MEMORANDUM

TO: Deborah A. McGrew  
Vice President and Chief Operating Officer, UTMB Health System

FROM: Kimberly K. Hagara, CPA, CIA, CISA, CRMA  
Associate Vice President, Audit Services

DATE: November 14, 2013

SUBJECT: Care Management - Observation Services Operational Review  
Audit Control Number 2013-008

Attached is the final audit report regarding the Care Management - Observation Services Operational Review. This audit will be presented at the next Institutional Audit Committee meeting.

Additionally, please find attached Audit Services audit recommendation follow up policy. Each of the recommendations is classified by type at the end of its identifying number: Significant (S), Risk Mitigation (R), or Process Improvement (P). As you will note in the policy, the classification of the recommendation determines the frequency of our follow up. All follow up results are reported quarterly to the Institutional Audit Committee.

Thank you for your cooperation and assistance during the course of this review. If you have any questions or comments regarding the audit or the follow-up process, please feel free to contact me at (409) 747-3277.

Attachments

c: Donna K. Sollenberger  
David R. Marshall  
Jennifer K. Zirkle
The University of Texas Medical Branch
Audit Services

Audit Report
Care Management - Observation Services Operational Review
Audit Control Number 2013-008
November 2013

The University of Texas Medical Branch
Audit Services
301 University Boulevard, Suite 4.100
Galveston, Texas 77555-0150
Care Management - Observation Services Operational Review
Audit Control Number: 2013-008

Background
The decision to admit a patient to the hospital involves complex medical judgment based primarily on the severity of illness and intensity of services needed to treat the patient’s condition. Patients may be admitted as either an inpatient or in observation status. Observation status or services are defined as hospital outpatient services that help support the physician’s decision to either transfer the patient to inpatient status or discharge him/her. Guidance published by the Centers for Medicare and Medicaid Services (CMS) indicates in the majority of cases, this decision can be made in less than 48 hours, usually in less than 24 hours. Clinical documentation in the patient’s health record must clearly support the medical necessity for placing a patient in either observation or inpatient status.

The University of Texas Medical Branch’s (UTMB Health’s) Care Management department, comprised of 14 Care Managers and 11 Social Workers, coordinates care for patients in the hospital and serves as a member of the interdisciplinary treatment team whose goal is to provide quality patient care in an efficient and effective manner. Care Managers utilize an evidence-based clinical decision support software system, InterQual, to assess the appropriateness of a patient’s admission, continued stay and discharge, working with the physician as needed to ensure their clinical documentation supports the patient’s course of care.

Observation and inpatient status classifications have financial implications for the hospital in terms of reimbursement from CMS, other third party payers, and patients. In 2010, CMS implemented a “recovery audit” program to identify improper payments to hospitals for observation and inpatient services. Audited payments subsequently denied result not only in repayment to CMS, but also expose the institution to possible fines and penalties.

Audit Objectives
The primary objective of this audit is to assess the adequacy and effectiveness of processes in place to classify and report observation services provided at UTMB Health’s John Sealy Hospital.

Scope of Work and Methodology
The scope of the review includes current Care Management operations relative to the provision of observation services for patients in UTMB Health’s John Sealy Hospital and excludes observation services provided at the Texas Department of Criminal Justice (TDCJ) Hospital. Our audit methodology included interviewing key departmental personnel, performing observations, and data analysis.

The audit was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing as promulgated by the Institute of Internal Auditors.

Audit Results
Training
A structured training and development program ensures that employees have consistent experience and background knowledge needed for their position. All employees need to be aware of the expectations and procedures within the department. Training within the Care
Care Management - Observation Services Operational Review
Audit Control Number: 2013-008

Management department consists of peer-to-peer training which may be modified depending on trainee's prior experience. Audit Services noted there is no formal documentation or training guidelines for Care Managers to ensure training is comprehensive and consistent among the trainers.

**Recommendation 2013-008-01-R:**
The Director of Care Management should create and implement formal, documented training guidelines to ensure new Care Managers receive comprehensive and consistent training during their onboarding and at appropriate ongoing intervals.

**Management’s Response:**
Recently the orientation process was formalized for the department. A Competency Based Orientation (CBO) tool for RN Care Manager and Social Worker was created. Additionally a 2 month calendar of orientation is scheduled and developed. Preceptors in the department are chosen based on their adaptability, performance and desire to train. Orientation is individualized for each staff member based on their past experiences. Each employee receives the same training but some may require more time with a preceptor. An iSpace reference manual is available for staff to access which contains resources, processes and procedures. Staff attends mandatory courses for Epic access, annual online and virtual interactive Interqual education. Monthly staff meetings, webinars and email communications inform staff regulatory, department and organizational changes. Director has explored options to ensure consistent application of Interqual and tools to ensure inter-rater reliability. The Interqual contract was up for renewal in November 2013. With the renewal of the contract the Interqual Inter-rater reliability module was added.

**Implementation Date:** Currently in-place, Interqual Inter-rate reliability module April 30, 2014

**Application of InterQual Criteria**
Care Managers use InterQual evidenced-based decision support software to assist with validating the appropriate level of acute care including admission as an inpatient or observation patient, continued stay and discharge. Leading care management practices note that although the criteria within the software are standardized, the application of the criteria may vary depending on the skill level and experience of the user. To help mitigate the risk of inconsistent criteria application, industry leaders recommend implementing processes to gauge inter-rater reliability among users.

Care Management leadership indicated InterQual’s current reporting functionality is limited to capturing the total number of reviews completed. For example, Care Managers completed 1908 reviews in May 2013 and 1894 reviews in June 2013; a patient may have multiple reviews during their course of stay in the hospital. Additional information that would assist with monitoring the accuracy and completeness of the Care Managers’ work is currently unavailable.
Care Management - Observation Services Operational Review
Audit Control Number: 2013-008

Recommendation 2013-008-02-R:
The Director of Care Management should develop and implement a quality assurance and monitoring process to help ensure the consistent application of InterQual criteria as well as identify and track other potential care management issues.

Management’s Response:
Director has explored options to ensure consistent application of Interqual and tools to ensure inter-rater reliability. The Interqual contract was up for renewal in November 2013. With the renewal of the contract the Interqual Inter-rater reliability module was added.

Implementation Date:   April 30, 2014

Monitoring Observation Status
For most patients, a decision regarding the plan of care can be made in less than 24 hours. However, in rare circumstances, patients may require up to 48 hours to determine the plan of care. It is the expectation of third party payers that UTMB Health ensures patients are in the correct status of observation or inpatient and any changes to status are made timely. Audit Services reviewed two Hours in Observation – Observation Patients reports which indicated the number of patients and their corresponding hours in observation status. Audit Services noted approximately 8-10% of the total patients in observation status were there greater than 48 hours.

Care Managers monitor patients in observation status and update Care Management leadership throughout the day on the events surrounding the need for continued observation status; however, they do not maintain summary documentation related to these events. Tracking and monitoring such information could assist in identifying quality and system improvement opportunities.

Recommendation 2013-008-03-R:
The Director of Care Management should create a formal tracking and monitoring process to ensure Care Managers are following up on patients in observation status greater than 23 hours and maintaining appropriate related documentation which could be used for identification of quality and system improvement opportunities.

Management’s Response:
With the recent CMS IPPS 2-Midnight Rule, the referral process to EHR has changed. CMS states for patients that are in the hospital less than 2 midnights should be in observation status, for patients that are in the hospital greater than 2 midnights, admission status is more appropriate. (the 23 hour guideline is no longer a benchmark) Each morning a list is distributed will all observation patients in house with current hours, this is monitored throughout the day by the Care Manager who is collaborating with the medical team regarding the plan of care. If it is determined the patient will be in the hospital greater than 2 midnights the CM will recommend changing to inpatient status. Additionally in the UR screens the CM is now able to track avoidable days or reasons for delays.
**Implementation Date:** Active, working on reporting ability (1/2/14).

**Physician Advisors**
Two Physician Advisors are available to the Care Managers to assist with questions or issues related to a patient’s status while in the hospital. This assistance can include reviewing clinical documentation and working with the attending physicians regarding billing and reimbursement rules and regulations. Interviews with the Physician Advisors and Care Management leadership indicated a need for additional training and guidance regarding the roles and responsibilities of the Physician Advisors.

**Recommendation 2013-008-04-R:**
The Director of Care Management, in consultation with the Hospital Administration leadership, should develop formal guidance related to the responsibilities of the Physician Advisors, the process for requesting Physician Advisor assistance and documenting and tracking to resolution those questions or concerns referred to the Physician Advisors.

**Management’s Response:**
The Physician Advisor/Medical Director role is growing and evolving. There are 2 Physician Advisors for the CM Department. Both attend the biweekly length of stay meeting. Patients that are in the hospital >7 days are discussed. A report sheet is used to communicate essential information. Each patient must have a plan of care; meet medical necessity and transition planning for the next level. If one of these elements is not defined, the Physician Advisor will offer guidance/recommendations or consult with physicians on the team to facilitate. Additionally the Physician Advisors round at separate times during the week with the Director, focusing on readmitted and unfunded patients. A data collection tool has been developed to track the type of interventions/actions done throughout the work day. This information will be analyzed and presented at weekly meetings with the Interim CMO.

**Implementation Date:** January 2, 2014

**Afterhours and Weekend Coverage**
Care Management schedules limited weekend Care Manager coverage to assist with emergent weekend Medicare discharges. Additionally, the Care Manager performs InterQual inpatient or observation status screening for Medicare patients presenting for acute care during this time period.

In addition to their admission, continued stay, and discharge screening and planning responsibilities, Care Managers transmit patient information to insurance companies for coverage determination. Many insurance companies require receipt of patient information within 24 hours of their request. Transmission of patient information to insurance companies
Care Management - Observation Services Operational Review  
Audit Control Number: 2013-008

does not occur after business hours or on weekends. By not transmitting the required  
information within the time frame required, the risk of denial of coverage increases requiring  
additional work to appeal and reverse the denial.

**Recommendation 2013-008-05-R:**
The Director of Care Management should ensure that there is adequate after hours and  
weekend coverage for sending required clinical information to commercial insurance  
payers timely to facilitate the avoidance of potential coverage denials due to lack of  
timely submission of information.

**Management’s Response:**
Some payors require clinical information be submitted within 24 hours of notification.  
The Care Management Department is exploring the following possibilities:
- Emergency Department- DSRIP project involving ED Case Management could cover this task on the weekend.
- Offer straight time for the core staff to work a few hours on weekends to cover  
this task.
- Epic enhancements (effective end of November) will allow staff to work from  
home with the ability to e-fax clinical information.
- Request adding additional FTE’s to meet the 24 hour notification timeframe.

**Implementation Date:** March 30, 2014

**Executive Health Resources (EHR) Consulting Services**
During FY 2013, UTMB Health experienced a significant increase in requests from CMS’s  
recovery audit contractors (RACs) for medical records involving Medicare claims paid for  
inpatient and observation services. Based on the initial results of these audits, UTMB Health  
contracted with Executive Health Resources (EHR) to appeal the denied claims on the  
institution’s behalf and establish a concurrent review process to ensure patients are placed in  
the appropriate admission status.

Case Management reviews all hospital admissions against InterQual inpatient criteria and those  
admissions not meeting inpatient criteria are referred to EHR for secondary review. The EHR  
clinical teams review the initial clinical data to provide a recommended patient admission  
status. During this process, if an admission status change is recommended, EHR works with the  
UTMB Health physician to ensure the appropriate admission status is achieved. Appropriate  
documentation is maintained in the medical record for all concurrent reviews and any changes  
in admission status.

During the period July 25, 2013 through October 2, 2013, Case Management referred 388 cases  
to EHR. While Care Management does have access to a report indicating the number of referred  
cases, it has not established a process for monitoring the resolution of the referred cases.  
Understanding the resolution of the referred cases would allow for ensuring that appropriate  
action was taken and documented timely, while also providing an opportunity for continuous  
process improvement.
Care Management - Observation Services Operational Review  
Audit Control Number: 2013-008

Recommendation 2013-008-06-R:
The Director of Care Management should establish an outcome monitoring process for observation cases referred to EHR. Monitoring of the outcome of cases referred to EHR will ensure timely updating of the patient's admission status and allow for analytical data to assist with continual process improvement.

Management's Response:
With the recent CMS IPPS 2-Midnight Rule, the referral process to EHR has changed. CMS states for patients that are in the hospital less than 2 midnights should be in observation status, for patients that are in the hospital greater than 2 midnights, admission status is more appropriate. Due to the new IPPS rule the number of referrals to EHR has decreased significantly. Decision flow charts have been developed to guide the staff when to refer cases to EHR. All observation cases are monitored throughout the day. Recommendations on cases referred to EHR are usually received within 2-4 hours. Care Managers track cases closely and utilize the EHR website for status updates, recommendations, letters and reports. The actions and outcomes are documented in the Epic Utilization Management Screens. On occasion the primary physician does not return phone calls to EHR to discuss the case. When this occurs the CM Director receives an escalation call to determine next steps. Additionally the primary physician can disagree with EHR's recommendation, when this occurs the CM will notify the CM Director. The case will be discussed and reviewed by one of the CM Medical Directors and physician peer to peer communication will occur. Care Management is developing a process to monitor and track reasons why EHR recommendations were not implemented and will report data to the Utilization Review Committee.

Implementation Date: December 2, 2013

Conclusion
Audit Services review of the Care Management department’s role related to the provision of observation services indicated an opportunity to strengthen departmental infrastructure related to training, monitoring, and service coverage.

We greatly appreciate the assistance provided by Care Management staff and hope that the information presented in our report is beneficial.

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