Avoiding Denials of Payment through Automated Notifications to Case Management
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4 hospitals
795 inpatient beds
60,000 hospital encounters
250+ outpatient practices
30+ specialties
1.9 million ambulatory visits per year
   - 310,000 primary care population
   - 59% patients in plan where UCLA shares some risk
   - 208,000 specialty care population
Problem

The Burning Platform

Complex gynecology oncology case

Patient came in through UCLA Transfer Center

Resident wrote a “Transfer Patient” order and updated patient class to “Inpatient” without writing an inpatient order

Patient discharged 23 days later without admission order
Problem
The Burning Platform

Complex gynecology oncology case

Patient came in through UCLA Transfer Center

Resident wrote a “Transfer Patient” order and updated patient class to “Inpatient” without writing an inpatient order

Patient discharged 23 days later without admission order

$400,000 in unreimbursed charges
Problem
High-Level Problem

Context:

- Declining reimbursements rates from payors
- Increased scrutiny from payors resulting in increasing denials
- UCLA leadership concerns regarding increasing complexity of utilization review processes
Problem Statement:

- UCLA utilization review relies on time-consuming manual audits to catch common admission order errors.
- These errors are easily missed and result in reimbursement denials and regulatory non-compliance.

Barriers:

- The interns who typically enters the orders have little to no training in hospital documentation requirements.
- The orders cannot be modified once the patient is physically discharged.
All patients need an *Admit To Inpatient* or *Place in Observation Order*.

- Admit to Inpatient (Attending only)
- Admit to Inpatient (Non-Attending)
- Place in Medical Observation Status
- Admit to PTU
- Place Post-Op/Post-Procedure Patient in Surgical Extended Recovery/TRU to RR/SM
- Place in Surgical Extended Recovery in Outpatient Surgery Center (200MP/SMSC)

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Problem

Rapid Improvement Event

By taking a look within, being open to change, and trying something new we can achieve a measurable, sustainable impact.
Problem
Complexity of the Process

- Process Step
- Role
- Opportunities
- Prioritized Opportunities
<table>
<thead>
<tr>
<th>Process Step</th>
<th>Role</th>
<th>Opportunities</th>
<th>Prioritized Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Clearance</td>
<td>Financial Clearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED/Inpatient Case Mgmt</td>
<td>MD Informatics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Documentation Improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UR Case Mgmt /Collections</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Problem**

Complexity of the Process

Data Reporting/Analytics
RIE Participants

Care Coordination
- Nancy Hayes
- Mary Noli Pilkington
- Susan Senatra
- Jane Venus-Nocentelli
- Jai Joseph
- Stephanie Everett
- Joy Laguardia
- Sheila Coots
- Wandisa Landry
- Joan Yamashiro
- Louisa Nalchadjian
- Colisha Quinton
- Mina Coyoca
- Daisy Adams
- Jody Lavy
- Derek Hoppe
- Ethel Flores

Project Champions
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- Marcia Colone
- Karen Grimley
- Bernadette Lodge-Lemon
- Dr. Mohammed Mahbouba
- Paul Staton

Patient Access
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- Jose Torres
- Anna Amamchyan
- Vanessa Mercurio
- Lamar Tillman
- Robert Waley
- Nick Baca
- Christian Mante
- Raquel Brambila
- Latrice Tabor

Patient Business Services
- Tanja Twist
- Vicky Hoffman
- Julio Estrada
- Maribel Hernandez
- Paul Mendoza
- Mariam Mamikonyan
- Anna Little
- Norma Gonzales
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Office of Healthcare Informatics and Analytics
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- Shital Pandya
- Carmen Pack
- Joycee Berin
- Vu Vu
- Jennifer Capps
- Nicole El Beyrouthy
- Seema Abukishk

EHR Team
- Dr. Darryl Hiyama
- Ellen Pollack
- Betty Tseng
- Liann Manifong
- Jose Vasconez
- Dr. Jennifer Singer

Clinical Documentation
- Dr. Joel Lipin
- Rica Panelo
- Mayra Ayala

UCLA Health Information Technology
Project Governance

Monthly Leadership Update led by CFO

- Hospital Operations
- Information Services and Solutions
- Finance

Care Coordination Leadership Meetings
Inpatient Advisory Group
Revenue Cycle Steering Committee
Project Considerations and Objectives

High Loss Scenarios
- Scenario 1: Missing inpatient (IP) order
- Scenario 2: Medicare < 2 midnight

Objectives
- “Get the patient in the right patient class at the right time”
- Provide near real time awareness of potential inappropriate patient class assignment
- Minimize any added burden for providers (“the EHR increases my work”)
- Minimize changes in existing workflows (“leverage what we have”)
Project Considerations and Objectives

Proposed Solutions:

• Alert to discharging provider to contact case manager
• Alert to provider if IP order missing after 24 hours
• Alert to case manager that IP order is missing
Project Considerations and Objectives

Implemented Solutions:

• Case manager patient list displays patient with missing IP order (preemptive)
• Automatically generated daily e-mail of inpatient discrepancies prior to discharge (preemptive)
• Pager notification to Case Management prompted by discharge order placed when IP order missing (fail-safe)
• Pager notification to Case Management prompted by discharge order placed for Medicare patient IP < 2 midnights (fail-safe)
### Scenario 1: Missing IP Order

<table>
<thead>
<tr>
<th>Scenario Drivers</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospital unable to submit charges if inpatient order is missing</td>
<td>• Obtain inpatient order as early as possible in the hospitalization</td>
</tr>
<tr>
<td></td>
<td>• Obtain inpatient order at least prior to patient leaving the room, which</td>
</tr>
</tbody>
</table>
Scenario 1: Missing IP Order

Highlights on the Patient List within the EHR

<table>
<thead>
<tr>
<th>Unit/Room/Bed</th>
<th>Service</th>
<th>Admission Date</th>
<th>Primary Plan</th>
<th>Patient Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>4ICU-4417-A</td>
<td>Medicine - Critical Care (ICU)</td>
<td>9/10/18</td>
<td>10170001-MEDICARE PART A &amp; B</td>
<td>Inpatient</td>
</tr>
<tr>
<td>4ICU-4419-A</td>
<td>Medicine - Critical Care (ICU)</td>
<td>8/22/18</td>
<td>10110001-UNITED HEALTHCARE PPO</td>
<td>Inpatient</td>
</tr>
<tr>
<td>4ICU-4421-A</td>
<td>Medicine - Critical Care (ICU)</td>
<td>8/29/18</td>
<td>10170001-MEDICARE PART A &amp; B</td>
<td>Inpatient</td>
</tr>
<tr>
<td>4ICU-4423-A</td>
<td>Medicine - Critical Care (ICU)</td>
<td>9/13/18</td>
<td>10190001-LOS ANGELES ACTIVE /FULL BENEFITS</td>
<td>Inpatient</td>
</tr>
<tr>
<td>4ICU-4425-A</td>
<td>Medicine - Critical Care (ICU)</td>
<td>8/7/18</td>
<td>10780001-UNITED RESOURCE NETWORKS</td>
<td>Inpatient</td>
</tr>
</tbody>
</table>

Potentially inappropriate classes are highlighted in orange on the case manager’s patient list – their daily view.
## Scenario 1: Missing IP Order

Automatically generated daily e-mail of inpatient discrepancies prior to discharge

<table>
<thead>
<tr>
<th>Hospital Area</th>
<th>Admit Unit</th>
<th>Unit</th>
<th>MRN Service</th>
<th>Patient Primary Plan</th>
<th>Admit Date/Time Case Manager</th>
<th>Length of Stay (Hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RONALD REAGAN</td>
<td>RR 8E</td>
<td>8E</td>
<td></td>
<td></td>
<td>08/07/2018 1752</td>
<td>12.13</td>
</tr>
<tr>
<td>UCLA MEDICAL</td>
<td></td>
<td></td>
<td></td>
<td>Surgery - Oncology (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CENTER</td>
<td></td>
<td></td>
<td>10170001-MEDICARE PART A &amp; B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RONALD REAGAN</td>
<td>RR 6W</td>
<td>6W</td>
<td></td>
<td></td>
<td>08/07/2018 2240</td>
<td>1.00</td>
</tr>
<tr>
<td>UCLA MEDICAL</td>
<td></td>
<td></td>
<td></td>
<td>Neurology - General</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CENTER</td>
<td></td>
<td></td>
<td>10170001-MEDICARE PART A &amp; B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RONALD REAGAN</td>
<td>RR 8ICU</td>
<td>8ICU</td>
<td></td>
<td></td>
<td>08/07/2018 2108</td>
<td>8.87</td>
</tr>
<tr>
<td>UCLA MEDICAL</td>
<td></td>
<td></td>
<td></td>
<td>Surgery - Liver Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CENTER</td>
<td></td>
<td></td>
<td>10780001-UNITED RESOURCE NETWORKS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Scenario 1: Missing IP Order

MD
- Writes D/C order

CMA
1. Receives page notification if Patient Class is Inpatient but there is no inpatient order
2. Sends email and page to CM and Manager to review case prior to patient leaving hospital

CM
3. Review Case:
   - IP order
   - IQ applied/met
   - EHR Review
   - Is operation on C-list
   - MD documentation
   - Stay > 2 midnights
   
   Does order need to be changed?
   - Yes: Contact MD to cancel D/C order and write admission order
   - No: Document that patient meets outpatient criteria using Smart Text, update patient class to Outpatient

4. Cancel D/C order, write admit order, write new D/C order

5. Documents that change has been made in Auth Cert notes

6. Looks for note in Auth Cert

Document change in pager log
### Scenario 2: Medicare < 2 Midnights

**Scenario Drivers**

- Inpatient class with stays < 2 midnights potentially deniable
- Federal and State mandates for patient notification

**Objectives**

- “Get the patient in the right patient class at the right time”
- Provide appropriate staff in near real time the need for case review to comply with mandates
- Correct patient class prior to patient leaving the room, which is about 2 hours after discharge order is signed
Scenario 2: Medicare < 2 midnights

1. MD:
   - Writes D/C order

2. CMA:
   - Receives page notification if LOS < 2 midnights
   - Sends email and page to CM and Manager to review case prior to patient leaving hospital

3. CM:
   - Review Case:
     - IP order
     - IQ applied/met
     - EHR Review
     - Is operation on C-list
     - MD documentation
   - Does order need to be changed?
     - Yes: Contact MD to cancel D/C order and write admission order
     - No: Document that patient meets inpatient criteria using Smart Text

4. Cancel D/C order, change admit order, write new D/C order

5. Documents that change has been made in Auth Cert notes

6. Looks for note in Auth Cert
   - Document change in pager log
## Daily Log of Pager Cases Reviewed

**Daily Notification Summary - Thursday, 08/30/2018**

### In-Patient Stay < 2 Midnights LOS

Medicare Patients with LOS < 2 midnights at time of discharge order

<table>
<thead>
<tr>
<th></th>
<th>RR</th>
<th>SM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td># Cases</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td># Cases reviewed prior to discharge</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td># Cases requiring documentation correction (orders, status, etc.)</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td># Cases successfully corrected</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>% Cases corrected</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

### Missing IP Order

Patients missing admit to inpatient order at time of discharge order

<table>
<thead>
<tr>
<th></th>
<th>RR</th>
<th>SM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td># Cases</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># Cases successfully corrected</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% Cases corrected</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
Operational Enhancements Required

Obtaining dedicated virtual pager for these scenarios

Adding virtual pager management to Case Manager Assistant’s responsibilities

Ensuring 24/7 Case Management coverage

Assigning virtual pager management to weekend and after-hours Case Management responsibilities
Value Derived

Scenario 1: Missing IP Order

Missing Admission Order Page Volume

Missing IP order page volume decreased over time because of patients with missing orders are identified sooner in the hospital stay.
## Value Derived

### Pager Workflow Cases - Reimbursement

<table>
<thead>
<tr>
<th>Workflow</th>
<th>Start Date</th>
<th>End Date</th>
<th>Pages Sent</th>
<th>Cases Corrected</th>
<th>Reimbursements from Corrected Cases</th>
<th>Annualized Reimbursements from Corrected Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 2: Medicare &lt; 2 Midnights Pager</td>
<td>2/27/2017</td>
<td>8/1/2018</td>
<td>3,152</td>
<td>404</td>
<td>$1,877,984</td>
<td>$1,315,670</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td></td>
<td><strong>3,366</strong></td>
<td><strong>498</strong></td>
<td><strong>$2,728,426</strong></td>
<td><strong>$2,005,473</strong></td>
</tr>
</tbody>
</table>

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**NOTE:**
- The values are annualized.
Project Costs

Implementation Costs
• $31,100 – EHR Analyst
• $51,260 – Physician Informaticist
• $126,720 – Project Management

Ongoing Costs
• $3,136 annually (0.04 FTE) for Case Manager Assistants to manage incoming pages
• $12,020 annually (0.26 FTE) for Case Managers to review and follow up on pager cases
Value Derived

Soft ROI

Reduced Rework Burden

- Documentation and orders are correct PRIOR to discharge

Better Relationships

- Interdepartmental: Care Coordination, Utilization Review, Revenue Cycle
- External payors: fewer audit discrepancies

Staff Engagement

- Daily staff awareness
- Daily feedback on performance
- Ownership
Ongoing Improvement

Pager Workflow to Medicare Surgery Cases

Created Clinical Decision Support to Guide Selection of Correct Patient Class

Created Alert For Surgery Patients With Incorrect Patient Class
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