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Observation Rates, Self-denials Increase for Commercial Cases

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The current reimbursement landscape has been nothing short of a daunting challenge for hospitals. Intense scrutiny by Medicare Recovery Auditors (RACs) and Medicare Administrative Contractors (MACs) on admission status assignment (i.e., inpatient versus outpatient/observation) has prompted providers to invest significant time and resources strengthening their utilization review (UR) processes.

The ripple effect that admission status determination causes introduces a whole new set of questions to be answered: What are the financial implications of these trends? How can providers offset the reimbursement reduction from Medicare and Medicaid to remain viable? How can the utilization management challenges in the commercial payer market be addressed?

Recent Medicare Changes

Although the 2016 Inpatient Prospective Payment System (IPPS) Final Rule did not have any significant changes, ironically the 2016 Outpatient Prospective Payment System (OPPS) rule, some may argue, went back to the future in terms of opening the door for reimbursement on zero- and one-midnight inpatient cases – as long as there is proper physician documentation of the medical necessity. Documentation will be the key moving forward.

The Centers for Medicare & Medicaid Services (CMS) also has enhanced the Ambulatory Payment Classifications (APCs), which was a bit of a blessing and a curse. Although there was an increase in the APC payment, the number of separate line items actually decreased. This means that the total payment for most facilities, even though the number of APCs went up, probably went down.

CMS Transmittal 3238 (an update of the hospital OPPS) was a big help from an inpatient-only procedure perspective in providing a little leeway to ensure that, for appropriate procedures, the correct status is being determined. Previously, the CMS policy denied inpatient-only procedures billed in an outpatient setting. Now, hospitals are no longer required to secure an inpatient

admission order from the physician prior to performing a procedure listed as “inpatient-only” (but it is still best practice to do so).

CMS Transmittal 138 was a big shot across the bow for critical access hospitals (CAHs), which are now being “invited to the party” and expected to employ the same type of clinical criteria for outpatient verses inpatient status assignment for all patients. The primary driver behind this, from my view, is that some of the CAHs are subject to more gaming due to the 96-hour rule.

When the audits do start up, CMS Transmittal 585 has the potential to catch a lot of hospitals off guard. Through Transmittal 585, MACs, Supplemental Medical Review Contractors (SMRCs), Comprehensive Error Rate Testing (CERT) contractors, Zone Program Integrity Contractors (ZPICs), and RACs can up-code or down-code claims and adjust provider payments accordingly when the medical record supports such a change.

After reviewing the list of recent regulatory updates, it becomes pretty clear why hospitals focus on Medicare compliance. In most hospitals, Medicare cases make up the clear majority of case reviews. This, in turn, brings about the need for some hospitals to retain an on-site physician advisor(s) to review cases, while other hospitals may solicit external compliance support to handle the case workload. Internal or external support depends heavily on a hospital’s time, budget, and resources.

As the number of case reviews increases, so do the number of denials. Whereas previously a Medicare denials management team handled these denials, now a dedicated RAC coordinator working on-site is the standard, not the exception. In the end, hospitals find themselves maintaining the financial reserves needed to support Medicare reviews and denials as a means to justify the dollars they could get back.

With all this going on in a hospital, it’s easy to see how commercial cases can be all but forgotten.

Taking a Back Seat

Limited staffing and resources are definitely leading factors in commercial case reviews receiving secondary status, since:

- Often a secondary or tertiary utilization review is not a priority;
- Commercial cases are only occasionally screened with admission criteria; and
- Commercial cases are rarely reviewed by a physician advisor.

To alleviate this, one possible solution would allow the payer to provide an on-site reviewer to handle these cases, but this option might not be ideal. It could be helpful, given that the payer would cover the salary of the on-site reviewer, but it could be problematic; a payer employee

(and not a hospital employee) may not go the extra mile to find documentation to support the appropriate status.

Other factors that place commercial reviews on the backburner include:

- Primary, and sometimes exclusive, case management focus on Medicare FFS reviews
- Multiplicity of plans, contracts, and utilization management (UM) requirements, which create operational confusion on the front lines
- Attending physicians of limited help due to unaligned reimbursement incentives and lack of UM knowledge
- Concurrent payer UM creating confrontation, persuasion, and influence of the patient status and billing

The payers have significant resources in the way of physicians, nurses, and coders that are scrutinizing commercial cases and ensuring that the cases that do not have sufficient information and clear documentation do not get paid. Proper documentation holds the key for reimbursement in commercial cases.

And This Can Lead to …

So, what's the impact when the primary focus is on Medicare and a secondary (or even tertiary) focus is on commercial cases? Observation rates, as well as self-denials, increase for commercial cases.

But an even longer-term and possibly more detrimental effect this shift in case priorities can have centers on the mindset of the case management staff itself. When case managers are continually faced with denials or lack of case overturns, it is not surprising that apathy can take over and an observation determination by the commercial payer can win out over inpatient assignment, even if the inpatient determination was appropriate.

About the Author

Dr. Ralph Wuebker serves as chief medical officer of Executive Health Resources (EHR). In this role, Dr. Wuebker provides clinical leadership within EHR and works closely with hospital leaders to ensure strong utilization review and compliance programs. Additionally, Dr. Wuebker oversees EHR's Audit, Compliance and Education (ACE) physician team, which is focused on providing on-site education for physicians, case managers, and hospital administrative personnel and on helping hospitals identify potential compliance vulnerabilities through ongoing internal audit.