



Navigating the perfect storm

by John Zelem, MD, FACS

Many in the industry recognize the financial hardships that hospitals and physicians are facing today—reimbursement reductions, rising operational costs, the onset of pay-for-performance initiatives, and the list goes on. As most would agree that physicians have often experienced financial hardships on the individual level, this group is on the cusp of facing many of the financial challenges that, up until now, only hospitals have had to deal with.

The rapidly changing regulatory landscape currently serves as the eye of a “perfect storm.” The government continues on its quest to recoup what it believes to be billions of dollars in overpayments made to hospitals, and, while the attempt by the government to reduce physician reimbursements was overturned in the eleventh hour previously, many anticipate CMS will continue to try and eventually will succeed.

There have been many regulatory changes that are fueling today’s perfect storm, including the following:

- **Recovery audit contractor (RAC) program:** The government mandated that the Centers for Medicare & Medicaid Services (CMS) work to uncover fraudulent activity and recover overpayments to hospitals, which resulted in the RAC pilot program. CMS claims that there was \$10.8 billion in overpayments in 2007 alone, which is actually 3.9 percent of the annual Medicare operating budget. It is important to note here that lack of medical necessity is the leading cause for these overpayments.

- **The Tax Relief and Healthcare Act:** This Act was signed into law in December 2006, expanding the RAC program nationally by 2010, and these auditors can look at medical records going back three years.

- **Quality improvement organizations (QIO),** formerly called peer review, had initiated focused one-, two-, and three-day stay review programs, reviewing high-risk diagnosis-related groups (DRG) as part of the eighth scope of work. Surgical procedures will also be looked at with a critical eye under these review programs. This initiative has pushed hospitals toward more liberal use of observation to help avoid scrutiny.

- **Medicare Administrative Contractor (MAC) program:** This legislation coordinates Medicare

Part A and Medicare Part B payments under a single processor and is directed to look for Part A/B billing mismatches.

- **Present on admission (POA):** POA was initiated in October 2007 along with severity-adjusted DRGs, which creates joint liability for both physicians and hospitals.

- **Medlearn Matters on Condition Code 44:** This code clearly demonstrates that CMS is committed to a “prior to discharge” requirement, which means hospitals and physicians must determine accurate patient status before the patient is discharged.

Today’s physicians need to be prepared to brave the storm if they want to maintain their own individual compliance and revenue integrity.

The RACs are coming

First, physicians need to understand the RAC program and the potential ramifications from inaccurate and/or vague documentation. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the RAC program on a three-year demonstration basis in three states: New York, Florida, and California; toward the end of the demonstration project, Massachusetts, South Carolina, and Arizona were added. According to federal regulations, RACs are tasked with detecting and correcting Medicare improper payments, which could include either collecting overpayments from providers or repaying underpayments to providers. During the RAC demonstration, only 4 percent of improper payments were underpayments that were repaid to providers.

RACs are paid through contingency fees whereby the auditors get a percentage of the overpayments they uncover, plus expenses. The contingency fee amounts were proprietary in the demonstration project but have been disclosed in the permanent program. When overpayments were identified, providers had to pay the total amount back but could submit an appeal if they disagreed with the RACs’ findings. The RACs focused on high-risk DRGs, short stays, and medical necessity, among other areas. For the moment, the RAC program is mainly focused on hospitals and skilled nursing facilities. However, it does not seem unreasonable to as-

sume the government will look to mandate and implement a similar focus, aimed at physicians and private practices, in the future.

The demonstration RACs that ended in March 2008 were allowed to go back four years to review charts. The permanent RACs can only go back three years and may not request charts from before October 2007.

As mentioned previously, the demonstration project in the first three states concluded earlier this year and the program is now set to roll out nationally by 2010 (see Figure 1, this page).

CMS has clearly demonstrated through the RAC program that lack of medical necessity is one of the largest causes for identified and recovered overpayments; it was the focus 62 percent of the time for in-patient hospitals. Nearly one-third of the identified and recovered overpayments in fiscal year 2007 resulted from this categorization (see Figure 2, this page).

Lack of medical necessity really equates to lack of documentation, and CMS has clearly demonstrated that there must be documentation to support the patient's status. Individual clinical opinions, as the sole standard beyond severity of illness and intensity of service criteria, is no longer acceptable to support this patient status as stated in CMS Ruling 95-1. It is imperative that physicians today document and prove medical necessity using evidence-based, literature-backed protocols. Detailed and consistent documentation is the key.

Figure 1

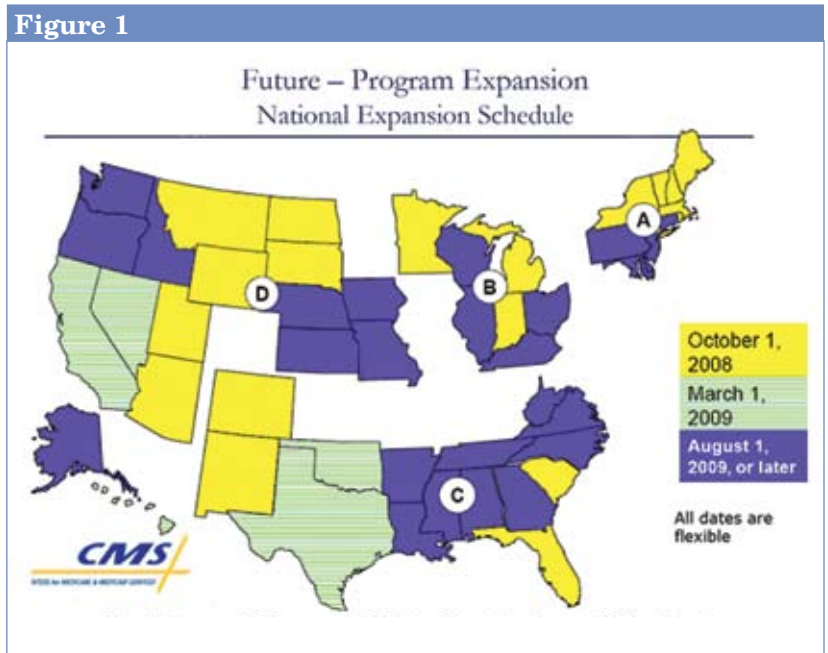
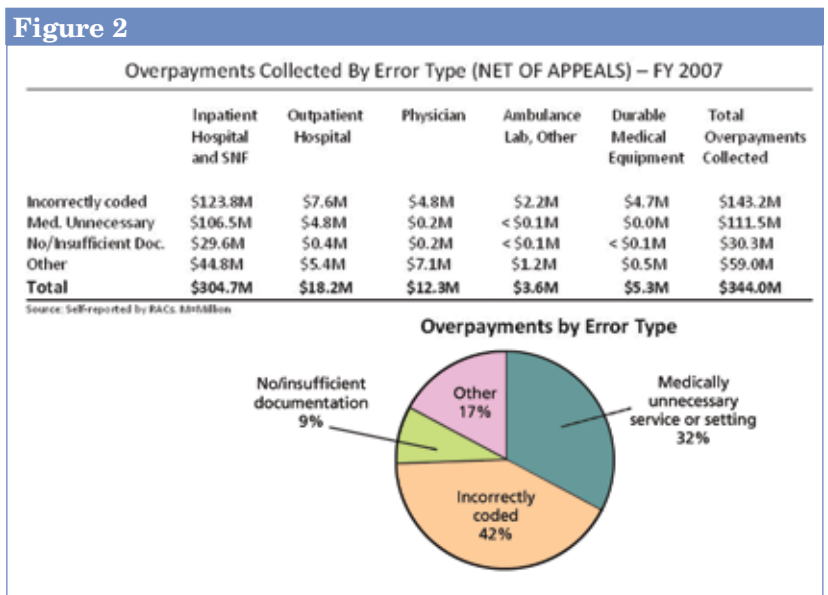


Figure 2



Getting patient status right

Physicians must pay greater attention to patient status in order to survive today's perfect storm. With the tendency for QIOs and other organizations to encourage a more liberal use of

observation status, physicians must have a better understanding of the definitions of inpatient versus observation status, as defined by Medicare in the first chapter of the *Medicare Benefit Policy Manual*.

Without properly understanding these definitions, an appropriate certification of inpatient status can be difficult, resulting in a need to use observation more frequently to avoid continued scrutiny, especially in high-risk DRGs. Overuse of observation brings with it negative effects on hospitals, physicians, and patients. These negative effects include a greater impact on hospital revenue when patients qualifying for an inpatient status are inadvertently placed in observation, artificially elevated lengths of stay at the hospital, higher co-pays and billings for tests and procedures for patients, and high compliance-related risks for both hospitals and physicians.

Although fully understanding that the definitions of inpatient versus observation status are important, medical necessity and adequate documentation surface again here as being imperative. Physician decisions in treating patients are, and should be, based securely on many years of training, education, experience, and evidence-based clinical standards of care. Realize that the determination of the correct patient status has no implication on this clinical care rendered. Yet, the medical necessity for this care must be clearly provided in adequate documentation.

Medicare states that “the decision to admit is a complex medical decision which can only be made after the physician has considered a number of factors.” Some of these factors include medical history, current medical needs, severity of signs and symptoms, and the predictability of an adverse event. Case reviewers need to be able to see the physician’s thought and decision-making process in each patient’s chart, which may help to mitigate the risk of a RAC denial.

Figure 3

Hospital utilization review determination	Physician order	Hospital claim (Part A)	Physician claim (Part B)	Physician impact
IP	IP	IP	IP	OK
IP	OBS	IP or none	OP	NC
IP	OBS	IP or none	IP	C
OBS	OBS	OP	OP	OK
OBS	OBS	OP	IP	NC
OBS	IP	OP or none	IP	NC

IP = Inpatient
OK = Concordant

OBS = Observation
C = Concordant but incorrect

OP = Outpatient
NC = Nonconcordant

The MACs are coming

Physicians, as a rule, have a tendency to think that patient status is only a hospital billing problem, right? No longer, as physicians will have more accountability in this matter going forward. Presently, physicians are paid by carriers and hospitals are paid by fiscal intermediaries. As the MACs are rolled out to all 50 states in the next few years, Medicare Part A and Part B payments to hospitals and physicians will be combined into a single process. With this payment system being combined, it will result in the data from physicians and hospitals being housed together and it must match. The MACs are authorized to search out mismatches for episodes of care.

There are four aspects to this concordance: the utilization review patient status decision, the treating physician order for admission patient status, the hospital claim (Medicare Part A), and the physician claim (Medicare Part B). If all four areas do not match, there is nonconcordance, which may lead to delays/denials of payments or other significant actions.

As can be seen in Figure 3 on this page, if a patient is listed as inpatient or observation across the board, there is no negative impact on the physician. Three of the four remaining situations are incorrect, but the last one has the most potential for negative impact on the physician. If the hospi-

tal utilization review decision is observation, yet the physician writes an order for inpatient and will not change it to the appropriate observation, the hospital will bill as outpatient or may not bill at all. If the physician then bills as inpatient, it can have a significant negative impact on the physician, as he or she is billing for a patient who seems to have never existed in the hospital system.

Medicare is presently working with 3M to develop software to find these nonconcordant hospital-physician claim mismatches and when they do identify them, it can lead to an audit of the physician billing practices. The consequences to those physicians when nonconcordance is determined and found to be a pattern of frequent use can include the following:

- Ask the physician for the money back
- Request that the claim be resubmitted if the two-year time frame for claim submission has not expired
- Pursue the physician for a potential penalty/investigation (usually only if this sort of billing is deemed to be a common practice)

As a result, it is crucial for hospitals and physicians to work together more closely today than ever before to make sure they are setting patient status and billing in unison. With the rise of MACs and concordance-related initiatives, physicians are now just as much affected by the perfect storm as hospitals are.

POA

Another area physicians need to pay attention to is the POA. Before October 2007, Medicare would pay for complications and comorbid conditions, sometimes totaling up to thousands of dollars more than just the standard DRG payment. With the advent of POA, Medicare will cease paying for certain situations that were not POA, including, but not limited to, the following:

- Serious preventable events
- Object left in patient during surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcers
- Vascular catheter-associated infection
- Surgical site infection: mediastinitis after coronary artery bypass graft surgery
- Falls and trauma: fractures, dislocations, in-

tracranial injuries, crushing injuries, and burns

CMS has come up with a way to pay less for what it deems as low quality, also known as value-based purchasing. This is CMS' attempt to transform Medicare from a passive payor to a purchaser of high-quality, efficient health care. Simply put, CMS does not want to pay for complications that occur during a hospitalization that it believes are preventable through evidence-based guidelines.

This stance is obviously a concern to both physicians and hospitals. Hospitals have to be worried about the impact this will have on revenue and physicians must be concerned with the data that will be generated regarding the quality of care they deliver to their patients and the outcomes of their patients' hospital stays. Again, medical necessity and strong documentation will play a big part in the ability of hospitals to appeal POA denials and the ability for physicians to accurately demonstrate the quality of care they provide to their patients.

In conclusion, this perfect storm no longer applies just to hospitals and other providers. Physicians will begin seeing the effects sooner rather than later and need to prepare now in order to successfully navigate this storm. [Q](#)

Author's note: The information and statistics relevant to the permanent RAC program contained within this article were up-to-date as of June 2008 when this article was submitted for consideration. The RAC Expansion Schedule, displayed in Figure 1, has been updated and data are current as of October 2008. For more details on the RAC program, visit Executive Health Resources' Compliance Library at www.ehrdocs.com.

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