Reducing Outpatient Billed as Inpatient Errors

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From 2006 to 2007, the Colorado Foundation for Medical Care (CFMC), the quality improvement organization (QIO) for Colorado, led a project to reduce the outpatient billed as inpatient billing error rate in five area hospitals. This article discusses the findings from the project, as well as best practices for hospitals to evaluate their performance.

Outpatient Billed as Inpatient Problems

Funded by the Centers for Medicare and Medicaid Services (CMS) as a component of the Hospital Payment Monitoring Program (HPMP), the project came about after an analysis of Colorado's HPMP error data from July 2002 to June 2005 found that billing errors were the biggest cause of overpayments.

The single largest category contributing to the billing error rate was outpatient claims billed as inpatient. Analysis of the data found that a 50 percent reduction in the failure rate would prevent an estimated overpayment of $882,000 annually for the five target hospitals.

CFMC selected five Colorado hospitals to explore the issues and ultimately reduce each hospital's outpatient billed as inpatient billing error rate by half. CFMC abstracted a fourth-quarter 2005 sample of up to 105 one-day stay Medicare discharges from each hospital for baseline measurements. Staff analyzed the initial findings and presented each hospital with its own individual findings.

Each hospital performed its own internal investigation and developed solutions for the problems that had caused the errors, which varied from hospital to hospital.

After the hospitals had implemented improvements, CFMC abstracted up to 105 Medicare one-day stay discharges from December 2006 to February 2007 to provide a post-intervention remeasurement.

The project exceeded expectations, resulting in an overall 64 percent reduction in the billing error rate (see "Percent of Records with an Outpatient Billed as Inpatient Billing Error," on page 86).

Interestingly, one hospital with a low initial error rate increased the error rate upon remeasurement. This was attributed to a reduction in work force, which resulted in the loss of a case manager and the inability to concurrently monitor inpatient records properly. The hospital was persuaded by these outcomes data to restaff case management to a level that permitted necessary monitoring.

Lessons Learned and Best Practices

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.

Hospitals were not always aware of billing Medicare observation accounts as inpatient accounts, thereby receiving overpayments. HIM professionals should raise awareness at their hospitals that this is a source of potential overpayment and is subject to the CMS fraud and abuse campaign. A hospital should monitor this area as part of its overall compliance plan to ascertain if physician orders were for inpatient or observation and subsequently billed as written.

Forms were often poorly designed. The most successful forms included a clear, preprinted checkbox choice such as "Admit to: **X** inpatient status **X** observation status." The print of some checkbox forms was too small and crowded, which encouraged errors.

In hospitals without preprinted forms, physicians wrote orders freehand, resulting in inconsistencies from physician to physician. One computerized physician order entry (CPOE) printout did not indicate inpatient or observation status, and simply printed "admit" for both.

HIM professionals should review their organizations' admission order forms, including emergency department (ED), attending physician, and specialized order forms (such as for telemetry, the critical care unit, or same-day surgery), as well as CPOE choices and printouts. Forms should be redesigned to clearly differentiate "inpatient" from "observation."

Checkbox forms existed but were not used. This happened a surprising number of times. HIM professionals should educate physicians (including ED physicians, attending physicians, residents, and interns) about the importance of consistently using checkbox forms, which can reduce errors.

Orders were clearly documented but not transmitted to or acted on by registration. This occurred at multiple hospitals: a clear order for observation existed in the record but the account was registered as inpatient. HIM professionals should evaluate the flow of communication between physician order and the entry of the registration status into the hospital information system. This should be done for both initial orders and for changes in admission status that might be ordered after 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. See the sidebar at right for the basic rules. An organization's QIO or fiscal intermediary can offer further 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.

One area that needs special attention is the ED, where admit decisions are made 24 hours a day and where emergent situations can lead to confusion and lapses in documentation. Another area requiring special attention is the infrequent admitter, who may not be familiar with the rules.

Organizations should 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. Organizations should establish a back-up system to catch and correct errors prior to billing. Some hospitals used case managers or HIM coding professionals for post-discharge review.

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 an attending physician. Permitting ED physicians to write initial admit orders provides back-up in the event attending physicians neglect to do so. HIM professionals should consider requesting a change if the hospital's medical staff rules and regulations do not permit ED physicians to write initial admit orders.

There was confusion between the issue of medical necessity and the issue of valid admission orders. For 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.

The status of the account must be whatever the physician orders, not what the case manager thinks it should be. The status may only be changed by physician order while the patient is still in-house.

Rules for Admission Status Orders

CFMC found a lack of understanding among the five hospitals of the rules affecting admission status orders. Here are some basic rules for admission status:

- **It is never permitted to retroactively change the admission status of the account after the patient has been discharged.** A 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. It may not bill for 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.
- **A physician may write an order while the patient is still in-house changing the status to outpatient as of the date of admission.** For example, a case is ordered as inpatient but found during the stay to not meet medical necessity for inpatient status. The outpatient claim must append condition code 44, "Inpatient Admission Changed to Outpatient."
- **A physician may write an order to inpatient status while the patient is still in-house, effective at the time the order is written.** Admission status may be upgraded to inpatient if the patient's condition changes to meet inpatient criteria.
- **There are conflicting guidelines from CMS whether it is permissible to change a patient's status from outpatient to inpatient on a retroactive basis while the patient is still in-house.** For example, a 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. CFMC has requested clarification from CMS. Pending resolution, organizations may contact their QIOs for guidance.
- **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.** For example, "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 preprinted 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. Organizations can contact their QIOs for advice.

Resources

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."

CMS. "Use of Condition Code 44, Inpatient Admission Changed to Outpatient." Transmittal 299 (Change Request 3444). September 10, 2004. Available online at www.cms.hhs.gov/transmittals/downloads/R299CP.pdf.

CMS. "Conditions of Participation for Hospitals." 42 CFR §482.

National Uniform Billing Committee. "Official UB-04 Data Specifications Manual 2008." Version 2.00. July 2007. Available online at www.nubc.org/subscribers/subscribers.html.

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Percent of Records with an Outpatient Billed as Inpatient Billing Error

CFMC's project to reduce outpatient billed as inpatient errors at five Colorado hospitals exceeded expectations as evidenced by the decreases in rates, shown here. A sample of one-day stay Medicare discharges in fourth quarter 2005 formed the baseline. A similar sample from approximately one year later reflects the improvements post-intervention. An increase in errors at hospital E reflects staff reductions that affected concurrent monitoring.

	Baseline (Fourth Quarter 2005)	Remeasurement (December 2006, January and February 2007)	Percent Reduction of Error Rate
Hospital A	17%	8%	53%
Hospital B	10%	0%	100%
Hospital C	4%	1%	66%
Hospital D	1%	0%	100%
Hospital E	2%	7%	-177%
Overall	9%	3%	64%

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