Observation – Is Our Service Medicare Compliant – Part 2

Wednesday, May 2 (3:00 – 3:30)

STROUDWATER ASSOCIATES

Payment Purpose, FI MAC or RAC Review

- ED form when placed in Observation through ED
- Physician order sheet
- Physician progress form (admitting note must support reason for Observation as discussed earlier)
- Nursing Admission form / note to include:
  - Admission time, admitting vital signs, chief complaint and condition on admission
  - Modified Assessment
  - Admission interview as used in Med/Surg to determine discharge needs
  - Modified problem focus assessment if patient came from the ED where a nurse did the full assessment
    - Complete full assessment if patient was placed in Observation directly from the community
  - Full skin assessment and Fall Precaution Need Assessment
  - List of medications (include dosages and frequency) patient is taking on a regular basis

contd.

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Payment Purpose, FI MAC or RAC Review

- Nursing progress notes – free hand notes when monitoring, assessments and treatments occur as well as discharge status
  - Recommended reassessment based on reason for Observation every 1 to 2 hrs
- MAR and V/S form
- Results of ancillary tests from ED and/or Observation as well as procedure reports
- Physician discharge progress note with discharge instruction and follow-up (if applicable)
- Copy of discharge instructions

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Calculating & Billing Hours of Observation

- Calculating hours of observation
  - Start with total hours in bed under nursing care
    - Minus time for procedures requiring active monitoring (see later explanation)
    - Minus hours where patient remains in bed but:
      - No longer in need of assessments and reassessments such as waiting for a ride
      - Monitoring for pre-op prep
      - Extended monitoring post procedure/surgery

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Calculating & Billing Hours of Observation

- G0378 is billed per hour (rounded to nearest hour
  - 0 – 30 minutes = 0
  - 31 – 60 minutes = 1 unit
  - For example, a patient who began receiving observation services at 2:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a 8 placed in the units field of the reported observation HCPCS code if they were all active monitoring.
- Bill all hours for a single encounter on one line even if the Observation service spans more than a calendar day
  - (e.g.: Observation – 26 units) – that means 26 hrs
- The line-item date of service is the date the patient is admitted to observation care

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Calculating & Billing Hours of Observation

- Use revenue code 0762 with HCPCS code G0378 for the total # of Observation hours meeting criteria when the patient is placed in Observation from the ED
- Use revenue code 0762 with no HCPCS code to report non-observational package nursing hours (hrs deducted from total hours due to active monitoring, extended nursing care etc)
- Observation hours provided prior to a condition code 44 inpatient review must be reported on the claim with no HCPCS G0378.
- Recommendation for CDM setup: In order to accomplish this, the CDM will need to have 2 lines to report Medicare

Description	RC	HCPCS	Fee
OBSERVATION PER HOUR	762	G0378	Facility Defined, the same fee applies for hours prior to and after UR review
OBS PER HOUR PRIOR TO UR REVIEW	762		

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Calculating & Billing Hours of Observation

- In addition, hospitals should also report HCPCS code G0379 when a patient is referred directly for observation care after being seen by a physician in the community
  - The number of units reported with HCPCS code G0379 must equal 1 as a non-chargeable item to denote that patient was seen in a physician's office (hence no ED charge)
- The number of units reported with HCPCS code G0378 must equal or exceed 8 hours with hospital charge per hour
  - **If patient had less than 8 hrs of Observation, the revenue code 0762 is used but with no HCPCS code**

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Facility billing for Observation services

- Report all services billable as OP services
  - Infusion (based on start and end time)
  - IV medication and Injections
  - Hydration
  - ECG
  - Catheter insertion, nursing procedures
  - Ancillary services – Lab, radiology, rehab
  - Respiratory therapy treatment
  - All procedures
  - Physical Therapy eval and units of treatment
- Ensure physician documentation of the tests, procedures and treatments with support for why if not obvious and nursing documentation of such taking place

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Facility billing for Observation services

Frequently Missed Charges

- Injections (96372, 96374, 96375, 96376, 96409, 96411)
- Hydration therapy (96360–96361)
- Infusion therapy (96365, 96366, 96367, 96368, 96413, 96415)
- Fingerstick blood sugar (Accucheck) (82962)
- Straight cath for medical reasons (51701)
- Foley cath, simple (51702)
- Foley cath, complicated (51703)
- Cath for specimen collection only (P9612)
- Guaiac/fecal occult test (82270, 82272, 82274, G0328)
- Collection of blood through completely implanted VAD (36591)
- Collection of blood through established central/ peripheral venous catheter (36592)
- Arterial puncture (36600)
- Paracentesis (32421)
- Unscheduled OP hemodialysis (G0257)

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Policy and Procedure re: Observation Item Content

- The Observation patient's medical record must include
  - The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
  - The physician order to "place in outpatient Observation……"
  - A history and physical giving pertinent medical findings and rationale for Observation status
  - The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care
  - Physician and nursing progress notes written with sufficient frequency and content to specify how the patient responds to care.

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Policy and procedure Observation items

- Documented appropriate and timely interventions which include the delivery of appropriate diagnostic and therapeutic services based on the patient's condition.
- When appropriate, the progress notes must state "continue outpatient observation" and what aspects of the patient's condition warrant extended Observation.
- Address abnormal test results.
- Document reassessment of the patient's medical, physical, psychological and social needs with appropriate referrals.
- The medical record will reflect patient teaching to include medication instructions, dietary advisements and wound care instructions.

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Policy and procedure Observation items

- Documented plan for appropriate follow-up care.
- Case Manager/UR to direct questions concerning the appropriate utilization of the observation patient with physician as soon as possible and refer to Medical Director and to Administration as needed
- Case Management to call the patient's physician, if after 24 hours of being placed in Observation (usually done before leaving for the evening), the medical record does not reflect orders to continue outpatient observation, admit or discharge the patient.

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Documentation considerations

- CMS Medical reviewers look for the following to determine medical necessity and intensity of the service
  - Does the physician's order accurately and clearly reflect the care setting required?
  - Does the documentation support the medical necessity of the services provided?
  - Does the documentation include sufficient rational to support the level of care ordered?

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Observation change of status – from IP to OP

- Condition Code 44
- Even if a physician orders that a patient be admitted to a hospital as an IP, CMS authorizes UR to change patient's status from IP to OP if:
  - The change is made while the patient is in the hospital
  - The hospital has not yet made a claim to Medicare for IP admission
  - A physician member of the UR committee determines the medical necessity and a treating physician concurs with UR's decision, and
  - The physician's concurrence is documented in the patient's medical records

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CMS FAQ re: Status Change

- May a hospital change a patient's status using Condition Code 44 when a physician changes the patient's status without utilization review (UR) committee involvement?
- No, the policy for changing a patient's status using Condition Code 44 requires that the determination to change a patient's status be made by the UR committee with physician concurrence.
- This physician member of the UR committee must be a different person from the concurring physician for Condition Code 44 use, who is the physician responsible for the care of the patient. For more information, see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.3.2 (When an Inpatient Admission May Be Changed to Outpatient Status).

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Retroactive review

- CMS reportedly allows retroactive reclassification (such as late night / weekend admissions when no case manager on duty) but warns that this should occur infrequently!!
- ED staff and house supervisors should be trained in UR to the fullest extent possible to prevent inappropriate admission
- Physicians must be orientated to requirements
- UR committee, with at least one physician member, must find that medical necessity for IP stay was not met
  - A physician can make the determination without a group review
  - Non physician UR member must have agreement from at least one physician other than concurring physician

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Retroactive review

- The attending physician must be allowed to present her / his views and any additional information to the committee prior to final decision
- If the attending does not respond, or does not contest then the findings are final
- If the attending contests, at least one other physician member of the committee must review the case. If two physician members agree that inpatient is not medically necessary, the decision is final.

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Billing for IP to OP Observation status change

- Use Condition Code 44; IP admission changed to OP
- A dated and timed physician order is required to change the status of care to place patient in OP Observation
- The hospital cannot report hours of Observation services using HCPCS code G0378 (hospital observation service per hour) for the time period during the hospital encounter prior to a physician's order for Observation services.
- Hours for the time prior to the order should be reported by Revenue code only, no HCPCS
- **Medicare does not permit retroactive orders or the inference of physician orders**
- The clock time begins at the time that Observation services are initiated in accordance with a physician order

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Billing for IP to OP Observation status change

- While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter.
- For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met.

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Billing for IP to OP Observation status change

- On the outpatient claim on an uncoded line (no HCPCS code) with revenue code 0762, the hospital would report the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services.
- For other rules related to billing and payment of observation services, see Chapter 4, §290 and Chapter 6, §20.6 of the Medicare Benefit Policy Manual, Pub. 100-02.

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OP Observation to IP Admission status change

- "Q: What if an initial observation order was determined at later point in time to have been inappropriate as patient should have been admitted as an inpatient. What can be done?"
- "A: Orders cannot be retroactive therefore since order is written for inpatient care on different date than referral to observation, the admission date is the date the inpatient order is written, even if patient could have been inpatient when the observation order was written."
  - Note: If it was the same date (IP after midnight – there would be no financial benefit of backing to 1:00 am since anytime after midnight to the following midnight is the 1st day of admission)
- Note: When an admission order is written but the patient status no longer supports the need for inpatient admission, the claim cannot be billed as an inpatient claim.

* Answer provided by the Noridian Administrative Services LLC who is the Medicare administrator contractor (MAC) for Arizona, Colorado, Montana, North Dakota, South Dakota, and Utah,

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Do we need to give an ABN?

- The purpose of an ABN is to provide prior notice to a beneficiary (or his or her representative, in the event that the beneficiary is not competent) when the provider believes that Medicare will not pay for certain Part B outpatient services because limitation on liability applies,"
- Limitation on liability applies when Part B outpatient services fall within one of three categories:
  - The services do not meet Medicare's medical necessity guidelines for a patient's condition;
  - The frequency of a screening service exceeds Medicare coverage for that benefit; or
  - The services are custodial

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Do we need to give an ABN?

- The intent of the ABN form is to explain to patients that a provider anticipates Medicare will not pay for certain services.
  - Patients will be responsible for payment to providers when they (or their representatives) opt to receive these services.
- Use of the ABN form is more common in outpatient settings, hence appropriate to be issued with Observation which is an OP service
  - For example, an observation patient who refuses to leave the hospital may receive an ABN form that explains Medicare will not pay for custodial care
  - The hospital must give proper notice to the beneficiary in advance of any custodial care provided in order to charge the beneficiary for the custodial care.
- CMS introduced a new ABN effective November 1, 2011
  - ABN forms with a March 2008 release date issued on or after November 1, 2011 will be invalid.
  - https://www.cms.gov/BNI/02_ABN.asp

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Notice of Exclusions or ABN

- ❑ For services that are not paid under the OPPS, but do not require an ABN such as providing drugs to the beneficiary that are usually self-administered, providers may use the Notice of Exclusion from Medicare Benefits to advise beneficiaries of any potential liability.
- See
- http://www.cms.hhs.gov/Medicare/Medicare-General-Information/BNI/ABN.html
- http://www.corcoranccg.com/GetFile.aspx?FileID=6f4413de-529a-4c67-8955-6674a3f1efb6
  - See next slide for samples of "Notice of Exclusion from Medicare Benefits"

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A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare

Sample Notice of Exclusion

(Customize top of form with name, address & phone) *(Provide 1 copy to patient, keep original in your files.)*

Patient's Name: Medicare # (HICN):

Notice of Exclusion from Medicare Benefits

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

Before you make a decision about your options, you should read this entire notice carefully.

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Informing The Patient

- Patient's should be clearly notified of their responsibilities:
- Consider the following:
  - Create a special consent form for Observation which would be signed by the patient/responsible party.
    - Explain that Observation is an OP service and whether they will be responsible for payment based on payor
    - Note that Medicare beneficiaries are responsible for 20% of charges…. that their co-insurance may cover…
    - Responsible for self administered drugs such as…..and explain their options
    - Have a bullet for them to sign that they are taking responsibility if they choose to bring their own meds in

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Informing The Patient

- What needs to be discussed as a hospital is whether they can bring their own medications and agree in what form such has – must be in the original pharmacy container…
  - Remember that as the patient gets more savvy the more they will insists on bringing their own meds
  - Meet with administration and pharmacists to develop an acceptable plan such as pharmacist to review medication before initial administration or ED MD and PDR comparison after hours
  - Ensure clear P&P for new process

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Informing The Patient

- Also consider providing community education using:
  - Framed sign explaining Medicare's rule and post it in ED and OP procedure areas.
  - Others are creating a simple pamphlet to notify patients of their Observation status and responsibility
    - It also instructs the Medicare beneficiaries to bring in their home meds…
  - Don't forget to have educational material to the point, short, large print, clear and who can they ask if they have any questions.

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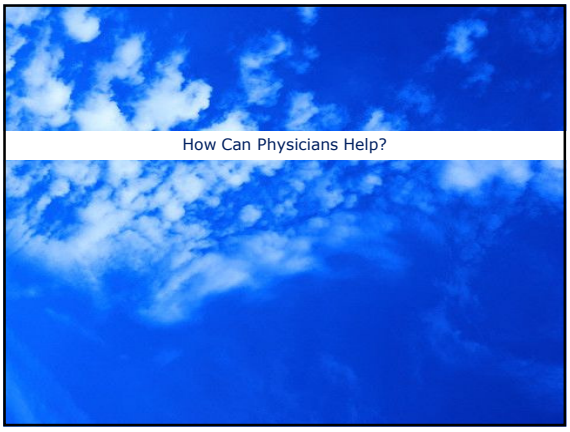

How can physicians help?

- Documented order for OP observation status
  - Remind ED physician when discussing plan
- Repeat visit / discharge visit – decision by the "24th hour" as to what the next step will be if patient is still in Observation
- Discharge progress note, plan of care and discharge instructions
- The decision to place into an Observation status is the responsibility of the physician, not the hospital. We do ask that physicians work closely with the hospital – at this time the physician still gets paid for visits to patient who's admission has been denied, the hospital does not – this may change
  - Imperative to educate both ED physicians and nurses and/or supervisors when available regarding Observation criteria
  - Care managers should round on Observation patients first thing in a.m. for utilization review

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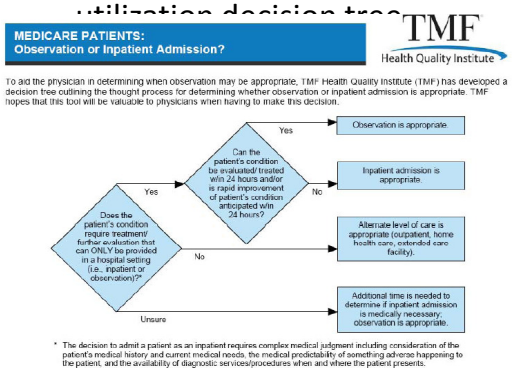
Use the Observation utilization decision tree



How can physicians help?

Medical necessity documentation is imperative

- **Factors contributing to medical necessity denials:**
  - Incomplete documentation (blank fields)
  - Inconsistent documentation
  - Illegible documentation
  - Lack of documentation to support change in patient's condition or care
  - Addendums must be provided in accordance with accepted standards for amending documentation

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Physician Billing for Observation Status

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Hospital Observation physician billing description

- For reporting purposes, time associated for these services is defined as unit / floor time, which includes:
  - Time physician spent on the unit and at the bedside rendering services – this includes:
    - Chart review
    - Patient exam
    - Writes notes and communicates with other professionals
    - Communication with family
  - Pre and post time is not included in the time reported (e.g.: reviewing pathology and/or radiology reports in another part of the hospital) but it was included in calculating the total work of typical services reported in physician surveys

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Who can bill initial Observation care?

- Contractors pay for initial observation care billed by only the physician who placed the patient in Observation and was responsible for the patient during his/her stay in Observation.
- A physician who does not have inpatient admitting privileges but who is authorized to place a patient to Observation status may bill these codes - such as an ED physician because Observation is an OP service
- Payment for an initial Observation care code is for all the care rendered by the admitting physician on the date the patient was placed in observation

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Who can bill initial Observation care?

- For a physician to bill the initial Observation care codes, there must be a medical Observation record for the patient which contains:
  - Dated and timed physician's admitting orders regarding the care the patient is to receive while in Observation,
  - Nursing notes, and
  - Initial and other progress notes as applicable prepared by the physician while the patient was in Observation status.
- Documentation identifying the admission and discharge notes were written by the billing physician.
- This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

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Who can bill initial Observation care?

- All other physicians who see the patient while he or she is in Observation must bill the office and other outpatient service codes or outpatient consultation codes as appropriate for the payor in question, when they provide services to the patient.
- Medicare does not accept consultation codes
- For example, if an internist places a patient to Observation and asks an allergist for a consultation on the patient's condition, only the internist may bill the initial Observation care code. The allergist must bill using the outpatient code that best represents the services he or she provided. The allergist cannot bill an inpatient consultation since the patient was not a hospital inpatient.

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Physician billing

- If patient was seen in ED, placed and followed in Observation status by the same physician, bill ED professional fee only as the initial assessment
- If patient seen in physician's office then placed in Observation status, the physician may choose to bill for office visit or initial Observation care code
- If patient is referred to primary physician from ED and both agree to the need for Observation, the ED physician may bill for the ED visit and the primary physician or hospitalist who will be following the care while in Observation may bill for Observation as per the extent of the service

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Physician billing

- Observation D/C and Acute Care Admission cannot be both billed on the same day
- Physicians may bill for an initial Observation care and an Observation D/C code if D/C is on other than initial date of "observation status"
- Following instructions (on next slides) affects physicians and qualified non-physician practitioners (NPPs) who can submit claims to Part A/B Medicare Administrative Contractors (A/B MACs) and carriers for hospital Observation services provided to Medicare beneficiaries during a hospital visit

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Physician billing

- Physicians and qualified NPPs should report Initial Observation Care using a code from CPT code range 99218 – 99220 when the observation care is less than 8 hours on the same calendar date.
- Physicians and qualified NPPs *should not report* an Observation Care Discharge Service (CPT code 99217) when the observation care is less than 8 hours on the same calendar date.
- Physicians and qualified NPPs should report Initial Observation Care using a code from CPT code range 99218 – 99220 and an Observation Care Discharge Service (CPT code 99217) when the patient is placed in a bed for observation care and discharged on a different calendar date.

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Physician billing

- Physicians and qualified NPPs should report Observation Care Service (Including Admission and Discharge Service) using a code from CPT code range 99234 – 99236 when the patient is placed in Observation care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date.
- Physicians and qualified NPPs should report Office or Other Outpatient Visit using a code from CPT code range 99211 – 99215 for a visit before the discharge date in those rare instances when a patient is held in Observation care status for more than two calendar dates.

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Admission to IP status from Observation

- If the same physician who placed a patient in Observation status also admits the patient to inpatient status from Observation before the end of the date on which the patient was placed in Observation, Medicare will pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service.
- In other words, the physician may not bill an initial Observation care code for services on the date that he or she admits the patient to inpatient status.

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Admission to IP status from Observation

- If the patient is admitted to inpatient status from Observation subsequent to the date of patient being placed in Observation, the physician must bill an initial hospital visit for the services provided on that date.
- The physician may not bill the hospital Observation discharge management code (code 99217) or an outpatient/office visit for the care provided in Observation on the date of admission to inpatient status.

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Observation during Global Surgical Period

- The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, and 99220, 99234, 99235, 99236) services unless the criteria for use of CPT modifiers "-24," "-25," or "-57" are met. Contractors must pay for these services in addition to the global surgical fee only if both of the following requirements are met:
  - The hospital observation service meets the criteria needed to justify billing it with CPT modifiers "-24," "-25," or "-57" (decision for major surgery); and
  - The hospital observation service furnished by the surgeon meets all of the criteria for the hospital observation code billed.

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Observation during Global Surgical Period

- Example 1 of the decision for surgery during a hospital observation period is:
  - An emergency department physician orders hospital outpatient observation services for a patient with a head injury.
  - A neurosurgeon is called in to evaluate the need for surgery while the patient is receiving observation services and decides that the patient requires surgery.
  - The surgeon would bill a new or established office or other outpatient visit code as appropriate with the "-57" modifier to indicate that the decision for surgery was made during the evaluation.
  - The surgeon must bill the office or other outpatient visit code because the patient receiving hospital outpatient observation services is not an inpatient of the hospital.
  - Only the physician who ordered hospital outpatient observation services may bill for initial observation care.
- Example 2 of the decision for surgery during a hospital observation period is:
  - A neurosurgeon orders hospital outpatient observation services for a patient with a head injury. During the observation period, the surgeon makes the decision for surgery. The surgeon would bill the appropriate level of hospital observation service.

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Two Hospital Visits Same Day

- Contractors pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase "per day" which means that the code and the payment established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

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Hospital Visits Same Day but Different Physicians

- In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, carriers do not pay physician B for the second visit. The hospital visit descriptors include the phrase "per day" meaning care for the day.
- If the physicians are each responsible for a different aspect of the patient's care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses. There are circumstances where concurrent care may be billed by physicians of the same specialty.

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Physician documentation

- Physicians and qualified NPPs should:
  - Document the medical record to satisfy the evaluation and management guidelines for admission to and discharge from Observation care or inpatient hospital care
  - Note that the documentation requirements for history, examination and medical decision making should be met
  - Document his/her physical presence
  - Document his/her personal provision of Observation care
  - Document the number of hours the patient remained in the Observation care status
  - Personally document the admission and discharge notes

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Physician Observation Billing Codes Synopsis	
Code	Description
	Initial Observation Care - Admission: less than 8 hours and D/C on same calendar date
99218	Low severity
99219	Moderate severity
99220	High severity
99234 99235 99236	Use when the patient is placed in Observation care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date.
	Observation care discharge code
99217	Use 99217 for discharge care when Observation admission is > than 8 hrs and discharge date is on a different day than the date the patient was placed in Observation
	Do not use when Observation is < than 8 hrs and discharged on the same calendar date as the admission
	Observation Care ***AND*** Observation D/C Codes
99218 99219 99220 99217	Use 99218-99220 for Admission and 99217 for Discharge for observation care > than 8 hours and D/C on a different date than when the patient was placed in Observation

Physician Observation Billing Codes Synopsis	
Code	Description
	Observation care > than 48 hrs
99211 99212 99233 99214 99215	Use 99211-99215 (office visit) for Observation care for those rare occasions when the patient remains in Observation longer than 48 hrs
	Initial Observation Care and Admission
99218 99219 99220	Cannot use Initial Observation Care codes on the same day as an IP admission
99218-99220 and 99221-99223	Use 99218 to 99220 for initial Observation Care and 99221 to 99223 for Initial Hospital visit if patient is admitted the calendar date following the date the patient was placed in Observation

Are you at risk?

- Do you know the CoP to maintain compliance?
- Does the CMgr/UR have available resources to serve as guidelines for the right level of care (InterQual, Milliman Roberts)
- Do you have Medical UR resource such as a UR Medical Director/Advisor
- Do you wrongfully allow auto-conversion,
  - Placed in Observation and automatically admitted after 24 hours? (should not allow)
  - Recovery room to Observation? (should not allow)
- Are staff oriented to Observation UR when Case Manager/UR not in-house? – Do we have a cheat sheet for
  - Delayed assessment of patient
  - Weekend admissions

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Are you at risk?

- Are you applying code 44 (from IP to Observation) as required
- Do you ensure NO start of Observation without physician orders?
- Do you ensure no start of billing for direct placement in? Observation from home/NH until physician comes in to evaluate the patient?
- Do you have an early process to evaluate and initiate changes to patient status
- Do you have somebody appointed to calculate the hrs to be billed and do they know the dos & don'ts?
- Do you discuss areas where you are at risk
- Do you educate physicians, nursing, case manager, coders and billers
- Do we teach nursing as to why they have to document the way they do

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Are you at risk?

- Do you audit charts for
  - Dated and timed orders for specific level of care
  - Meeting medical necessity
  - Automatic conversions
  - Ensure differentiation between IP and OP only procedures
  - Are correct billing codes used for hospital and physician if you bill for them
  - Do we have correct D/C codes
  - Infusion and procedure documentation
  - Active observation procedures subtracted
- Does nursing have the tools needed to document? Do they document observations in relations to the reason the patient was put in Observation and/or the effects of the treatment(s)
- Inform staff of audit findings – do we graph and celebrate improvement?

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Are you at risk?

- Do we develop action plan to maintain compliance
- Does case management track data to identify issues and celebrate when meeting goals:
  - Acute admissions and days per month
  - Observation admissions and total hours per month/24 to = days/month
  - # of 1 and 2 day IP admissions (separately)
  - # of IP changed to Observation status
    - Due to Case Management review and MD/DO decisions
    - Due to clerical errors
  - # of Observation who end up being admitted
  - # of ED re-visits within 72 hrs
  - # of Observation return within 7 days
  - # of readmissions with 30 days post D/C
- Do we analyze the data and work on PI based on data?

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PI Action Plan

- Create a team to review this presentation and get together to discuss by _____
- Make a list of the known issues and potential issues
- Have everyone write down their questions/comments
- Meet on set date to discuss questions/concerns including the slides regarding the risk of doing nothing etc…
- Develop an action plan based on the needs identified using a table with the following headings:
  - Name of action
  - Goal
  - What is to be done (measurable)
  - Who is the person responsible to facilitate what needs to be done
  - By when will you have the action done
- Set date and time for next meeting and expect all responsible party to have completed their tasks

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PI Action Plan

- Agree on new processes
- EDUCATE staff
- Remember, it's not what you Expect, it's what you Inspect so do on-going "inspection"
- Create audit tools to correct data before it gets to billing – time to fix is very aggravating, inefficient, and costly – not to mention what we don't fix
- Other

A STITCH IN TIME SAVES NINE !!!

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Performance Improvement Action Plan

Some say we do not have time to meet and fix all the concerns .

Performance improvement says – "we do not have the time NOT TO FIX or prevent the issue from occurring."

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