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AUDITING MANAGED CARE CONTRACTS

As providers are faced with increasing pressure to their bottoms lines, the importance of both generating and protecting existing revenue is paramount. With Medicare and Medicaid at fixed rates, that leaves managed care contracts as the prime source for growing patient-generated revenue. With such tight margins, that means there's also a greater need to protect that growing revenue source. One tool that can be used to protect revenue emanating from managed care payers is the audit. Audits are internal checks on payments from payers. Providers are checking actual versus expected payments from commercial payers.

Providers can benefit greatly from checking up on their payers, especially as managed care contracts have become increasingly complex, leaving plenty of room for differences in

interpretation and outright errors. Providers use audits as a way to ensure that they're getting paid the correct amount according to their managed care contracts. Basically, the burden falls on providers to make sure that they are paid correctly.

Providers should conduct monthly audits on their managed care contracts. Also it is important to conduct these audits in a timely fashion because generally a managed care contract will include a time period for how long a claim can be under review before it is considered paid in full.

There should be a concentration on high-cost areas that are normally prone to payment errors or differences in interpretations of the contractual terms such as cardiology, orthopedics, neurosurgery, pediatrics, outpatient surgery, the



emergency room, and behavioral health. Such areas have outliers that can be the source of confusion, resulting in underpayments or denials.

**QUOTE OF THE
MONTH**

Progress is impossible without change, and those who cannot change their minds cannot change anything.

George Bernard Shaw



From All of us at American Healthcare Audit professionals, Wishing You a Very Happy and Prosperous New Year...

OUTPATIENT & INPATIENT

Medicare patients increasingly fall into a "medical necessity" gray area between inpatient admission and observation/outpatient designation.

Often, however, and much to the chagrin of hospital providers, this becomes more of a payer/contractual status designation than a clinical choice. The clinical determination of "medical necessity" as decided by attending physicians frequently tends to fall to established criteria, which appears to ignore contractual or regulatory implications regarding the designation and frequently leads to requests for more specific documentation from hospital

staff (such as coders or HIM). This poses an increasingly high-risk area under current regulatory expectations because RACs have let it be known that this is a significant focus for them. And, to make matters worse, they aren't the only ones focused on it. Others are watching you, too.

Late in 2008, CMS changed designations for certain inpatient procedures to outpatient, a move that carries significant reimbursement implications for hospitals and physicians. Such procedures, for example, include certain cardiac procedures, such as Post Cardiac Implant (PCI), which previously have been

considered to be appropriate for inpatient admission but now are considered to be safely managed in an outpatient setting. The driving force behind the CMS decision to change these designations is certainly economics. However, proper patient risk screening is (and always was) necessary to identify patients whose conditions (i.e., their 'medical necessity') are appropriately cared for in the outpatient versus inpatient setting. Provider liability will continue to require accuracy in screening and adequacy of documentation to support the status and the resultant billing of the services.

Low-risk patients could and should be identified by provider prior to an elective, scheduled procedure and 'observed' over a 10-to-12 hour time period following it, then safely discharged. High-risk patients should be identified for inpatient care (inpatient designation) and must have complete and specific physician documentation in the record to that effect in order to be in a position to stand up to subsequent RAC (or any other regulatory agency) review and challenge.

Understanding the admission criteria and getting the assignment correct is the function of a physician

Continued on pg. 3— Outpatient & Inpatient..

DISRUPTIVE BEHAVIOR

Behavior problems between doctors and nurses were reported by more than 97% of the nurses and doctors who participated in an **American College of Physician Executives' survey**, which found that the most common complaints were degrading comments, yelling, cursing, inappropriate joking and refusing to work with one another.

The survey results paint a picture of "treachery and backstabbing" as doctors and nurses try to undermine each other, often right in front of bewildered patients, according to the ACPE. The organization e-mailed the survey to some 13,000 nurse

and physician executives, with roughly a 67% to 33% split between the two factions, and 1,428 nurses (67.2% of respondents) and 696 doctors (32.8%) responded between July 9 and Aug. 10, 2009. In addition to those mentioned above, other complaints included refusing to speak to each other, spreading malicious rumors, trying to get someone unjustly disciplined or fired, throwing objects and sexual harassment. Actual physical assaults, however, were reported by only 2.8% of the

respondents. When asked who most often exhibits behavior problems, 47.9% said it was an even mix; 45.4% said doctors; and 6.8% said nurses. Also, 61.2% reported having nurses terminated at their organization for behavior problems, while only 22.2% said the same of doctors.

Behavior problems arise several times a year, said 30.9% of the respondents, with 30% saying it happens weekly; 25.6% saying monthly; 9.5%, daily; 2.9%, once a year; and 1.2% saying less than once a year.

The most common complaint involved degrading comments or insults, with 85.5% (1,493) of the respondents reporting that this happened at their organization. Yelling was the next-most common, at 73.3% (1,294). A degrading comment highlighted in the survey was a physician telling a nurse: "You don't look dumber than my dog. Why can't you fetch what I need?"

By [Andis Robeznieks](#)

Modern Physician

TOP 10 NEW YEAR'S RESOLUTIONS

Every year we do it. Some folks are more serious about making their commitments. Some only make one, while others make multiple resolutions. Whichever route is taken, the economy is on the minds of most people in choosing their annual promise to themselves. The following is a list of this year's top 10:

1. Spend More Time with Family (and Friends)

More than 50% of Americans plan to appreciate loved ones and spend more time with their family and friends this year.

2. Getting in Shape

Most keep their commitment for a few weeks and then taper off. The main excuse for not getting in shape is

either no time, or bad weather.

3. Losing Weight

Over 2/3rds of adult Americans are considered overweight (or obese). The key to any commitment is to set reasonable goals, and make changes in your daily routine that will help in your efforts.

4. Get Out of Debt

5. Enjoying Life More

Along with reducing stress most folks feel that simply kicking back and taking a "one-day-at a time" attitude is a lot more satisfying.

6. Stop or Control Drinking

7. Quit Smoking!!!!

Statistically, an average smoker will quit at least 3

times before they quit for good. Then they jump on the "I wish everyone would quit" Bandwagon.

8. Getting Organized

Whether at home or in business, most people recognize that some portion of their daily life could be improved if they simply made it easier to find things, or made decision making easier.

9-10. The last two resolutions that Americans make each year are split between commitments to: "Learn a Hobby", "Volunteer to Help Others", "Learn a New Part Time Way to Make Money" and "Not make Resolutions They Can't Keep"!



OUTPATIENT & INPATIENT...CONTINUED FROM PAGE 2

To make a contractually appropriate assignment, this question must be asked and answered: do the patient and the conditions being treated, monitored or evaluated, and documented by the physician, serve to meet the inpatient criteria necessary to receive payment as an inpatient, or in fact, does the case seem to relate more to an observation stay or an outpatient visit?

As patients present to hospitals (elective or emergent), the decision on whether they should be given an inpatient, outpatient observation status needs to be clearly and accurately

determined.

A "short" prescription is to educate, educate, and educate some more. Plus a provider facility must insure that its processes for determining and documenting admission status are sound.

Admission status criteria either can be published and generally accepted medical standards (such as **InterQual** or **Milliman**) or **pre-established, hospital-specific standards**.

- Admitting physicians, either ED or Primary Care MDs, must identify in the record an order to place a patient into and discharge from observation or inpatient status. This must be stated

clearly and consistent criteria must be followed across the entire medical staff for the hospital.

- ED case managers or ED nursing staff can assist the physician with their determination of "medical necessity" for admission status, which of course means that they must be educated appropriately on the subject.

- There must be a supportive process in place for the physicians so that the hospital's and the physician's own billings for services can be accurate, consistent and supported in both the billing document and the medical record. By this we mean other staff must be available and willing to support the physicians. This process is not meant to be done in a vacuum - physicians should not have to memorize these criteria, as this is in no way a component of their medical judgment. Staff is the logical choice to support them in this area.

Admitting physicians, either ED or Primary Care MDs, must identify in the record an order to place a patient into and discharge from observation or inpatient status. This must be stated clearly and consistent criteria must be followed across the entire medical staff for the hospital.

www.AHAPInc.com

**AMERICAN HEALTHCARE
AUDIT PROFESSIONALS**

27068 La Paz Road, Suite 316

Aliso Viejo, CA 92656

Phone #: (949)-448-8296

Fax #: (949)-203-2298

E-mail: info@ahapinc.com

Web: www.AHAPInc.com



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MAKING A DIFFERENCE WHERE IT COUNTS...

EHR USE IN UNITED STATES

Doctors in the United States and Canada lag behind several other countries in the use of electronic health records (EHRs), according to responses of 10,000 physicians in 11 countries queried for the 2009 Commonwealth Fund International Health Policy Survey, the results of which recently were published online in the journal *Health Affairs*.

Forty-six percent of doctors in the United States and 37 percent of physicians in Canada use EHRs, compared with 99 percent in the Netherlands, 97 percent in New Zealand and Norway, 96 percent in the United Kingdom, 95 percent in Australia, and 94 percent in Italy and Sweden. The rate of EHR use was 72 percent in

Germany and 68 percent in France.

In addition to basic EHRs, the 2009 survey asked about a range of 14 possible computer functions, including electronic medication prescribing and alerts for medication errors, ordering lab tests and viewing test results, and support and prompts for preventive care and follow-up care with patients. Countries with one half or more of participating physicians reporting the use of at least nine of the 14 functions included New Zealand (92 percent), Australia (91 percent), the United Kingdom (89 percent), Italy (66 percent), and the Netherlands (54 percent). The rate was 36 percent in Germany. Countries with about one-fourth or less of participating doctors using at

least nine of the 14 functions were the United States (26 percent), Norway (19 percent), France (15 percent), and Canada (14 percent).

In the United States, advanced information capacity was concentrated in larger group practices and those affiliated with integrated care systems. In contrast, in the seven countries with near universal use of EHRs, there was little or no difference in advanced health information technology use by practice size. The authors noted that in these countries, national policies and standards have supported wide adoption of information technology in primary care practices.

By: [Ron RajECKi](#)
Medical Economics

