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ACPA Update
September 2022

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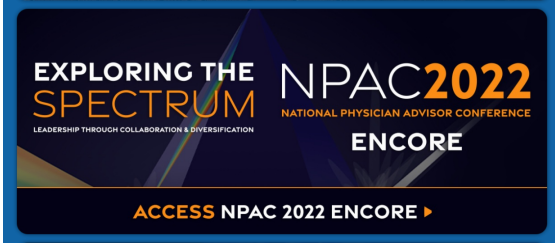


Editor's Note

Ronald Hirsch, MD, FACP, CHCQM-PHYADV, CHRI
Member, ACPA Advisory Board
Member, ACPA Government Affairs Committee
Editor, ACPA Update

Did you all listen to the ACPA Town Hall on Medicare Advantage denials? It was amazing! It received press coverage and provided listeners with valuable tips. The MA plans are not going away soon and their increasing enrollment numbers seems to have emboldened them to be even more aggressive and outrageous in their tactics. If you missed it, the recording is available on the ACPAdvisors.org home page. (You have visited the ACPA web page, haven't you??? There are lots of resources available there.)

This month's issue includes an article by yours truly, so I am going to keep this note short and simply say "read the articles and respond to the observation cases by going to the SurveyMonkey link." I appreciate all the time and effort expended by the authors.

And speaking of authors, wouldn't you like to write an article for the ACPA newsletter? Email me at signaturedoc@gmail.com for the submission guidelines. I accept articles of any length and on any topic.

June 2022 Observation Case Responses

Provided by the members of the ACPA Observation Committee

The case presented in June read:

A Medicare patient with schizophrenia and seizure disorder presented to the ER on 5.3.22. Documented noted progressive weakness, fatigue and lethargy. Physical examination noted a patient in moderate distress who was "ill-appearing" with a "listless level of consciousness". Sodium was 121 and potassium 2.6.
The **ER physician** placed an "admit to inpatient" order on behalf of a private physician at 22:34 on 5.3.22. On 5.4.22 at 7:23 AM the private physician voided the admission order and changed the patient to a hospitalist service. The hospitalist entered an **observation** order 5.4.22 at 8:46 AM and notified a different hospitalist to see the patient.
The H&P from the second hospitalist stated, "Justification for Hospitalization – Patient is admitted for hyponatremia. He will require > 2 MN stay for IV fluid hydration, serial lab monitoring and nephrology consultation."
The patient was discharged on 5.5.22 without an inpatient order after receiving 2 midnights of medically necessary care. The physician advisor was asked to review for proper admission status.

Your responses:

- About 52% of respondents recommended billing as Inpatient status. Comments supporting inpatient billing referred to acuity of presentation with severe hyponatremia, hypokalemia, and documentation of clear intent for 2 MNs of medical care. Some of the comments supporting that recommendation included non-compliant code 44 process as the UR committee concurrence is not documented thus making the change to observation status invalid. On the other hand, about 42% of the respondents felt observation billing will be appropriate. Out of the 42%, about 31% felt that observation charges should be initiated from the hospitalist observation order on 5/4 instead of 5/3 since the attending refusal made the order invalid. Another comment suggested once the observation order is placed, a claim for inpatient can no longer be submitted. One of the comments mentioned that observation order was entered in error however one must be cautious about not assuming an error but finding corresponding documentation in the medical record indicating clearly that it was an error. In this case, there was no mention in the question stem of observation order being entered in error. There were several process improvement opportunities highlighted with need for increased awareness by CM/UM team to catch these encounters prior to discharge and obtain a valid inpatient order.

Educational Opportunity: CMS Reference for Condition Code 44

- Utilization review committee's decision recommending Inpatient admission to be changed to outpatient with a rationale documented in the patients' medical record
- Physician order changing patient status from Inpatient to Outpatient made PRIOR to discharge while beneficiary is still a patient at the hospital
- Patient notified of the change in status from Inpatient to Outpatient.

Reference: MLN Matters SE0622

- Majority of about 40% felt the claim should be billed observation starting 5/4 since the original order was invalid. Another 15% felt the claim can be billed observation however with a start date of 5/3. About 30% felt they would contact the private physician to unvoid the inpatient order and obtain a valid inpatient order whereas

12% felt they would reach out to the hospitalist to write a new valid inpatient order. The comments were like the rationale discussed in #1 above regarding validity of inpatient order and invalid condition code 44.

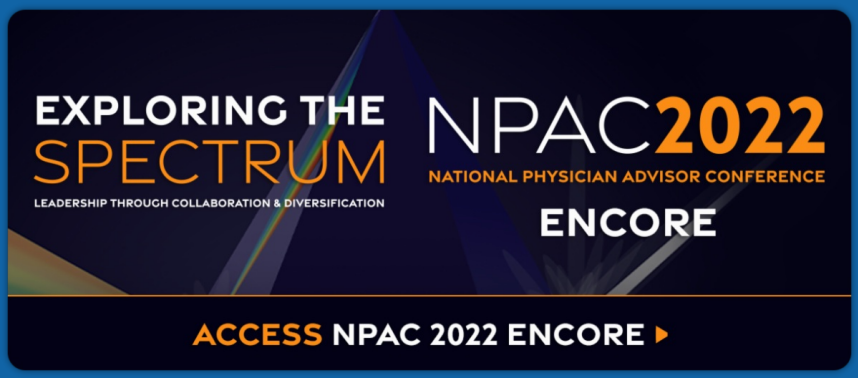
- 92% of respondents would have recommended admit to inpatient status had they been called for a second level review on the first night. Supporting rationale in comments including management of symptomatic hyponatremia with neurologic manifestations, severity of illness and treatment plan would support the 2-midnight expectation for medically necessary care. There were only 8% of respondents who would recommend outpatient with observation. The combination of patient presentation on admission and the high likelihood of slow correction of sodium level will make expectation of 2MN on the night of 5/3 very reasonable based on Code of Federal Regulations.

Educational Opportunity

… an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.

(i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

Reference: 42 CFR §412.3



Clinical Validation: The Physician Advisor's Role

Erica E. Remer, MD, FACEP, CCDS
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Chair, ACPA Clinical Documentation Integrity Committee

There are billions of reasons why denials are generated ($). The level of care/medical necessity physician advisor (PA) may be more versed in the medical necessity/status denial, whereas the clinical documentation integrity (CDI) PA is tasked with clinical validation. Originally, coding denials were Diagnosis Related Group (DRG) validation audits. The auditor was evaluating whether the correct codes had been assigned and whether the sequencing of diagnoses was accurate. The question being considered was, "Was the encounter coded correctly?"

The clinical validation (CV) denial has become much more prevalent and has been requiring enormous expenditure of time, effort, and resources to combat. CV is the determination of whether conditions documented in the medical record were actually present. The question asked is, "Are the diagnoses claimed supported by the clinical evidence?"

Clinical validation is a bit of a misnomer. Adjudicating whether a condition is present, i.e., valid, can really only be done by a clinician caring for the patient. They are familiar with all the additional observations, discussions, and thoughts that never made it into the chart. For our purposes, however, the clinical validation process is the act of someone reading the documentation and questioning whether the diagnosis seems legitimate.

The Recovery Audit Contractor Statement of Work (2011, p. 23) is oft quoted as saying,

"Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials." (Draft Statement of Work for the Recovery Audit Contractors (cms.gov)) This is the rule for the RAC, not for your organization. Anyone whom you deem competent to perform CV may do so, and this may include a knowledgeable coder.

CV is an ongoing process. The PA participates in multiple steps.

A CV issue may be picked up by a CDI specialist or coder. Let's just call that individual a CDIS for the purposes of this article. The CDIS recognizes a potential issue and must determine a plan of action.

- The CDIS must understand the clinical conditions, especially ones which often result in CV questions (e.g., sepsis, pneumonia, respiratory failure, encephalopathy). The PA may be instrumental in educating them on the clinical aspects.
- The PA may be exposed to CV queries in the course of chart reviews and have an opinion as to the CDIS' understanding of the issues and the effectiveness of their queries. The PA can work with the CDI manager/supervisor/director to improve the CDIS knowledge base and queries.

The PA may be recruited to assist with CV as another set of eyes and a second opinion. There are two points of entry – concurrently regarding necessity for a CV query and retrospectively to fight CV denials.

- Does the PA think the condition being questioned concurrently is clinically valid?
    - Yes…could it be that the CDIS needs education?
    - Yes, the condition is valid, but the documentation is substandard. The PA can assist by educating the provider as to best documentation practices.
    - No, it doesn't seem valid. Again, the provider may need feedback and education. A CV query may be indicated.
    - Indeterminate…this merits a CV query.

Most organizations do not have the PA composing CDI queries. I agree with the philosophy that it is better to separate educational duties from querying. Have PAs educate their peers; delegate querying to the CDIS. If the PA's organization endorses them querying, it should be ensured that the queries are done in a compliant fashion (see *CDI Querying* on the CDI Resource page on ACPAdvisors.org website). The PA can help design compliant, effective CV query templates. However, under no circumstances should a PA who has not taken care of the patient clinically document in the record to shore up support for a diagnosis, even if the condition is clinically valid.

PAs are well positioned to fight CV denials, either primarily or secondarily. Some facilities have someone from the CDI team offer the first appeal and then escalate further appeals to the PA. The PA must assess whether the CV denial is well-founded, which is the converse of whether the condition is clinically valid.

- Yes, the denial is valid. If the condition wasn't present, the claim should be allowed to be adjusted.
- No, the condition was clearly present (whether documented well or not). This denial should be fought tooth and nail using current literature and up-to-date references.
- It is unclear whether the condition was present, so it is understandable that a denial was generated. The encounter will be out of the window to query for definitive clarification (CV denials often come long after the encounter), but the PA could discuss with the clinician, if desired. If the condition was present but suboptimally documented, at least try a pass at overturning the denial. You may have to weigh the time/effort/aggravation investment against the likelihood of success at some point in the denial appeal process. Choose your battles wisely.

The final action is always to close the loop with feedback and education. Feedback is informing the provider that a denial occurred, explaining why and how to avoid another one in the future. Education can be anticipatory and prospective or reactive targeting a topic according to a provider's or service line's needs. Issues which elicit frequent CV queries or denials can be the game plan for education, templates, and internal clinical guidelines.

Internal clinical guidelines are meant to standardize and hopefully optimize diagnosis and treatment of medical conditions where there may be some controversary or

variability in clinical practice. The CDI PA should have a seat at that table, advocating for CDI needs as well as ensuring current best-practice clinical care. Organizations cannot just make up their own definitions and clinical criteria, however, and expect that the payers will accede.

Denials management is likely to continue to constitute a significant expenditure of the PA's time. Having a concrete plan in place may minimize the work effort required. And an ounce of prevention on the front end (education, CV queries) is worth a pound of cure on the back end (fighting CV denials)!

Dr. Erica Remer is the Founder and President of Erica Remer, MD, Inc., a CDI consulting firm in Beachwood, OH

Surviving Denial Management…

Sharon Easterling, MHA, RHIA, CCS, CDIP, CRC, FAHIMA
Member, ACPA Advisory Board

Denial management can be an exhausting job. This is even more true when you are the lone denial coordinator managing the entire process of identifying or receiving a denial letter, performing data entry, responding to the denial from initial response through all levels of the appeals process, monitoring status, and following up. Of course, that does not include receiving and logging the determinations that can be joyous or quite frankly…the pits. Yes, especially when you just knew that was a good letter you wrote. Staff turnover in denial management can be real. The payers and contractors are always looking through a different lens. The success may not come often and there can be a feeling of defeat. New staff in denials are coming on board every day and providing insight and knowledge is a continuous cycle; never ending frankly. Keep your head up! There is hope to help retain your staff, reduce turnover, and alleviate employee dread. The following are best practices that can lead to success:

- Hire the right staff: Your vision for the job will dictate the perfect candidate. If your vision is just level of care response and support from coding for coding issues, you may want a nurse with care management (CM)/utilization review (UR) experience. If your vision is the coordinator responding to coding and billing with support from CM/UR, you may want an experienced coder with IP and OP experience. This can be done inhouse, but outsourcing this process in some way may be the answer for you. Know your volumes, what you are seeing, and this will lead to the best approach.
- Physician support: This support is invaluable and can help you with level of care, clinical validation, and DRG denials. Ensure there is a physician available to support the coordinator and the appeal process. It can make the difference between a denial being upheld or overturned. This is also key to successful peer-to-peer discussions with payers and contractors.
- Staff training: Denials come in many formats and a multitude of types. Make sure your coordinator understands the type of denial received and how to address it. This may involve some on-the-job training but there are resources out there to gain a good foundation. This will be helpful if your process is hybrid with external vendors or all internal and aligned with key departmental staff to reach out to for assistance.
- Get organized: Not being organized can be the difference between a good day and dollars lost. Keep denials in a format that detail is easy retrieved and can be easily tracked. Folders can be maintained alphanumerically for provide easy

access or numerically. Decide what works best for you.

- Spreadsheets vs Software: When there are no other options due to budget constraints, spreadsheets are an answer. Keep in mind you can link spreadsheets now and use Power BI to connect data and visualize. If at all possible, eliminate spreadsheets and obtain software to help manage the process. This provides all information in a click and can be ideal for reporting. When you can budget and obtain software, you can centralize your process and bring in other users with different levels of access and responsibilities. There are many types of software and prices vary. Do your homework and due diligence to find the right product for your organization. I have talked with many providers that have made a bad choice and had to reinvest or be stuck with an inadequate product.
- Stay connected: Staying abreast of the latest and the greatest news is vital in denials. What are your MACs doing, what is happening with recovery contractors, what is the OIG up to, how are others handing Medicare Advantage, etc. These are a few areas that are important to monitor the pulse of. Follow and signup for email alerts from payers, CMS, contractors, and groups/associations to stay ahead of the game. Key links below:

    - CMS Listserv signup
    - OIG alerts
    - CMS Contacts Database
    - CMS Functional Contractors
    - CMS MACs

- Support staff: Regardless of how you maintain data, support staff is crucial. The coordinator can not do it alone. Of course, volume plays a role in this decision. These days a 400-bed facility can receive around 10-40 denials per week. These come in the form of letters and via the billing system. Investigate how the coordinator can get support for data entry and reporting. It is unrealistic to think you can respond well and get good data without adequate tracking.
- Celebrate the wins: Everyone likes to feel appreciated and know they are valued. Highlight the success of your team. They have your back and may be warding off potential undue scrutiny.

Don't let your denial coordinator burn out. Put tools in place to assist them and set them up to be successful. Remember, ineffective Denial Management is like opening a window and throwing out dollars. Keep your windows closed and keep the revenue you deserve in.

Sharon is the CEO and founder of Upskillz and creator of the HCCWise, CDIWise, and E&MWise Apps and Strategic Client Executive with eCatalyst

The Regulatory Nuances of Observation

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In the August, 2022 edition of Compliance Today, a publication of the Health Care Compliance Association (HCCA), I wrote a comprehensive article on the nuances of billing Observation services. You can read the full article here: https://bit.ly/3oMJR2F.

As with many issues, the rules seem to change as fast as we can learn them. The professional fee billing of Observation will change dramatically on January 1, 2023 when

the Observation visit codes are eliminated and providers will instead use the initial and subsequent hospital visit codes 99221-99233. They will still need to ensure they bill with the correct place of service, either inpatient or outpatient hospital, and affix the -AI modifier to inpatient claims where appropriate but not to outpatient claims. While the number of code choices has lessened, the confusion and opportunity for error has not. It will be interesting to see how the payers and auditors handle these changes.

On the facility fee side of Observation billing, the biggest confusion lies in the billing of the many hours of care that are provided to outpatients that are not medically necessary. Is it appropriate to bill the four hours of Observation that a patient sits and waits for their ride to arrive? What about the patient who stays an extra day or two because a test cannot be performed or a specialist is not available to see the patient?

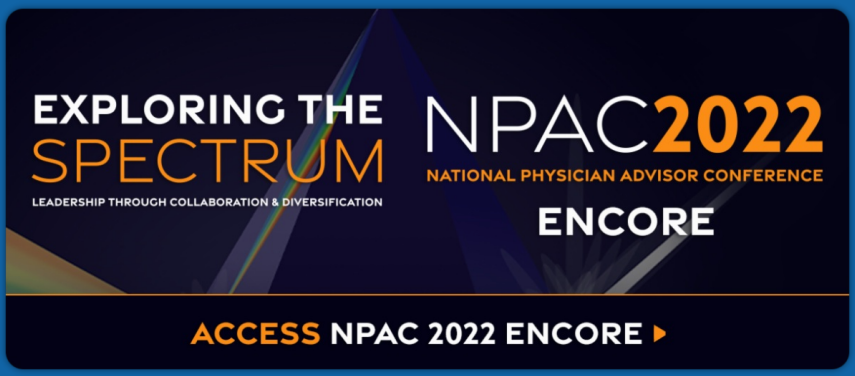
Observation and surgery continue to confound many. The “old timers” like myself recall the days of surgeons ordering “23 hour Observation” for the patient who is staying overnight for routine recovery. While surgeons are great at learning new surgical techniques, they are often less adept at forgetting old habits when it comes to placing status orders. That can create confusion and potentially false claim submissions.

The misuse of Observation by commercial and Medicare Advantage plans continues to be an issue. If any of you listen to Monitor Monday, a weekly webcast produced by RACmonitor.com, you will know that David Glaser, a health law attorney, and I often debate whether the MA plans must follow the Two Midnight Rule. Whether they must follow it or not, it is clear that they are not following it.

And finally the handling of Observation hours on rebilled claims can be vexing. Can you add Observation hours to an inpatient claim that was denied by a payer other than Medicare?

I hope you’ll take the time to click the link above and read my article. Access may be time-limited so consider saving as a pdf. And remember, when I wrote it, the change in Observation professional billing had not yet been announced so don’t roll your eyes when you read that section!

Dr. Hirsch is Vice President of Regulations and Education at R1 RCM Inc



Observation Case September 2022

Provided by the members of the ACPA Observation Committee

A 74-year-old Medicare fee for service beneficiary with history of hypertension, hyperlipidemia, schizophrenia, type II diabetes mellitus, non-insulin requiring, with A1c of 4.5 presented to ED with complaints of generalized weakness for the past 1 to 2 weeks. Patient had been hospitalized 9 days prior w/ similar complaints and was discharged home with home health services, however patient continues to have weakness and recurrent falls at home. BP 175/62, O2 Sat RA 96%, Pulse- 109.

Glucose: 105, BUN 21, creatinine 0.8 Calcium 11, sodium 146 Potassium 3.6, Bicarb 28, albumin 4 Total protein 7.8, ALT 34, AST 16, ALP 100, Bilirubin 0.7, CK 122, Phosphorus 3.1, magnesium 1.9, TSH 1.5, free thyroxine 1.16, Trop I 48.5, WBC 8.14, hemoglobin 13.2, MCV 83, platelet count 226.

The patient was placed in observation for evaluation of rehab placement evaluation since failed outpatient, hypercalcemia, and diabetes medication adjustment. PT evaluated and recommended SNF placement, but because of patient’s hx of schizophrenia, patient required Level II PASRR. Evaluation from state, for Level II

PASRR evaluation, stated it would take 7-10 days to evaluate patient for placement.

Patient was then transferred to sister hospital while awaiting placement as acute medical issues had now resolved and continued in observation status. Main hospital was not in a surge capacity issue at the time, however due to waiting period was worried that they may have a bed issue and wanted to move the patient just in case. Patient sat at the sister hospital in observation for 10 days awaiting placement approval from the state for transfer.

Please go to https://www.surveymonkey.com/r/WTZFBVW to answer questions. Case details will be repeated there.

American College of Physician Advisors

President's Corner

September 2022

Summer break is over, the kids are back in school, and it feels like 2023 will be here before we know it. COVID-19 variants or no, the world seems to have embraced the idea of life in the perpetual shadow of infection which feels to many to be a lot more bearable post-immunization and boosters. Even the United States government is dipping a toe into the waters of "normalcy," announcing last month that maybe…just maybe, we will no longer be working under the layers of blankets called Public Health Emergency waivers in the foreseeable future.

So much seemed to go out the window when our hospitals were inundated with patients suffering from severe COVID-19 symptoms. We did everything possible to ensure medical care remained stellar but ultimately, something had to give. Perhaps your providers' "unable to determine" answers to Clinical Documentation Integrity queries crept up. Maybe once scheduled surgeries started getting back to normal levels, no one appreciated how many were slipping by without required prior authorization from payors. Or, perhaps a third of your case management staff has overturned since 2020 and now you find yourself with a team who only vaguely remembers what the Medicare Three Midnight Rule was.

A promise of things possibly "slowing down" in regard to the sense of overwhelming panic related to the pandemic is on the horizon. But, keep an eye on upcoming changes which will be necessary to make and newly discovered issues which will have to be addressed. Unfortunately, I anticipate a lot of us will be stumbling across situations which have flown under the radar for a couple of years, now. But, let's look at this as another opportunity to come together as a community and share our experiences. Keep in mind that the 2023 National Physician Advisor Conference is not too far away in April and soon we will be opening for presentation submissions. ACPA's educational offerings through webinars via The Learning Center is always expanding and evolving. And, as Dr. Hirsch reminds us every month, this newsletter perpetually needs new content via your articles. So, if you find something that needs fixing or adjusting since

all hell broke loose at the start of 2020 and you devise a clever and effective way to solve it, please share with us! We'd love to promote your work and your expertise.

Juliet B. Ugarte Hopkins, MD, CHCQM-PHYADV
(Pronouns: She/Her)
President, ACPA

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