Physician Primer for Medical Necessity Documentation

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HCQ CONSULTING

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- Medical School: Vanderbilt (1976)
- Health Care Consultant since 2003:
  - Care Management
  - Medical Necessity
  - Clinical Resource Utilization
  - Clinical Documentation Improvement
  - Coding Accuracy
  - Physician Education
  - Compliance

Agenda

- RAC and MAC Reviews
- Medicare Regulations
- Inpatient Criteria
  - General
  - Specific
- Observation Care
- Diagnostic Documentation Accuracy

Recovery Audit Contractors

- Recover Medicare "overpayments" to hospitals and physicians
- Scope of RAC Reviews
  - DRG Validation
  - Inpatient Medical Necessity (vs. observation)
    - 1-2 day inpatient stays (chest pain, syncope, TIA, back pain, gastroenteritis, dehydration, etc.)
    - Inpatient procedures (elective cath, cardiac stent, etc.)
- Documentation must support coding and medical necessity

Recovery Audit Contractors

- Scope of RAC Reviews
  - Compliance with regulatory requirements
  - Inpatient order ("Admit") required
  - Legibility
- Pre-payment Review (100% Hospital Claims) Demonstration
  - DRGs: Syncope – TIA – GI Bleed – Diabetes
  - June 1, 2012
  - Part B "Cross Claim" review uncertain

Medicare Administrative Contractor (MAC)

- Functions as Fiscal Intermediary for Part A (facility inpatient) and Carrier for Part B (pro-fees and facility outpatient)
- MAC Pre-payment Review (100%)
  - "Cross-Claim" review of selected procedures
    - Pre-payment review of Hospital Claim (Part A)
    - If denied, "cross-over" post-payment review of physician services (Part B)
  - Reviews medical necessity indications for performing procedure using professional practice guidelines
  - Inpatient and outpatient (office records) documentation must "stand alone"

Medicare Administrative Contractor (MAC)

- Target Procedures:
  - Total Hip & Knee Replacement (DRGs 469-470)
  - Spinal Fusion – non-cervical (DRGs 459-460)
  - PCI with w/ or w/o stent (DRGs 246-251)
  - Cardiac Pacemaker (DRGs 242-244)
  - Cardiac Defibrillator Implant (DRGs 224-227)
  - Peripheral Vascular Angioplasty with or w/o stent (DRGs 252-254)

Level of Care Assignment

- Observation Care
  - Additional time (usually 24 hrs) is needed to determine if inpatient status is medically necessary (e.g., chest pain, abdominal pain)
  - 24 hours to treat the patient who will then probably be well enough to go home (gastroenteritis, dehydration, asthma)
  - May go home, be converted to inpatient status or transferred to alternative level of care
- Inpatient Admission
  - Typically requires more than 24 hrs of inpatient services
  - Must have an order to "admit"
  - Medicare Inpatient guidance
  - CMS requires both
    - Severity of Illness (SI), and
    - Intensity of Service (IS)

Medicare Regulations

"Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis."

"Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting."

"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…."

Medicare Regulations

"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…"

Physicians should consider any **"pre-existing medical problems or extenuating circumstances** that make admission of the beneficiary medically necessary." Nevertheless, **acute severity must first be present!**

Compliant Billing

- Inpatient admission requires inpatient medical necessity at the time of admission
  - Observation patient met inpatient criteria on admit but not when case manager reviews = remains observation
  - CMS does not permit/recognize "retroactive" orders
- No time limits on observation care
  - Medicare pays observation charge for 8-48 hrs of observation services plus all medically necessary services provided as line-item outpatient charges
  - CMS expects a disposition (home, inpatient, alternative level of care) to be made within 48 hours but cannot be inpatient without medically necessity
  - Patient has 20% co-pay for outpatient/observation services
  - OIG work-plan includes observation >48 hours

Compliant Billing

- Difference in hospital reimbursement
  - DRG payment much higher than line-item outpatient
  - "False Claim" if inpatient not medically necessary (overpayment)
  - Example: unexplained syncope with telemetry, echocardiogram, carotid US, MRI.
    - DRG = $4,200
    - Observation = $1,500

InterQual & Milliman

- Industry standard, evidence-based guidelines for assignment of patient level of care (Inpatient vs. Observation, etc.)
- More than 30 years of validating, clinical application
  - Has this changed now?
  - What has core measures compliance got to do with medical necessity?

Specific Diagnoses

- Pneumonia
- Syncope
- TIA
- CHF
- Chest Pain / ACS / Angina
- COPD / Bronchospasm / Asthma
- Abnormal Cardiac Rhythm
- Typical Observation Circumstances

Pneumonia

- Confirmed by imaging (CXR or CT)
  - If not, clinical basis explained
- 2 Lobes or more
- HCAP (Health-care associated pneumonia)
- Pulse oximetry on room air (< 89%)
- Resp rate >30
- IV antibiotics almost always used for inpatient

Pneumonia Severity Score

Pneumonia Severity Scoring Tool [1]

	Value	Score
Men	Age (yrs)	
Women	Age (yrs) – 10	
Nursing Home resident	+10	
Comorbid Illnesses:		
Neoplastic disease	+30	
Liver disease	+20	
CHF	+10	
Cerebrovascular disease	+10	
Renal disease	+10	
Physical exam findings:		
Altered mental status	+20	
RR > 30	+20	
Systolic BP < 90	+20	
Temp < 35C (95F) or > 40C (104F)	+15	
Pulse >125	+10	
Lab/Radiologic:		
Arterial blood pH < 7.35	+30	
BUN > 30	+20	
Na < 130	+20	
Glucose > 250	+10	
Hematocrit < 30	+10	
Arterial PO2 < 60 or O2 sat <90	+10	
Pleural effusion	+10	

Risk Category	Risk Level	Risk Score	Treatment Venue
I	Low	< 50	Oral antibxs at home
II	Low	51 – 70	Oral antibxs at home - if vomiting/ unreliable, then observation (<24)
III	Low	71 – 90	Oral antibxs at home - if vomiting/ unreliable, then observation (<24)
IV	Mod	91 – 130	Inpatient stay + IV antibxs
V	High	> 130	Inpatient stay (TICU) + IV antibxs

[1] Source: *Fine MJ, et al. NEJM 336:243-250, 1997.*

Syncope / Presyncope

- **Inpatient if documented as likely / suspected as due to:**
  - Known cardiac disease (CHF, Ischemic, Valvular)
  - CV drug-induced
  - Systolic BP < 90
  - Pulse < 60, or
  - High-degree AV-block
- **Management must include:**
  - Cardiac telemetry (monitoring)
- **Observation if either:**
  - Unexplained and none of the above, or
  - Simple “vaso-vagal” or “orthostatic”

TIA

- Inpatient supported if any of the following:
  - ABCD^2 score is >3 (IQ = 3 or more), or
  - Persistent Neuro deficit > 24 hours from **onset** (not from presentation to ER) = CVA, or
  - CVA on imaging study
- Management must include both:
  - Neuro check every 4 hours, and
  - Aspirin, or anti-platelet, or anti-coagulant (unless contraindication documented)

ABCD²

Transient Ischemic Attack (TIA):
Prognosis and Key Management Considerations

ABCD² Score

The ABCD² score is a risk assessment tool designed to improve the prediction of short-term stroke after a transient ischemic attack (TIA). The score is optimized to predict the risk of stroke within 2 da after a TIA, but also predicts stroke risk within 90 days. The ABCD² score is calculated by summing points for five independent factors.

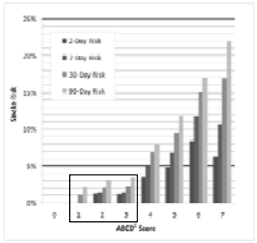
Risk Factor	Points	Score
Age		
≥ 60 years	1	☐
Blood pressure		
Systolic BP ≥ 140 mm Hg *OR* Diastolic BP ≥ 90 mm Hg	1	☐
Clinical features of TIA (choose one)		
Unilateral weakness with or without speech impairment *OR*	2	☐
Speech impairment without unilateral weakness	1	
Duration		
TIA duration ≥ 60 minutes	2	☐
TIA duration 10-59 minutes	1	
Diabetes	1	☐
Total ABCD² score	0-7	☐

ABCD²

Using the ABCD² Score

Higher ABCD² scores are associated with greater risk of stroke during the 2, 7, 30, and 90 days after a TIA (Figure). The authors of the ABCD² score made the following recommendations for hospital observation:[1]

ABCD² Score	2-day Stroke Risk	Comment
0-3	1.0%	Hospital observation may be unnecessary without another indication (e.g., new atrial fibrillation)
4-5	4.1%	Hospital observation justified in most situations
6-7	8.1%	Hospital observation worthwhile



[1] Johnston SC, Rothwell PM, Nguyen-Huynh MN, Giles MF, Elkins JS, Bernstein S, "Validation and refinement of scores to predict very early stroke risk after transient ischemic attack," *Lancet*, 369:283-292, 2007.

CHF

- Document Severity:
  - Degree of dyspnea
  - Pulse oximetry on room air (< 89%)
  - CXR findings
  - Accurate respiratory rate and heart rate
  - Edema
  - Recent weight gain (> 3# in 48hrs?)
  - Failed outpatient treatment
- For new-onset right heart failure:
  - Edema
  - Hepatomegaly
  - JVD

CHF

- Management of CHF should include all:
  - Supplemental oxygen
  - Pulse oximetry or ABG
  - ACEI or ARB **and** Beta-blocker (unless contraindication documented)
  - IV diuretic (eg Lasix) ≥ 2 doses
  - Cardiac monitor/telemetry
  - DVT prophylaxis(?)
  - Sometimes nitrates

Chest Pain / ACS / Angina

- Observation if all:
  - Chest pain relieved, and
  - Unremarkable ER evaluation
  - Vital signs stable
  - EKG w/o significant findings or unchanged from prior EKG
  - Negative CXR
  - Normal cardiac markers
- Inpatient if any:
  - STEMI
  - NSTEMI
  - ACS w/ LBBB (new or undetermined age)
  - Significant EKG findings:
    - **ST depression > 0.5 mm*, or**
    - **T wave inversion > 1 mm*, or**
    - **LBBB (new or undetermined age)**
    - **Paced rhythm**

** new, acute finding*

Chest Pain / ACS / Angina

- Management should include all:
  - *Beta-blocker or CCB including P.O.
  - *Aspirin
  - *Anti-platelet drug (e.g. Plavix)
  - *Anti-coagulant (e.g. Heparin or Lovenox)
  - Nitrates (IV, topical, oral) – not just prn NTG
  - Cardiac monitor/telemetry

**unless contraindicated*

COPD / Bronchospasm / Asthma

- Inpatient if any:
  - PEF < 40%
  - PEF < 70% & unresponsive
  - SpO2 < 89%
  - pCO2 > 50 and pH < 7.35

ER must do PEFs and SpO2 on room air

- Management should include all:
  - Supplemental oxygen
  - Pulse oximetry or ABG
  - Bronchodilator (beta-agonist) nebulizer or MDI w/ spacer q 4 hrs
  - Corticosteroids – orally or IV

Abnormal Cardiac Rhythm

- Tachyarrhythmia
  - Atrial fib or flutter, or PSVT <120 requiring IV medication
  - Atrial fib or flutter, or PSVT >120 unresponsive to treatment in ER
  - PVT
- Bradyarrhythmia
  - Bradycardia < 60 if any of:
    Systolic BP < 90, or Syncope, or
    Second degree block (Type II), or
    Documented pause > 3 seconds, or
    Junctional escape due to dig-toxicity
  - Third Degree Block

Observation Circumstances

- Treatment, stabilization and discharge may occur within 24 hours
- Minor complication of outpatient surgery
  - Hospital "observation charge" not allowed in conjunction with procedures
- Unsafe discharge circumstances

Observation Circumstances

- Abdominal Pain – non-specific
- Chest Pain / ACS / Unstable Angina
  - Initial ER evaluation unremarkable (inpatient if abnormal EKG or ↑ cardiac marker)
  - "Non-aggressive" management
- Back Pain
- GI Bleeding with stable VS and Hct >25 & Platelets >60K or <1.0 M.
- Gastroenteritis / Nausea / Vomiting
- Dehydration (uncomplicated)
- DVT – uncomplicated
- Syncope – unexplained, orthostatic, uncomplicated

ER Support

- Document in a Prominent Place
  - PEF before & after treatment for COPD, asthma, bronchospasm
  - SpO2 on room air
  - Orthostatic BP & Pulse if:
    - Syncope
    - Hypotension
    - GI Bleed
    - Anemia

Documentation with Diagnostic Accuracy

- Accurate Documentation that can be correctly coded to reflect the true complexity of care and severity of illness:
  - Ensures Proper Payment
  - Demonstrates Quality of Care provided
  - Justifies Medical Necessity and Resource Utilization
  - Supports RAC-resistance
  - Allows Physicians and Hospitals to survive in an ever more competitive healthcare environment

Sepsis

- Definition: systemic inflammatory response syndrome ("SIRS") due to confirmed or suspected infection
- Criteria: an ill-appearing patient with infection and 2 or more of the following*:
  - Fever (≥ 101°F) or Hypothermia (< 96.8°F)
  - WBC > 12,000 or < 4,000 or Bands > 10%
  - Heart rate > 90
  - Respiratory rate > 20

*not easily explained by another condition

Others including: hypotension, altered mental status, elevated C-reactive protein (CRP), lactate or procalcitonin level, evidence of acute organ failure

Sepsis

- Performance

DRG	GMLOS	Mortality
Sepsis	**4.3**	**10% – 50%**
UTI	**3.3**	**< 1%**

Acute Respiratory Failure

- Difficulty breathing, and
- ABGs (room air)
  - pO2 < 60 (= SpO2 < 89%), or
  - pCO2 > 50 + pH < 7.35 (e.g., COPD)

Cannot be coded as Respiratory Failure:

Respiratory distress
Severe dyspnea
Respiratory insufficiency
Hypoxemia

Acute Renal Failure

- Acute Renal Failure = Acute Kidney Injury ("AKI")
- Diagnostic Criteria:
  - Increase in serum Creatinine by 0.3 mg/dl within 48 hrs
  - Increase in serum Creatinine by 1 ½ times (50%) above baseline presumed to have occurred within 7 days

Dehydration is most common cause

Example
Creatinine = 1.7 on admission
Creatinine = 1.0 three days later

Difference: 0.7 = 70% increase < 7 days

Encephalopathy

- Is the altered mental status really due to encephalopathy?
- Definition: Acute generalized (global) alteration in mental function due to an underlying process, usually systemic and reversible.
- Examples:
  - Metabolic: Fever, dehydration, electrolyte imbalance, acidosis, hypoxia, infection, sepsis
  - Toxic: Drugs, chemicals, alcohol, medications