

## **Billing Error Reduction Project: A Hospital Payment Monitoring Program Special Study**

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The Colorado Foundation for Medical Care (CFMC) is the Quality Improvement Organization (QIO) for Colorado. During July 2006 through October 2007, Christina Martinez, RHIT, Review Services Manager at CFMC, led a project funded by the Centers for Medicare and Medicaid Services (CMS) as a component of the Hospital Payment Monitoring Program (HPMP) to reduce the “outpatient billed as inpatient” billing error rate by 50%. The project was identified by analyzing HPMP error data from Colorado’s one-day stay Medicare discharges from July 2002 through June 2005. Billing errors were identified as having the largest dollar impact with \$171,036 in overpayments for the three-year period. The single largest category contributing to the billing error rate was “outpatient billed as inpatient.”

For the five participating hospitals’ one-day stays, we estimated that approximately 9% have an “outpatient billed as inpatient” billing error with an average of approximately \$5,600 per error. These five hospitals had approximately 3,500 one-day stay Medicare discharges per year. Extrapolating the 9% and \$5,600 per error to this total suggested approximately 315 (3,500 \* 9%) “outpatient billed as inpatient” one-day stay billing errors existed for a total of \$1,764,000 (315 errors \* \$5,600/error). A 50% reduction in the failure rate was expected to prevent approximately 158 “outpatient billed as inpatient” billing errors for a total saving of \$882,000 per year (\$73,500 per month).

CFMC collaborated with five participating Colorado hospitals to investigate the problem and to implement solutions to reduce each hospital’s “outpatient billed as inpatient” billing error rate by one-half. A sample size of up to 105 one-day stay Medicare discharges from each of the five hospitals from fourth quarter 2005 were abstracted for baseline measurements. The initial findings were analyzed and presented to each participating hospital. Hospitals responded with appropriate interventions. After the implementation of improvements, up to 105 Medicare one-day stay discharges from each of the five hospitals from December 2006, January and February 2007 were abstracted to provide a post-intervention remeasurement.

### **Lessons Learned: Evaluate Your Hospital’s Performance**

Among the five hospitals, patterns became obvious that likely exist at other hospitals. A review of these patterns can assist any hospital in evaluating its own procedures to reduce its billing error rate.

- **There was not always awareness of hospitals billing Medicare observation accounts as inpatient accounts, thereby receiving overpayments. Solution:** Raise awareness at your hospital that this is another variant source of potential overpayment, and as such, is subject to the CMS fraud and abuse campaign. Any hospital that thinks no such problem exists at its facility might do well to copy the methodology of the CFMC project by pulling one-day stays that were billed as inpatients, reviewing the orders, and ascertaining if the physician orders were for inpatient or for observation.
- **Forms were often poorly designed.** The most successful forms included a clear preprinted checkbox choice such as “Admit to: [ ] inpatient status [ ] observation status.” Some hospitals had no such forms, so that physicians wrote orders freehand, and inconsistently from physician to physician. Some forms had checkboxes, but the print was too small and crowded, confusing to fill out and to read. One computerized physician order entry (CPOE) printout did not indicate inpatient or observation status, and simply printed “admit” for both inpatient and observation accounts. **Solution:** Review the admission order forms at your hospital, including emergency department (ED) order forms, attending physician order forms, specialized order forms (such as for telemetry, the critical care unit, or same-day surgery), and CPOE choices and printouts. Redesign them to include clear checkbox choices that differentiate “inpatient” from “observation.”
- **Checkbox forms existed but were not used.** This happened a surprising number of times. **Solution:** Educate physicians (including ED physicians, attending physicians, residents and interns) about the importance of the issue and how consistent use of the checkbox forms can help solve the problem.

- **Orders were clear in the record but not transmitted to or acted upon by registration.** This occurred at multiple hospitals: a clear order for observation existed in the record but the account was nonetheless registered as inpatient. **Solution:** Evaluate the flow of communication between the writing of the order and the entry of the registration status into the hospital information system. Do this for both initial orders and for changes in admission status that might be ordered sometime after the initial orders.
- **There was a lack of understanding of the correct rules.** Hospital personnel sometimes struggled with the interpretation of the rules affecting admission status orders and medical necessity. **Solution:** See Table 1 for the basic rules. Contact your QIO and/or fiscal intermediary (FI) for clarification.
- **There was inadequate staffing to concurrently monitor the appropriate admission status.** Some hospitals did not monitor this issue at all; one hospital that experienced a layoff demonstrated deterioration of compliance as a result. Special areas needing attention: EDs, where admit decisions are made 24 hours a day and where emergent situations can lead to confusion and lapses in documentation, and orders by infrequent admitters, who may not be familiar with the rules. **Solution:** Provide sufficient staffing to concurrently monitor this function. Medical necessity and appropriate assignment of patient status should be established upon admission, or at the very least while the patient is still in-house.
- **There was inadequate post-discharge back-up monitoring.** Although admission order status cannot be changed retroactively after discharge, it is permitted and necessary to change registration status after discharge to match the actual orders in the chart. Some hospitals used case managers or HIM coders for post-discharge review. **Solution:** Establish a back-up system to catch and correct errors prior to billing.
- **Not all hospitals permitted ED physicians to write admission orders.** An ED order is valid for the duration of the stay in the absence of a different order by the attending physician. Permitting ED physicians to write initial admit orders provides back-up in the event attending physicians neglect to do so. **Solution:** Consider requesting a change in your hospital's Medical Staff Rules and Regulations if the hospital does not permit ED physicians to write initial admit orders.
- **There was sometimes confusion between the issue of medical necessity and the issue of valid admission orders.** Example: an account was ordered as observation, but registered as inpatient. Upon post-discharge review, the case manager determined that medical necessity for inpatient was met and erroneously permitted the account to be billed as inpatient, even though the actual order was for observation. **Solution:** Do not confuse these two issues. The status of the account must be whatever the physician orders it to be, not what the case manager thinks it should be, and may only be changed by physician order while the patient is still in-house.

## Project Results

A key indicator and performance goal for the project was the percentage of records with an “outpatient billed as inpatient” billing error. These were records that carried physician orders for observation status, but were registered, billed and paid as inpatient accounts, resulting in overpayment to hospitals. One goal of the project was to reduce this error rate by 50%. The project handsomely exceeded expectations (see Table 2), with a combined 63.63% reduction in the billing error rate for this billing error category at the five participating hospitals. Interestingly, one hospital with an initial low error rate increased the error rate upon remeasurement. This was attributed to a reduction in force, which had resulted in the loss of a case manager and the inability to concurrently monitor inpatient records properly. Among other results of this project, the hospital in question was persuaded by these outcomes data to re-staff case management to a level that permitted necessary monitoring.

The results of this project suggested that the QIO working with hospitals accomplished a significant reduction in the “outpatient billed as inpatient” billing errors and the dollars associated with these billing errors. Four of the five hospitals reduced their “outpatient billed as inpatient” billing error rate from baseline to remeasurement (see Table 2). The total dollars in error at baseline was \$195,031, for a weighted average of \$285 per record. At remeasurement, the total dollars in error were \$87,086 (weighted average of \$155). This resulted in a savings of \$73,369 for the remeasurement period.

## HIM Involvement in Status Orders

Coding delays associated with post-discharge case management review and status changes drive up accounts receivable (AR). Coders may be asked to review and flag status orders at the time of coding. Account status determines whether the account is coded as inpatient or outpatient. Educate HIM managers and coders to understand the rules for status orders to ensure effective collaboration with case management, registration, and billing.

### Resources

National Uniform Billing Committee (NUBC). *Official UB-04 Data Specifications Manual 2008*, Version 2.00 effective July 2007, Condition Codes, page 59.

Centers for Medicare and Medicaid Services (CMS). *Medicare Claims Processing Manual*, Chapter 1, Section 50.3, "When an Inpatient Admission May be Changed to Outpatient Status."

Centers for Medicare and Medicaid Services (CMS). Transmittal 299 (Change Request 3444), September 10, 2004, "Use of Condition Code 44, Inpatient Admission Changed to Outpatient." The accompanying MedLearn Matters Number is SE0622, and includes substantial additional information and references.

Conditions of Participation for Hospitals, 42 CFR §482.

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Table 1 (to go in a separate box from the main content of the article)

### Rules for Admission Status Orders

- **It is never permitted to retroactively change the admission status of the account after the patient has been discharged.** The case manager may review an account after discharge and wish to change the status of the account, but it is not permitted to ask the physician to write a retroactive order to change the case to a different status. If the account was originally ordered as inpatient, but is found after discharge to not meet medical necessity, then the hospital may only bill for covered Part B services, and no Part A services. If the account was originally ordered as outpatient, but is found after discharge to meet medical necessity for inpatient status, then the hospital must bill the account as outpatient.
- **Inpatient to Outpatient, while the patient is still in-house.** A case is ordered as inpatient, but found during the stay to not meet medical necessity for inpatient status. The physician may write an order while the patient is still in-house changing the status to outpatient as of the date of admission. The outpatient claim must append condition code 44, "Inpatient Admission Changed to Outpatient."
- **Outpatient to Inpatient, while the patient is still in-house.** Admission status may be upgraded to inpatient anytime the patient's condition changes to meet inpatient criteria. The physician may write an order to inpatient status while the patient is still in-house, effective at the time the order is written.

- **Outpatient to Inpatient, on a retroactive basis, while the patient is still in-house.** The physician orders admission to outpatient status. At a later date, but while the patient is still in-house, it is established that the case met medical necessity upon admission, and the physician changes the admission status to inpatient retroactive to the original date of admission. There are conflicting guidelines from CMS whether this is permissible. CFMC has requested clarification from CMS. Pending resolution, contact your QIO for advice.
- **An initial admission order by the ED physician is valid for the duration of the stay unless the attending physician changes it.**
- **It is permissible and necessary to change the account status in the registration system to match the order on the chart at any time, including after discharge.** This is deemed a clerical error, not a physician order error, and so may be corrected anytime prior to claims submission.
- **An unqualified “admit” is presumed by default to be inpatient status.** Examples: “admit,” “admit to Dr. X,” “admit to the xth floor” or “admit to the ICU” are all presumed to be inpatient status. However, it is good practice to make pre-printed order forms and freehand orders clear by fully describing “admit to inpatient status” or “admit to observation status.” This point may be interpreted differently by different QIOs. Contact your QIO for advice.

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Table 2 (to go in a separate box from the main content of the article)

**Percent of Records with an “Outpatient Billed as Inpatient” Billing Error**

	<b>Baseline (Fourth Quarter 2005)</b>	<b>Remeasurement (December 2006, January and February 2007)</b>	<b>Percent Reduction of Error Rate</b>
<b>OVERALL</b>	<b>8.77%</b>	<b>3.19%</b>	<b>63.63%</b>
Hospital A	16.53%	7.78%	53%
Hospital B	10.07%	0%	100%
Hospital C	3.92%	1.32%	66%
Hospital D	0.98%	0%	100%
Hospital E	2.35%	6.51%	-177%

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