• “[I]n most cases, the admission order, medical record, and progress notes will contain sufficient information to support the medical necessity of an inpatient admission without a separate requirement of an additional, formal, physician certification.”
• Certification required at Day 20 or upon identification of a cost outlier case.
Question 2

Beginning on January 1, 2015, formal certification is required for which of the following?

A. Every Hospitalization
B. Long-stay (20 days or more) and outlier cases
C. To demonstrate beneficiary need for SNF or NH
D. None of the above
“SGR Fix”

- Medicare Access and CHIP Reauthorization Act of 2015
- Signed into law on April 17, 2015
- Repeal of Medicare’s sustainable growth rate (SGR) formula for physician reimbursement
- The bill blocked a 21-percent cut in Medicare payments.
- **Prohibits RA post payment patient status review audits through September 30, 2015**
- **BUT also gives discretion to CMS to continue the Probe & Educate program through September 30, 2015.**
• Changes to the 2 midnight rule?

• Despite these planned alterations to the Recovery Audit Program, we note that hospitals and physicians continue to voice their concern with parts of the 2-midnight rule finalized in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50943 through 50954). Therefore, we are considering this feedback carefully, as well as recent MedPAC recommendations, and expect to include a further discussion of the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation services, and the related -0.2 percent IPPS payment adjustment in the CY 2016 hospital outpatient prospective payment system proposed rule that will be published this summer.
The Future
“Notice of Observation Treatment and Implication for Care Eligibility Act”

• “ … with respect to each individual who receives observation services as an outpatient … **for more than 24 hours**, to provide to such individual not later than 36 hours after the time such individual begins receiving such services (or, if sooner, upon release)—

• … oral explanation of the written notification

• … a written notification … which—

… explains the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reasons for such status of such individual …

… explains the implications of such status … such as implications for cost-sharing requirements under this title and for subsequent eligibility for coverage under this title for services furnished by a skilled nursing facility;
Issued on September 4, 2014
  - Effective date: September 8, 2014

MACs and ZPICs may deny “related” claims, either after review or automatically

Medicare’s example:
  - When the Part A Inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon's Part B services. For services where the patient’s history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician’s Part B service.
XV. Short Inpatient Hospital Stays (80 FR 39348-39353)

• The 2016 OPPS proposed rule was released on July 1, 2015 and officially published in the July 8, 2015 Federal Register.

• Section XV is divided into two subsections:

  A. Background for the 2-Midnight Rule

  B. Proposed Policy Clarification for Medical Review of Inpatient Hospital Admissions under Medicare Part A
Key Points

• **Renewed emphasis on provider judgment and medical necessity**
  – Inpatient Hospital Care rather than Hospital Level of Care

• **Renewed enforcement by Quality Improvement Organizations (QIO)**
  – Extensive referral possibilities
    • MACs for “payment adjustments”
    • Recovery Auditors for additional payment audits
    • DOJ/OIG/ZPIC

• **QIO auditing begins on October 1, 2015**
  – Recovery Auditors may resume performing patient status reviews for dates claims with admission of October 1, 2015 or later.
• Staying the same:

“We are not proposing any changes for hospital stays that are expected to be greater than 2 midnights; that is, if the physician expects the patient to require hospital care that spans at least 2 midnights and admits the patient based on that expectation, the services are generally appropriate for Medicare Part A payment” (80 FR 39351).
### Current Guidance:

“When a beneficiary enters a hospital for a surgical procedure not specified as inpatient only under § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for only a limited period of time that does not cross 2 midnights, the services would be generally inappropriate for payment under Medicare Part A” (80 FR 39349).

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### Proposed Guidance:

“Under the proposed policy change, for stays for which the physician expects the patient to need less than 2 midnights of hospital care and the procedure is not on the inpatient only list or on the national exception list, an inpatient admission would be payable on a case-by-case basis under Medicare Part A in those circumstances under which the physician determines that an inpatient stay is warranted and the documentation in the medical record supports that an inpatient admission is necessary” (80 FR 39351).
For payment purposes, the following factors, among others, would be relevant to determining whether an inpatient admission where the patient stay is expected to be less than 2 midnights is nonetheless appropriate for Part A payment:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient; and
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).

Source: 80 FR 39350-39351
Case-by-Case Review Determinations: Who will be making them?
Quality Improvement Organizations (QIOs)

- What are QIOs?

  - A QIO is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs work under the direction of the Centers for Medicare & Medicaid Services to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.

Source: CMS.gov
“Regardless of whether we finalize the policy proposals outlined above, we are announcing that, no later than October 1, 2015, we are changing the medical review strategy and plan to have Quality Improvement Organization (QIO) contractors conduct these reviews of short inpatient stays rather than the MACs” (80 FR 39352).
QIO Review of Short Inpatient Hospital Stays

• QIOs will review a sample of *post-payment* claims and make a determination of the medical appropriateness of the admission as an inpatient. (80 FR 39353).

• QIOs will refer claim denials to the MACs for payment adjustments.

• The process for providers to appeal denied claims by the QIO will remain unchanged.

Source: 80 FR 39353
The MACs will no longer be responsible for conducting these types of reviews (as they had been under Probe & Educate).

QIOs will educate hospitals about claims denied under the 2-midnight policy and collaborate with hospitals to develop a quality improvement framework to improve organizational processes and/or systems.

Source: 80 FR 39353
Scope of Review for Short Inpatient Hospital Stays: MACs, QIOs, and Recovery Auditors
Medicare Administrative Contractors (MAC)

• CMS has instructed the Medicare Administrative Contractors that, absent evidence of systematic gaming or abuse, they are not to review claims spanning 2 or more midnights after admission for a determination of whether the inpatient hospital admission and patient status was appropriate.
  – Questions and Answers Relating to Patient Status Reviews 3/12/14

• CMS will direct MACs NOT to focus their medical review efforts on stays spanning at least 2 midnights after admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. However, MACs may review these claims as part of routine monitoring activity or as part of other targeted reviews.
  – Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013 (Last Updated: 2/24/2014)
QIO Referral to Recovery Auditors

• Under the QIO short-stay inpatient review process, hospitals that are found to exhibit the following pattern of practices will be referred to the Recovery Auditor:
  – Having high denial rates
    • The proposed rule did not define a “high denial rate”
  – Consistently failing to adhere to the 2-midnight rule
    • This includes having frequent inpatient hospital admissions for stays that do not span one midnight
    • Outside of same-day admissions, the proposed rule did not define what would constitute “consistently failing to adhere to the 2-midnight rule”
  – Failing to improve their performance after QIO educational intervention
    • The proposed rule did not define the measure of improvement necessary to avoid Recovery Auditor referral
Recovery Auditors

• CMS has instructed the Recovery Auditors that, absent evidence of systematic gaming or abuse, they are not to review claims spanning 2 or more midnights after admission for a determination of whether the inpatient hospital admission and patient status was appropriate.

• The Medicare Access and CHIP Reauthorization Act of 2015 permitted CMS to extend the moratorium that precludes recovery auditor reviews of inpatient hospital patient status for claims with dates of admission through September 30, 2015.

Sources: 80 FR 39350 and Questions and Answers Relating to Patient Status Reviews 3/12/14
“Under current law, recovery auditors may resume [performing patient status reviews] for dates of admission of October 1, 2015 and later. After that date, the recovery auditors will conduct patient status reviews focused on those providers that are referred from the QIOs and have high denial rates. The number of claims that a recovery auditor will be allowed to review for patient status will be based on the claim volume of the hospital and the denial rate identified by the QIO” (80 FR 39352).
Question 3

The number of claims Recovery Auditors will be able to be review post January 1, 2016, will be based on?

A. Medicare Administrative Contractor denial rate
B. Number of denials upheld at the ALJ
C. Claim volume and the denial rate Identified by the QIO
D. Compliance with Medicare's Conditions of Participation
E. None of the above
Now…..Back to the Future…..

• Questions hospitals should consider:
  
  – Will the documentation be sufficient to support the admitting physician’s determination that the patient requires inpatient hospital care despite an ELOS < 2 MN?
  
  – If you don’t document medical necessity to demonstrate a “complex medical decision” supporting inpatient what will you document?
  
  – What medical necessity cases will RAs target in Oct?
    • 2+ midnight IP cases
      – Target of Custodial, Delay and Convenience?
    • 1 midnight IP cases
  
  – Will OIG and DOJ increase activity?
  
  – QIO audits: pre or post bill review of 1 midnight IP cases?
    • Will they provide “real” and “accurate” education and feedback?
  
  – Will auditors focus on surgical and cardiac procedures?
Recommended Utilization Review Plan & Components

**PLAN**
- The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

**REVIEW**
- The committee must review professional services provided in order to determine medical necessity and to promote the most efficient use of available health facilities and services.

**INTERPRET**
- The UR Plan is the documented process by which the organization will adhere to the standards identified in the Conditions of Participation as well as the defined operational standard for the Utilization Review Committee.
Conditions of Participation

CoP must be followed

• “We did not propose and are not finalizing a policy that would allow hospitals to bill Part B following an inpatient reasonable and necessary self-audit determination that does not conform to the requirements for utilization review under the CoPs.”

2014 IPPS, Pg. 50,913

• 482.30 (c)(1): The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of:
  I. Admissions to the institution;
  II. The duration of stays; and
  III. Professional services furnished, including drugs and biologicals.
Best Practices for Compliance Review

  
  – “Because it is not reasonable to expect that physicians can screen all admissions, continued stays, etc. for appropriateness, screening criteria must be adopted by physicians that can be used by the UM staff to screen admissions, length of stay, etc. The criteria used should screen both the severity of illness (condition) and the intensity of service (treatment). There are numerous commercial screening criteria available. In addition, some QIOs have developed their own criteria for screening medical necessity of admissions and procedures. CMS does not endorse any one type of screening criteria.”

  – “Cases that fail the criteria should be referred to physicians for review. For your UM program to screen medical necessity appropriately, the decision to admit, retain, or discharge a patient should be made by a physician, either through the use of physician approved or developed criteria, or through a physician advisor.”
Points to remember:

- This is a proposed rule at this point in time
- The comment window is currently open but set to close by 8/31/2015
- OPPS proposal becomes final Oct-Nov
  - Goes into effect Jan 1
- Consider your concurrent process and if any changes need to be made
- Audits may increase on Oct 1
Documentation Principles
Documentation Requirements

5 key pieces of documentation for Medicare cases and determining medical necessity of Inpatient:

• Medical history
• Current medical needs
• Severity of signs and symptoms
• Facilities available for adequate care
• **Predictability of an adverse outcome**

• **Expectation of a 2 midnight stay**

*CMS Medicare Benefit Policy Manual*
Chapter 1, §10
“Expected length of stay and the determination of the underlying need for medical or surgical care at the hospital must be supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which Medicare review contractors will expect to be documented in the physician assessment and plan of care.”
A/P Template

IP/OP/OBS level of care is warranted for this patient…

Because…

He/she presents with…

Suspicions…

And I have a high/low level of concern for…
(Diagnosis, not symptom)

Concerns…

He/she is at high/low risk for…

Predictable Risks…

Plan of care/treatment includes…
Must also include intent for 2MN stay

Intent…
Inpatient or Observation?

- 70 y/o female with no significant PMHx presents after a buffet meal with epigastric burning. She has normal vital signs and physical exam, her EKG is unchanged, and the initial cardiac enzymes are negative.

- 82 y/o female with a PMHx of CAD, previous MI, and 3vCABG presents complaining of chest pain similar to her previous MI. NTG provided only temporary relief. She has normal vital signs and physical exam, her EKG is unchanged, and the initial cardiac enzymes are negative.
Inpatient or Observation?

Observation level of care is warranted because this 70 y/o female with no significant history presents with reflux following a large meal. My concern is for GERD as symptoms improved with minimal interventions (antacids). She is at low-risk for cardiac ischemia based on her presentation, history, and objective findings. She is stable and ready for discharge.

Inpatient level of care is warranted because this 82 y/o female with known CAD, CABG, and PCI with recurrent angina similar to her previous cardiac event. My concern is for unstable angina as it is reoccurring at rest with SL NTG only providing short-term relief. She is at high-risk for progression of cardiac ischemia and myocardial injury and patient care is expected to require a hospital stay crossing 2 or more midnights.
One Helpful Word…

“BECAUSE”

• Great transition word
• I am admitting this patient “because”
• I am ordering this test “because”
• I am keeping this patient another day “because”
Observation Care

• Documentation must support
  – Order of observation *prior* to placing the patient in observation status
  – Initiation of observation status
  – Supervision of the care plan for observation
  – Clinical course in the unit
  – Performance of periodic reassessments
  – Medical decision-making (i.e., diagnosis, etc.)
  – Final examination
  – Discharge, or admit, plans made
Observation Tips

- Be sure to include:
  - Timed order to place in observation status
  - Provisional diagnosis
  - Assessment notes throughout observation encounter
  - Final diagnosis
  - Timed discharge order
  - Disposition
  - Most important, *who is managing the observation encounter?!* (e.g., EDMD, PMD, RN, etc.)
THANK YOU.
Questions?

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