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Physician Advisor Services

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Timing of Orders

Timing of orders is a subject that generates a great deal of discussion and its importance in regards to level of care determinations cannot be overemphasized. So much is dependent on the time that the physician order is recorded in the medical record. And, since the issue defined as "Inpatient Admission without the Physician's Inpatient Admit Order" has been added to the list of CMS approved issues for RAC audit, one can assume that timing is not the only "order" concern that hospitals have. Therefore, one can assume that RACs will be paying close attention to the timing.

In the Conditions of Participation 42 CFR Part 482, it states "...all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or other practitioner who is responsible for the care the patient as specified under 482.12 and authorized to write orders by hospital policy in accordance with state law." Plus, the interpretation of other CMS guidance is that an inpatient admission begins only after the order is given (written or verbal). So, the ramifications of untimely orders can be great for the hospital and the patient. For example, the loss of time that counts towards a three day qualifying stay can result from orders not being recorded in a timely manner. Also, it can alter MS-DRG 273 transfer payment totals (SNF, Inpatient Rehab, Home Health, Inpatient Psych, etc.)

There is no option for backdating orders which some hospitals in the past have considered "correcting an error."

Marc Harstein, Deputy Director of the Hospital & Ambulatory Policy Group addressed whether hospitals can make an order retroactive to the beginning of the stay by stating in a CMS Open Forum the following:

"We attempted to clarify our position regarding back dating an inpatient admission order that was not entered timely in the medical record. We were asked whether it would be appropriate to add or alter medical records to clarify confusing orders or to create missing orders. We indicated it is impermissible to back date or retroactively create an admission order. Such actions would conflict with Medicare regulations and were not allowed. We are again going to reiterate that backdating or retroactively editing admission orders to add missing data or alter confusing orders is never permissible under Medicare."

In conclusion, the physician's order in the medical record is the all important trigger that must be in place to meet CMS criteria for the appropriate level of care. It is important to have processes in place that support timely orders. A strong physician advisor program can help you meet your goals of compliance with the CMS regulations and guidance.

The link to the Proposed Rule:

http://www.ofr.gov/OFRUpload/OFRData/2011-09644_PI.pdf

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)

CMS Proposed IPPS Changes for 2012

The CMS proposed changes to the Inpatient Prospective Payment System (IPPS) were posted on April 19th and will be published in the Federal Register on May 5th. CMS will accept comments on the proposed rule after the Federal Register publication, until June 20, and will respond to them in a final rule to be issued by August 1.

For fiscal year 2012, the proposed rule makes limited changes to complications and comorbidities, however, proposes new MS-DRGs for excisional debridement. The change will revise the existing MS-DRGs 573-578 to include skin graft only procedures to account for cost differences between excisional debridement and skin graft procedures. This change may help hospitals whose reimbursement for skin graft procedures has been less due to the excisional debridement procedures being included in the same MS-DRGs. Coders will continue to face difficulty in interpreting documentation of excision, removal, debridement and excisional debridement. CMS did keep the excisional debridement procedures as operating room procedures rather than change them to non-operative procedures. With the coding issues and the difference in reimbursement between excisional debridement and skin graft procedures, hospitals should expect that RACs and other external reviewers will continue to scrutinize the billing practices around these MS-DRGs.

CMS also proposes a new condition to the current hospital-acquired conditions (HACs). Contrast-induced kidney injury is proposed to be subject to reduced payments provisions.

The proposed IPPS rule lays the groundwork for the Hospital Readmission Reduction Program that is mandated by the Patient Protection and Affordable Care Act (PPACA). In the CMS press release about the proposed rule it states, "research by the Medicare Payment Advisory Commission (MedPAC) and others show that as many as 1 in 3 Medicare patients who leave the hospital will be readmitted within 30 days of discharge, and that a large portion of these readmissions can be avoided through well-coordinated, high quality hospital care." The payment reduction program is to incentivize hospitals "to improve care coordination." Beginning in FY 2013, the payments will be reduced to hospitals that have excess readmissions for certain conditions. The proposed rule details measures for readmission rates for three conditions, acute myocardial infarction, heart failure and pneumonia. CMS is also proposing a methodology to calculate the excess readmission rates for the program. It is anticipated that future rules will add more conditions to be tracked. CMS proposes to use the National Quality Forum definition which defines a readmission "as occurring when a patient is discharged from the applicable hospital to a non-acute setting (for example, home health, skilled nursing, rehabilitation or home) and then is admitted to the same or another acute care hospital within a specified time period from the time of discharge from the index hospitalization. The time period specified for these measures is 30 days."

To view the entire proposed rule, click here.

RAC FAQs - Excerpts From CMS Website

If I receive a demand letter from a Recovery Audit Contractors (RAC) because a service didn't meet Medicare's medical necessity criteria for an inpatient level of service, can we re-bill all the services on an outpatient basis? Providers can re-bill for Inpatient Part B services, also known as ancillary services, but only for the services on the list in the Benefit Policy Manual. That list can be found in Ch. 6, Section 10: http://www.cms.hhs.gov/manuals/downloads/bp102c06.pdf. Rebilling for any service will only be allowed if all claim processing rules and claim timeliness rules are met. There are no exceptions to the rules in the national program. Normal timely filing rules can be found in the Claims Processing Manual, Chapter 1, Section 70: http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

Will providers be required to submit a UB-92 with medical records to the RACs? The decision to request a UB-92 will be up to the individual RAC. If this information is needed it will be notated on the medical record request letter.

Will the RAC appeal process mirror the regular Medicare appeal process? The Medicare Appeals process will remain the same for physicians under Part B and A non-inpatient claims. The only difference under Part A is for the inpatient hospital claims under the Prospective Payment System. In the current appeals process, the first level will go to the Quality Improvement Organization (QIO); however, the RAC appeals will to the Fiscal Intermediary that processed the claim.

To view all of the CMS RAC FAQs, click here.