Utilization Review: The View from Madison

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Glossary

- IP: inpatient
- OP: outpatient
- OBS: observation
- OSS: outpatient short stay
- SNF: skilled nursing facility
- CMS: Centers for Medicare and Medicaid Services
- MN: “medical necessity” or maybe “midnight”
No disclosures to report

Fraud should not, must not be tolerated in any circumstance

Most data/regulations/statements apply to traditional Medicare patients
  – Around 1/3 of our patients
  – Dictates our default posture

Managed Medicare, Medicaid, and private insurers play a different game

UW Health strives to be a national compliance leader…
And we have chosen to fight…

We shall defend our island, whatever the cost may be, we shall fight on the beaches, we shall fight on the landing grounds, we shall fight in the fields and in the streets, we shall fight in the hills; we shall never surrender.

(Winston Churchill)
Background

- University of Wisconsin Hospitals and Clinics
- 592-bed tertiary academic medical center
- FY2013:
  - ~35,000 discharges
    - 4143 Observation, 4455 Outpatient
  - 605,174 OP visits, 47,369 ED visits
- FY2015:
  - 30,794 IP admissions
  - 1.84 million OP visits, 55,660 ED visits
Some Basic Concepts
Medicare 101

• Medicare for Inpatients:
  – Part A covers inpatient services
    • $1288 for a “benefit period”
    • additional coinsurance after day 61
  – Part B pays for “doctor services”
    • $104.90/mo, $166 annual deductible, 20% copay
    – May qualify for SNF rehab benefits

• Medicare for Outpatients:
  – Part B pays as above for individual services
  – No part A or SNF benefit

• Observation care is outpatient!
What about SNFs?

- Benefits if all conditions are met/patient has:
  - Part A, days left in benefit period.
  - Qualifying hospital stay.
  - Need for daily skilled care.
  - Gets these skilled services in a SNF that's certified by Medicare.
  - Services needed for a medical condition that was either:
    - hospital-related medical condition.
    - condition that started while getting SNF care for a hospital-related medical condition.
Not so very long ago at UWHC…

- ~25% of all “general medicine” patients were Observation (OBS) status; ~25% stayed >48 hours
- Margin for hospital: *negative* $33/hr/patient
- “Medical necessity” definition unclear
  - Caregiver definition: things patients need
  - Auditor definition: *setting* of service
- Nationally, percentage of CMS beneficiaries in OBS rose dramatically after 2006…
- CMS felt this represented (fraudulent) cost-shifting from facilities to patients
On the RAC

• A limited Medicare fraud audit of inpatient billings piloted, 2005-2008
• Identified $1.03 billion in improper payments (96% overpayments, recollected)
  – What they found: lots of “inpatients” who should have been “observation”
  – By far the majority of money/cases
• Audits permanent in 2006, nationwide in 2010
• “Recovery Audit Contractors (RACs)”
  – Private companies paid on contingency
Lies, damn lies, and statistics

- FY2012: returned $1.9 billion, 7% of appeals successful
- FY2013: returned $3.03 billion, 9.3% of appeals successful
- FY2014: returned $1.6 billion, less clear what % appeals successful
- Or so they say…
  - Not clearly “apples to apples”
  - “Discussion period” not an appeal
  - “68% solution” not a successful appeal
  - They count lots of stuff as “audits”
Status Determination
Determining status

- Clinicians know that whether a patient is IP or OBS is irrelevant in terms of care received.
- Patient’s financial liability varies greatly.
- Prior to 10/1/13*, determination based on intensity of service/severity of illness…
  - InterQual and/or Milliman references, provider judgment, documentation
  - *enforcement of change delayed until 1/1/2016
- After 10/1/13, the “Two-Midnight Rule” went into effect (Medicare only)
New IP definition for Medicare

- If, at the time of presentation, the admitting physician expects care to span 2 midnights or more, IP is correct status
  - APPs and residents may be delegated to
  - ED and OSH midnights count
- Patients may/should “upgrade” if stay is prolonged for acute medical needs
- Clear and specific certification of expectation/need must be present
- “IP-only” procedure list trumps LOS
- Multiple hooks present…
New IP definition for Medicare

• The good:
  – No more OBS for weeks and weeks
  – Rule a lot simpler than old InterQual (maybe)

• The bad:
  – Dramatic and abrupt change in practice
  – Rollout so awful that audits were on hiatus
  – CMS not providing any useful answers

• The ugly:
  – Timing is everything now!
  – Defining medical necessity/acute needs
  – Inter-payor variability
New IP definition for Medicare

- After 1 MIDNIGHT, an OBS patient should be discharged or made inpatient…probably

- Exceptions to CMS 2 midnight requirement:
  - Patient acutely intubated
  - Patient dies or opts for new hospice
  - Patient leaves AMA despite 2-midnight need
  - Unexpected transfer to another hospital
  - Inpatient-only procedure
  - Medical miracle

- 2016 change to OPPS: not a change
UW Health Approach
Prior to “Two Midnights”

• Highly active multidisciplinary group charged with responding to various auditing bodies and internal monitoring (“RAC Pack”)
  – Strong Compliance and Internal Audit groups
• Leadership aware and invested in “RAC threat”
• Two physician advisors (sharing 0.5FTE), both practicing hospitalists
• Experienced RN content expert dedicated to Medicare audit activities
• Aggressive provider education during InterQual era
• Progress made!
Rules Change

• Very aggressive/proactive from the start
• Decided to let Medicare dictate default posture
• Admission order contains a click-button affirmation of an IP need and a “CeRT” field with hard stops:
  – Clear diagnosis
  – Evaluations planned
  – Treatments offered
• BPA fires for attendings only if admission order not cosigned
• Discharge hard stop in effect for IPs (whether or not order is valid/superseded)
Admit to IP order (blank)
Only attendings can see it!

Admit to Inpatient Order Requiring Cosign

This patient does not have an admission order cosigned by an attending physician familiar with the case. A cosign is required prior to discharge.

If you are the admitting or attending physician, please verify and cosign this order immediately by clicking the link below.

If you have clinical questions you may contact Dr. Bart Caponi. Optional: You may also click on this link with questions or feedback on this BPA.

Click Here to go to Orders to be Cosigned
The cosignature challenge

- Cosignatures remained a problem for months…
- Given hiatus, need for buy-in, decided to take a strategic approach to issue
- Aggressive data tracking, including the potential reimbursement at risk, collated
  - Department chairs shown aggregate numbers
  - Individual malefactors shown money per incident
- Ongoing education continued
  - Focused on consultant attendings (any staff physician familiar with case can verify…)

UW Health
End game (for cosignatures, at least)

Order Validation

⚠️ The following information is missing or may need your attention

You cannot sign the Discharge Patient order because there is an Admit to Inpatient order that has not been cosigned. Please have an Attending Physician familiar with the patient cosign the Admit to Inpatient order, and then sign the Discharge Patient order.

These orders cannot be signed. OK
More status issues

- If a patient presents with an ACUTE medical issue, and weakness/inability to return home safely is NEWLY identified…
  - Then one could argue for inpatient status

- If the patient presents with an ACUTE issue, recovers, and is unsafe, which is a PREVIOUSLY PRESENT issue…
  - Probably should not be inpatient

- A true “no medical needs/no safe place” patient…should not an inpatient
  - UR physicians review all such cases (ideally)
Non-Medicare Insurers

• Most have not adopted two-midnight rule
• Anecdotally, Medicare Replacement plans are aggressively auditing and denying IP claims
  – Restricted short-term appeals window
• We don’t track this data especially well, and I think we need to do so
• Private payors seem to be less of an issue
• Has proven difficult to get physicians to change practice vis-à-vis different insurers
• Probe and Educate denial:
  – CErT statement: “Patient is here with hypoxia, with recent lung cancer diagnosis and large pleural effusion, will need bronchoscopy, drainage of effusion and further workup and management of her hypoxia, probably need >2 midnights”
  – Rationale for denial: “The documentation does not support the physician expected the beneficiary to require care that crosses 2 MNs”
• Initial QIO audit: results 4+ weeks overdue
The Appeals Process

- We have had multiple level 3 (Administrative Law Judge) hearings for both Medicare and Medicaid
- Former still severely backlogged
- No requests for further records from either agency in quite some time
- Appeals very labor-intensive at all levels
Current issues

- CErT statements/documentation vary wildly
- Refinement of “affirmation statement”
  - Now includes LOS >2MN, complexity/intensity, IP-only surgery, and “prior auths” to cover all possibilities
- Case Management culture resistant to shedding InterQual; physicians resistant to remembering
- Blanket application of 2MN to all admissions
- Need for constant re-education
- Informing patients of outpatient status
- Documentation quality and hygiene, timing
Documentation (good and bad)

• Be explicit: “I am admitting to inpatient status because…”
• “infective endocarditis” vs “infective endocarditis—needs serial cultures, TEE, PICC, IV abx, possible cardiac surgery”
• “doing worse”, “failure to thrive”, “will observe” are not helpful
• “fx—OR—OR”
• Avoid use of the word “observation” in any way—easily misinterpreted
  – “We will admit for observation for a three-day stay so she can go to a SNF”
Take-home points from UWHC

• Be proactive! Audits are never going away…
• Be as patient-centered as possible
  – Easier said than done, given lack of any useful guidance from CMS pending audits
• For Medicare patients, 2MN/acute need is only rule—not InterQual or Milliman
• Documentation hygiene—good documentation is as close to a panacea as there can be
  – Always tell the truth!
• Hard stops!
• Data tracking!
DO NOT DISTURB ME