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Using Physician Advisors to Gain Access to Risk Prediction and Stratification Models to Improve Compliance and Secure Appropriate Reimbursement

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Hospitals have to decide how to appropriately classify patients in compliance with rules and regulations to secure proper reimbursement. Classification is challenging because of the constantly changing regulatory environment, including the evolving "Two-Midnight" rule. Classification errors can have costly consequences. If hospitals misclassify a patient's level of care status they may miss significant compliant revenue and may be at risk for subsequent denials. Because of these challenges and consequences, physician advisory teams and risk stratification tools have become valuable resources for helping hospitals maintain compliance and protect revenues.

Adreima's physician advisory team plays an important role in helping hospital partners improve compliance and secure appropriate reimbursement. Utilizing risk stratification tools, such as those developed by the American College of Cardiology and implemented through Health Outcomes Sciences (HOS), physician advisors appropriately identify instances when a patient's clinical presentation, comorbidities and/or risk of complications may dictate and support an inpatient admission.

The Two-Midnight rule has raised the challenges and consequences of correctly classifying patients. CMS has recognized the difficulties the Two-Midnight rule has caused and is attempting to clarify guidelines for hospitals in its new proposed rule, the 2016 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System.[i] The proposed rule reads in part:

> *…for stays for which the physician expects the patient to need less than 2 midnights of hospital care and the procedure is not on the inpatient only list or on the national exception list, an inpatient admission would be payable on a case-by-case basis under Medicare Part A in those circumstances under which the physician determines that an inpatient stay is warranted and the documentation in the medical record supports that an inpatient admission is necessary.*

This proposed rule places the clinical decision for admissions back in the hands of the physician. Factors that support the decision, such as medical history and comorbidities, severity of signs and symptoms, current medical needs and the risk of an adverse medical event occurring, must be clearly documented in the medical records. Thus models that help predict risk of life-threatening complications and/or mortality are essential to support the clinical decision process for admission

status. In fact, these models accurately integrate numerous patient characteristics into an evidence-based risk estimate that can be used as the foundation for tailoring treatments and admissions to a patient's personalized risk.

Determining Appropriate Admission Status

The patient's admission status plays an important role in a hospital's compliance. It also plays an important role in hospital finances, because the hospital's reimbursement varies depending on the billing status. For example, the average Medicare reimbursement for short inpatient stays ($5,142) was nearly three times higher than the average reimbursement for observation stays ($1,741) in 2012.[ii]

Many hospitals experienced declining admissions after the Two-Midnight rule was proposed. For example, admissions declined an average of 1.4 percent across 13 large hospital systems in the third quarter of 2014 according to a Modern Healthcare analysis of American Hospital Association data.[iii] The Cleveland Clinic Health System reported a 3.3 percent decline in admissions for its 11-hospital network that quarter, meanwhile its outpatient observations increased 14.1 percent during the same period.[iv]

The Two-Midnight rule imposed in 2013 has been identified as one of the principal drivers behind the subsequent trend in declining hospital admissions, because the acuity of the patient's condition, the patient demographics, the plan of care requiring hospitalization and similar clinical factors were probably relatively consistent over the period of comparison. These data appear to indicate that hospitals, when faced with the need to accurately classify patients as requiring inpatient admission versus an outpatient observation stay, disproportionately favored observation despite the lower reimbursement. The current environment of audits and potential penalties likely also played a role in classification decisions.

The upside to the recent proposed regulatory change in the Two-Midnight rule is that it restores physicians, and physician advisors knowledgeable in regulatory requirements, to the primary role in the decision to admit their patients. Once again, the appropriate alignment of responsibility and authority to make a fundamentally clinical decision that is based on medical judgment, not the clock, is back where it belongs – with the physician. Hospitals can support physicians by giving them convenient access to decision support tools, care standards and relevant medical literature.

Hospitals will continue to be audited by several different organizations to ensure that every Medicare-paid service meets CMS' medical necessity criteria. Under the 2016 proposed rule, Quality Improvement Organizations (QIOs) will provide oversight of short inpatient stays, while Recovery Audit Contractors (RACs) will focus on providers with high denial rates referred by the QIOs. To protect revenue and guarantee regulatory compliance, it is critical that clinical documentation in the chart supports the medical necessity of the services being rendered.

Supporting Medical Judgment with Better Information Access

The QIO should review the inpatient admissions on a case-by-case basis to determine whether the admission was medically necessary. According to the Medicare Benefit Policy Manual Chapter 1 Section 10:

> *QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g. test results) which becomes available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.*

In addition, the Health Care Financing Administration Rulings 95-1-30 Section V states:

> *Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical*

community, rely on published medical literature, a consensus of expert medical opinion, and consultants with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association."

Both these regulations demand that physicians use appropriate medical judgment, based on their knowledge of medical literature and standards of practice, to determine the admission decision, which would then be payable under Medicare Part A.

Adreima's physician advisors can help hospitals and healthcare organizations ensure compliance, accurate reimbursement and quality patient care. Our team of physicians and physician advisors can help ensure that the necessary detailed clinical documentation is in the medical record to support the appropriate level of care. Adreima also possesses key knowledge of the evidence-based medical literature to quantify the patient's risk of adverse outcomes or mortality based on his or her clinical presentation. Finally, we have access to an array of proprietary clinical decision-support risk prediction and stratification models that can support the clinical decision in precise, quantitative terms.

Risk Prediction and Stratification Models

Since clinical decision-support tools can help physicians make accurate and timely recommendations at the point of care, Adreima has partnered with Health Outcomes Sciences (HOS) to leverage an array of seasoned risk prediction models. Here is an example of how this collaboration and the intelligent application of risk stratification tools can reduce non-compliance risk and protect revenue for hospitals.

Improving compliance and thus securing appropriate reimbursement for interventional cardiac procedures is particularly critical under the new proposed rules. Patients undergoing these procedures are often age 65 or older, have multiple comorbid conditions, and are at risk for major bleeding, nephropathy, arrhythmia, myocardial infarction, stroke and even mortality.

HOS created a bleeding risk stratification tool for post percutaneous coronary intervention (PCI). The tool was developed from the National Cardiovascular Registry (NCDR) Cath/PCI Registry and is based on 1,043,759 PCI procedures at 1,142 U.S. centers. HOS has also developed models that predict mortality or complication risks based on pre-procedural, angiographic or other evidence-defined factors.

A study based on the HOS PCI risk stratification tool found that 4.12 percent patients at high risk for post-PCI bleeding experience an incident of major bleeding, and that their in-hospital mortality rates are more than 30 times higher than low-risk patients.[v] In addition to higher short- and long-term mortality, post-procedural bleeding is associated with nonfatal myocardial infarction, stroke, blood transfusion, prolonged hospital stays and re-hospitalization.

Therefore using the correct level of care status classification is especially critical for carefully managing risk and securing the appropriate reimbursement for PCI procedures. A scheduled PCI in a young, healthy individual may well be appropriate for outpatient reimbursement, but a PCI in an elderly female with advanced cardiac disease and impaired renal function is probably appropriate for inpatient admission and reimbursement, because of the increased risk of major bleeding within 72 hours post procedure.

Adreima's physician advisors leverage their access to data from the PCI and other HOS risk stratification tools, along with their knowledge of medical literature to provide a compliant, evidence-based, level-of-care

recommendation. We consider the patient's medical history and comorbidities, severity of signs and symptoms, current medical needs and the risk of an adverse event occurring based on published medical literature to determine if an inpatient admission will be warranted. Adreima's physician advisors also ensure that appropriate supporting clinical documentation is in the medical record to justify that an inpatient admission would be payable under Part A and to increase defensibility if there is a retrospective denial.

Having the data and documentation to support PCI decisions is essential. PCIs are high-cost, high-reimbursement procedures. The national average 2015 Medicare outpatient hospital payment for coronary angioplasty was $4,537, while the national average inpatient hospital payment for percutaneous cardiovascular procedure without stent was approximately $11,900 without MCC and $17,500 with MCC.[vi] Therefore the difference in reimbursement for the inpatient admission compared to a monitored outpatient falls between $7,400 and $13,000 per case.

Conclusion

Clinical judgment and accurate documentation by physicians and physician advisors will be increasingly important to hospitals as they seek to secure appropriate reimbursement and enhance compliance. Because hospitals are experiencing a decline in admissions, and patients are being asked to pay a greater share of their hospital bill when classified as observation, hospitals need to closely manage their revenue flow by ensuring the patient status is assigned correctly.

Implementing a second-level physician advisory program that includes access to proprietary risk prediction models will help hospitals better manage care status for patients. Adreima's teams have expertise in understanding the elements in the patient's clinical presentation, comorbidities and adverse outcomes risks that need to be present and documented to justify an inpatient admission on a case-by-case basis. Applying quantitative risk estimates specific to the individual patient derived from evidence-based clinical risk prediction models helps secure appropriate reimbursement in compliance with federal rules and regulations. ■

References:

i The complete rule and more information about it are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-P.html.

ii Department of Health and Human Services Office of Inspector General memorandum report "Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, OEI-02-12-00040" July 29, 2013.

iii *Modern Healthcare* "Hospital Admissions Still Declining" December 31, 2014.

iv Ibid

v Adnan K. Chhatriwalla, MD; Amit P. Amin, MD; Kevin F. Kennedy, MS; John A. House, MS; David J. Cohen, MD, MSc; Sunil V. Rao, MD; John C. Messenger, MD; Steven P. Marso, MD ; for the National Cardiovascular Data Registry "Association Between Bleeding Events and In-hospital Mortality After Percutaneous Coronary Intervention" JAMA. 2013;309(10):1022-1029. doi:10.1001/jama.2013.1556.

vi Boston Scientific Reimbursement Guide.

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