

PHYSICIAN ADVISOR SERVICES

INSIDE THIS ISSUE:

<i>CMS Concerned by Increase in Longer Stays in Observation Care</i>	1
<i>Three Day SNF Requirement May Get Relief</i>	2
<i>RAC FAQs - Excerpts from CMS Website</i>	2

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CMS CONCERNED BY INCREASE IN LONGER STAYS IN OBSERVATION CARE

In an interesting letter dated July 7, 2010, Marilyn Tavenner, Acting Administrator and Chief Operating Officer of CMS addressed the agency's concern that Medicare beneficiaries are "remaining in observation care for longer periods of time, sometimes exceeding 48 hours." The letter was addressed to Mr. Richard Umbdenstock, President and Chief Executive Officer of the American Hospital Association (AHA) with copies to Chip Kahn of the Federation of American Hospitals and Darrell G. Kirch, M.D. of the Association of American Medical Colleges.

The letter presented the Medicare definition of observation services and described the "tremendous impact" that extended observation care can have on Medicare beneficiaries. Major impacts on beneficiaries include the fact that they "are liable for approximately 20% of the costs of outpatient services that are paid by the Medicare Part B program while the patient is receiving observation, and, in some situations, the full costs of self-administered drugs during

that time. Further, a beneficiary must stay in the hospital a minimum of 3 days as an inpatient before Medicare will pay for skilled nursing facility care; prolonged outpatient encounters do not count towards this statutory requirement."

On October 27, 2010 Rick Pollack, Executive Vice President of AHA sent a response back to Ms. Tavenner thanking her for the letter and expressed like concern over the impact of extended observation to Medicare beneficiaries and welcomed the opportunity to work with CMS to address the issue "in the most productive manner." Mr. Pollack pointed out that hospitals have the goal of providing "the right care at the right time in the right setting."

Mr. Pollack stated that several federal policies could be driving the impact on the use of observation services. Those policies include the activities of the Recovery Audit Contractors (RACs) and hospitals concerns regarding enforcement actions. Technology and medical practice changes also allow some

services to be done in an outpatient setting that were traditionally done as inpatient hospital services. The response notes that Medicare policies affect how hospitals furnish and bill for observation services. For example the changes to the "Condition Code 44" policy likely affected the level of care determinations.

Hospitals also react to the enforcement risk of prosecution under the False Claims Act. The costs associated with defending well intended decisions becomes burdensome. The costs include direct costs, as well as damaged reputations so providers may be wary about admitting patients for short inpatient stays.

To view the letter from CMS click [here](#). To view the response letter from the AHA, click [here](#). If you would like more information regarding this article please contact Ann Purdy at 205-314-8859 or email her at apurdy@medmanagementllc.com.



<http://www.govtrack.us/congress/billtext.xpd?bill=h111-5950>

Region A-DCS
<http://www.dcsrac.com/IssuesUnderReview.aspx>
 1-866-201-0580

Region B-CGI
<http://racb.cgi.com/Issues.aspx?st=1>
 1-877-316-7222

Region C-Connolly Healthcare
http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx
 1-866-360-2507

Region D-HDI
<https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx>
 866-590-5598 (Part A)
 866-376-2319 (Part B)

THREE DAY SNF REQUIREMENT MAY GET RELIEF

In the House of Representatives a bill has been introduced by Joe Courtney, Democrat from Connecticut, that would give hospitals, skilled nursing facilities (SNF) and Medicare beneficiaries relief in regards to the three-day qualifying stay. The bill (HR 5950) would allow observation stays that exceed 24 hours to count toward the three-day inpatient hospital stay required for Medicare coverage in a SNF. It is expected that a similar bill will be introduced in the Senate.

Three day qualifying stays have caused hospitals concerns as they try

to effectively follow the CMS regulations on level of care determinations. Frequently hospitals have run into problems when applying Interqual or Milliman as the only determinant in level of care. Although a patient may meet the inpatient criteria as defined by CMS, when a screening criteria such as Interqual is utilized a lesser level of care may be indicated. Hospitals must be diligent in understanding and correctly applying the CMS criteria which is more “patient centered” than commercial screening tools and is based upon the “complex medical judgment” of a physician.

Using physician advisors (PAs) to help navigate the level of care determination is an effective way of placing patients in the most appropriate level of care. PAs who understand the CMS criteria can assist attending/admitting physicians in making sure that the order is appropriate and that documentation is clear and complete to support the billed level of care.

To review the bill, click [here](#).

If you have questions, please contact Ann Purdy by clicking [here](#) or call her at 205-314-8859.

RAC FAQs - EXCERPTS FROM CMS WEBSITE

Can a Recovery Audit Contractor (RAC) review a claim more than once?

The RAC can review a claim either through automated or complex review more than once. The exact claim line cannot be reviewed more than once but the RAC may review different claim lines in separate reviews. In addition, the RAC may conduct a DRG Validation review and then separately request documentation to complete a medical necessity review.

Who should providers contact with questions concerning RAC communications?

Providers should first attempt to contact the RAC through the customer service line. If that does not answer the provider’s questions and/or concerns, then the provider can contact CMS. CMS has set up a special email address for the provider community to use. It is CMS.RAC@cms.hhs.gov.

Can the RAC do a medical necessity review on a claim that they originally reviewed for DRG validation?

Beginning November 1, 2010 if the RAC has already requested documentation and issued a review results letter to the

provider for a DRG validation, the RAC will be allowed to re-review the claim again for medical necessity. However, if both issues are approved (DRG Validation and medical necessity) prior to the request of the additional documentation, the RAC may also conduct both reviews simultaneously. Each additional documentation request (ADR) is subject to the same review timeframes and counts toward the provider’s ADR limit.

To view all of the RAC FAQs on the CMS website click [here](#).