How to Survive a CMS Audit and New CMS Guidelines

Zeev N. Kain, MD, MBA

Chair, Department of Anesthesiology

Associate Dean of Clinical Operations

University of California, Irvine

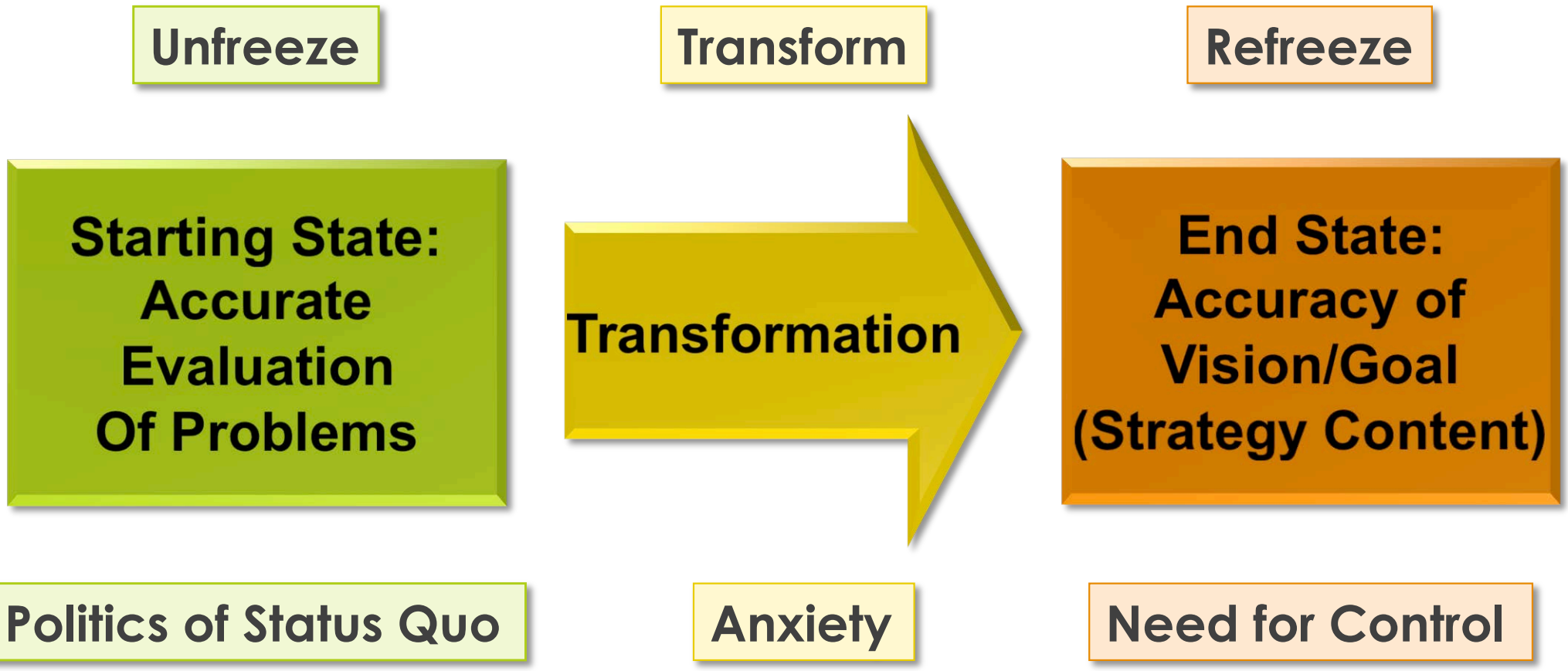
Department of Anesthesiology
& Perioperative Care
UC Irvine School of Medicine

March 2nd, 2008:
A New job, A New Sunny Day

TimeLine Jan 2008-August 2008

- January 2008 (negotiations)
  - New hospital & SIM CTR, new OR equipment, AIMS
  - Identified vulnerabilities
- March 1-2, 2008: Strategic Retreat
- April 2008: Compliance & Safety officer, Compliance plan, AIMS contract, administration changes, record
- May 20, 2008: Visit by CMS
  - What info they had, process, exit interview
- June-Aug, 2008: Compliance training, policies & procedures (don't wait)

UCI Anesthesiology Transformation Process: Conceptual Framework



TimeLine Jan 2008-August 2008

- January 2008 (request for outside audit-denied)
- March 1, 2008: Start
  - Assessment of vulnerabilities, strategic retreat
  - All new equipment, standardization, anesth techs, AIMS
- April 2008: Compliance & Safety officer, Compliance plan, AIMS contract, administration changes
- May 20, 2008: Visit by CMS
- June-Aug, 2008: Compliance training, policies & procedures (don't wait)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

TimeLine August 2008-October 2008

- August 19, 2008: CMS Report
  - The politics, COP threat, the media circus
  - Main issues: pre-filling (2002-2007), inaccurate charting
  - Corrective action/report (CMS is not only about billing!)
- Sept 2008
  - AIMS going live*, Policies, training, training, 100% audits (findings)
- October 2008:
  - CMS is back for a FULL validation survey
  - The process this time, exit interview
  - tension with hospital compliance

TimeLine October 2008-June 2009

- January, 2009: CMS Report
  - Findings in other areas of the hospital: no anesthesia findings
- March, 2009
  - Compliance Group is engaged (took more than a year)
- April, 2009: RRC (5 years)
- June 2009, CMS visit (again): no anesthesia findings
- We are allowed (finally) to change our billing group
  - Billing today vs. 3 years ago

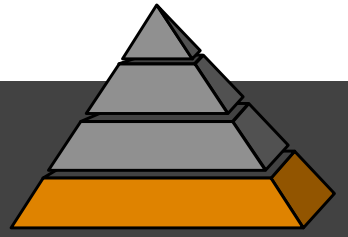
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Some Observations: The Team!

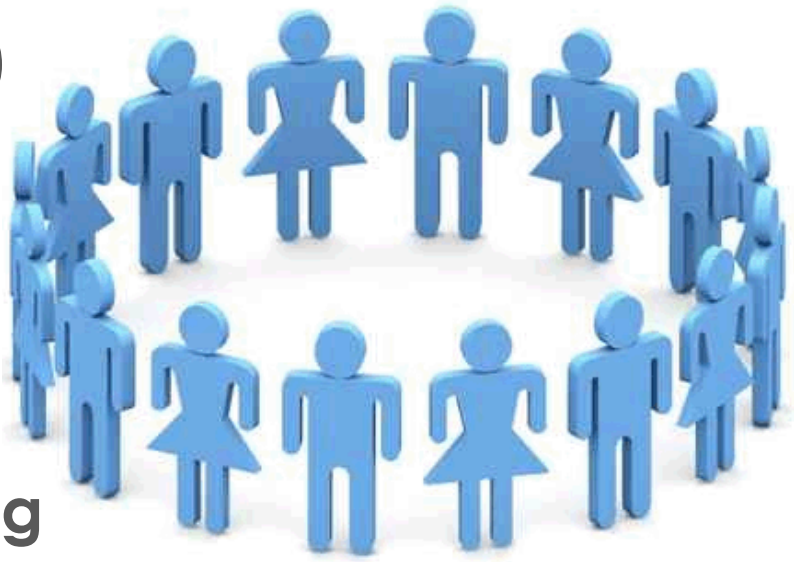
Department of Anesthesiology
& Perioperative Care
UC Irvine School of Medicine

Some Observations: Not a Good Way to Respond to CMS

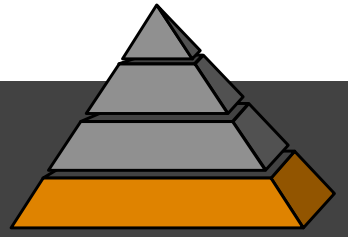
Some observations

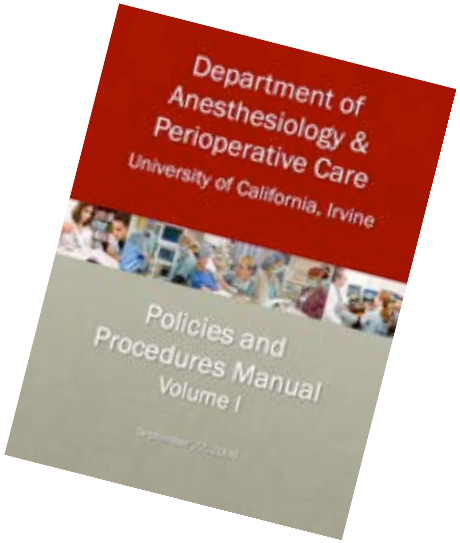


- Continue with plans and don't get entirely distracted
- Use this to your advantage (get stuff)
- CMS can/will look at everything
- Proactive vs. reactive (new COP)
- "All hands on board"
- People/organizations are more willing to change under a crises



Policies, Procedures, etc

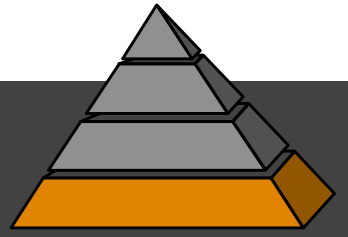




- Well Developed QA Plan (AIMS) (Perioperative SafetyNet)
- Departmental Compliance Plan (lawyer)
- Policies &Procedures Manuals
  - Many hundreds of pages
  - Covers administrative, clinical, infection control, equipment, etc

Department of Anesthesiology
& Perioperative Care
UC Irvine School of Medicine

Image Management



- West Coast vs. North East
- Information from within the dept
- Go on the offensive
- Hire a publicist
- Truth? Does it sell newspapers?
- WWW management
- Invest in your web site

Department of Anesthesiology
& Perioperative Care
UC Irvine School of Medicine

The CMS Crises: Using the Energy

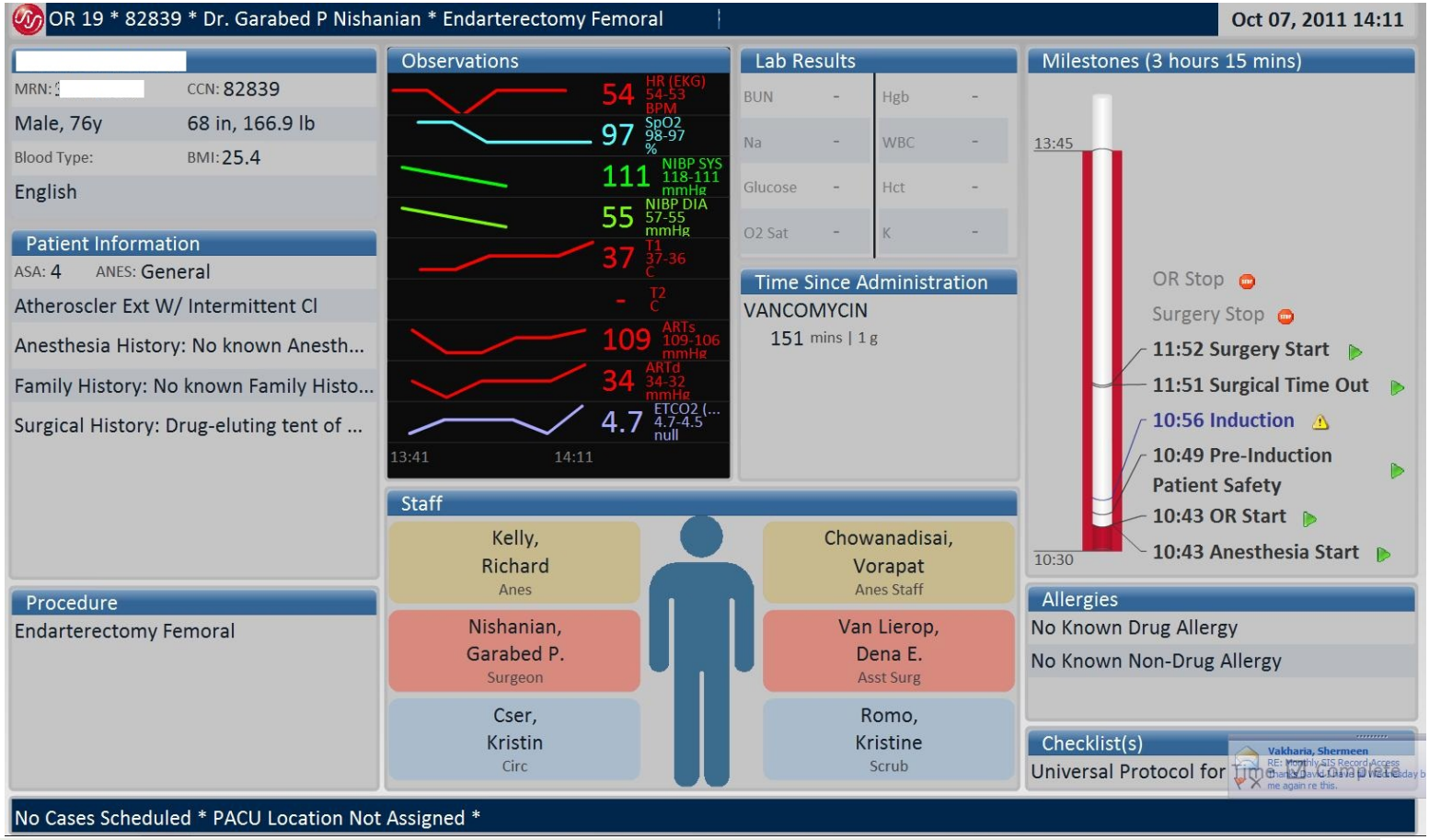
Using the Energy: IT

- IT Innovations
  - Department Website
  - AIMS
  - Scheduling system
  - New Innovations
  - Billing Platform
  - Near Miss

Department of Anesthesiology & Perioperative Care
UC Irvine School of Medicine

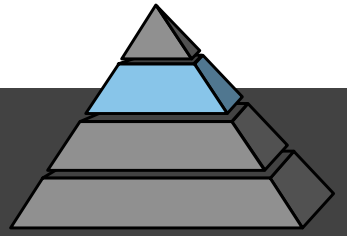
Using the Energy: AIMS

- We are now an Alpha Site
- **Page system for all 7 elements**
- **Ongoing review of compliance**



Department of Anesthesiology
& Perioperative Care
UC Irvine School of Medicine

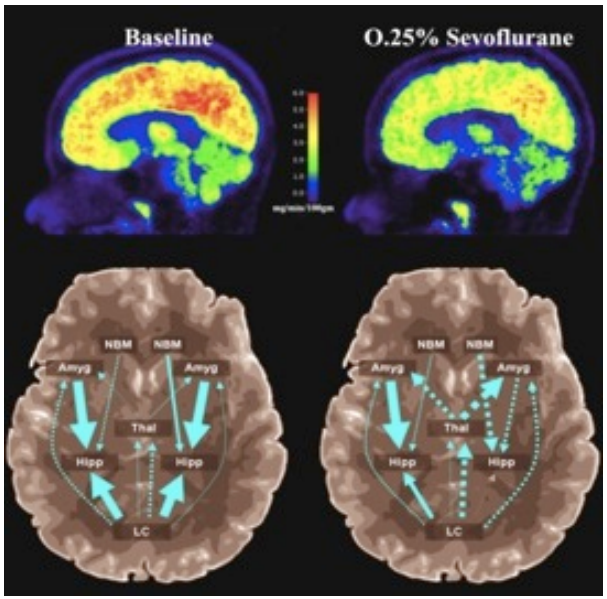
Using the Energy: Residency Program



- ★ 5 year accreditation
- ★ 4 year program
- ★ Increase in class size by 25%
- ★ Recruitment competitive
- ★ Innovative programs

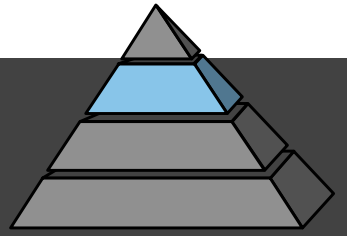
Using the energy: Discover

- Over 50 publications in top tier journals in 2010
- On track for 75 top tier publications in 2011
- Faculty on editorial boards and reviewers for prominent journals
  - Anesthesiology, New England Journal of Medicine, Pediatrics, Journal of Neuroscience, Intensive Care Medicine
- 11 NIH grants, 4 NIH grants pending
- Applying for T32 training grant



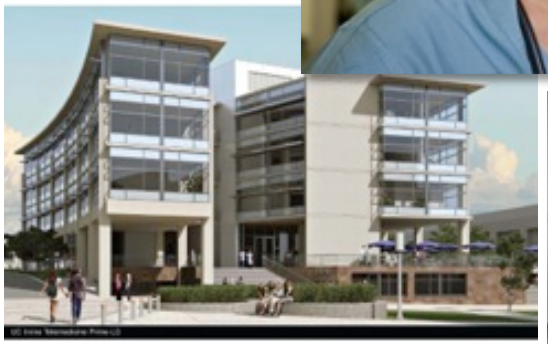
Department of Anesthesiology & Perioperative Care
UC Irvine School of Medicine

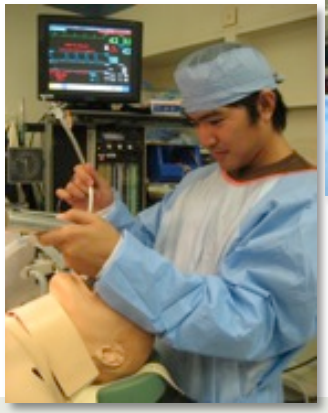
Using the Energy: Simulation Center



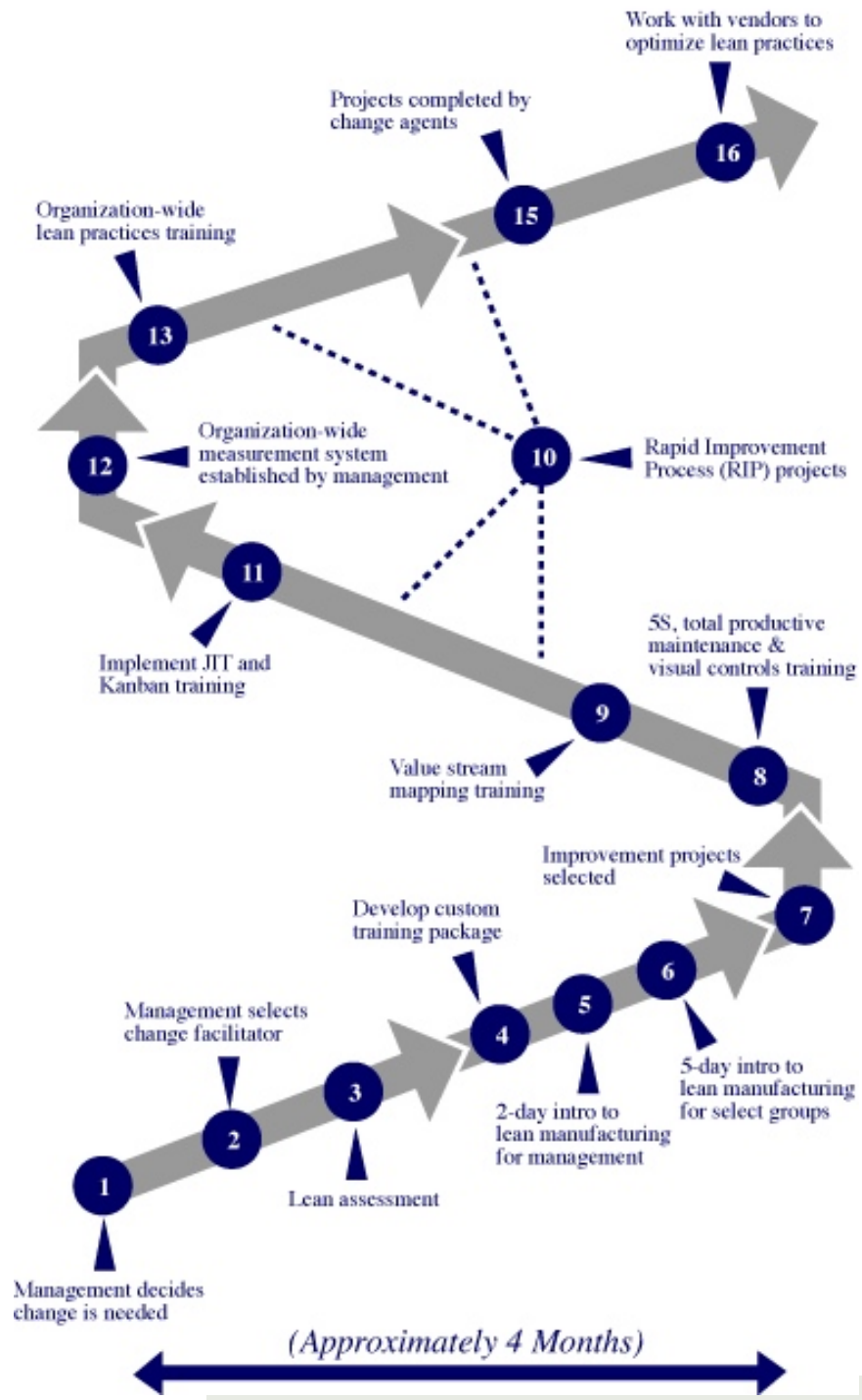
- Four simulation pods located on 2nd floor: operating room, trauma/ critical care, obstetrics, emergency room

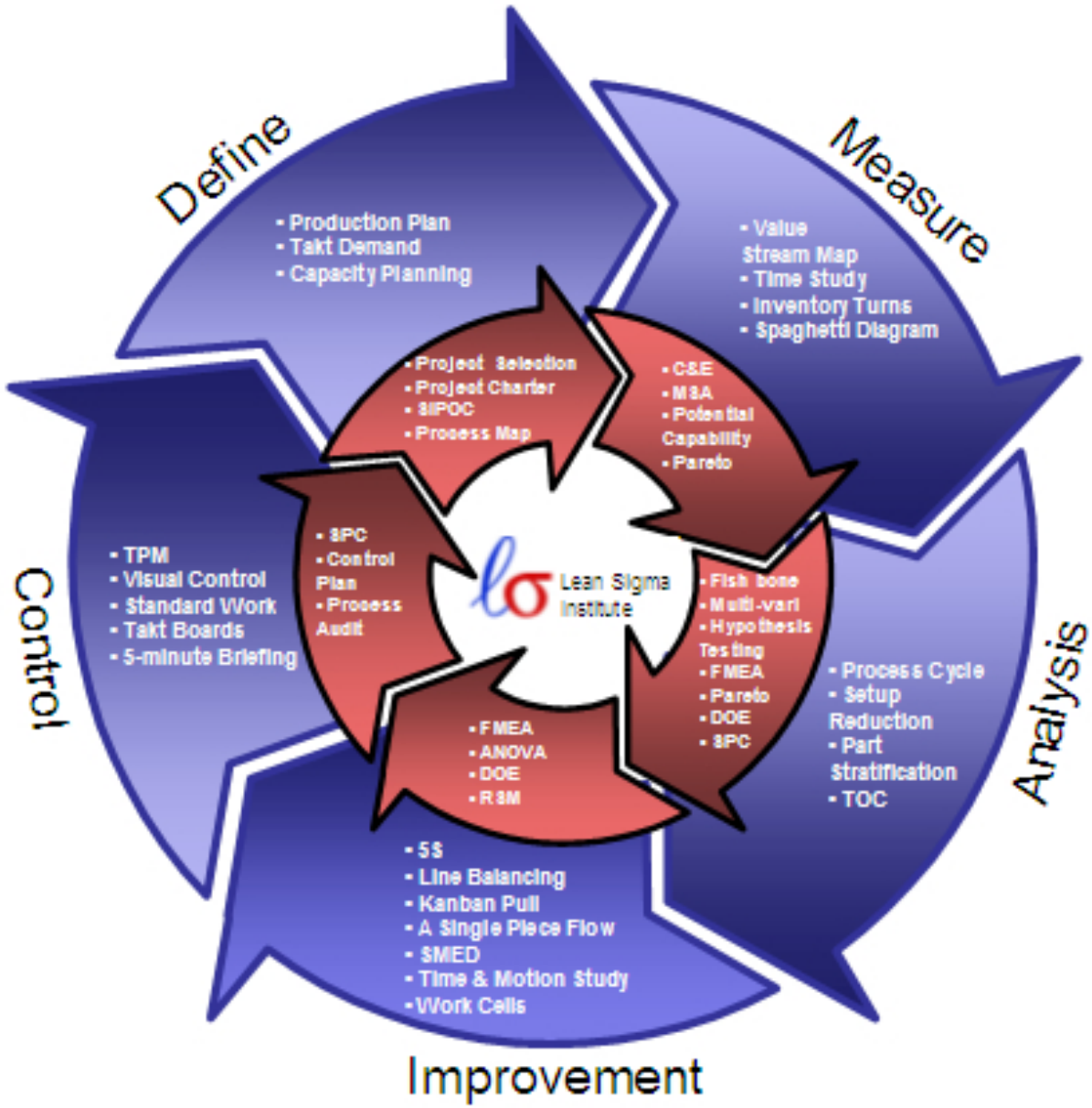
- State of the art simulation equipment:
  - METI Human Patient Simulator
  - Laerdal Sim Man 3G Wireless
  - Pediatric anesthesia simulator
  - Ultrasound guided regional anesthesia simulation
  - Invasive lines, neuraxial block simulation





THE LEAN PROCESS





Where are 36 months later?: We survived and moved forward!

- Culture Change
- New: Hospital/Sim Building/ Pain Ctr
- Innovative IT and Quality Programs
- 5 year accreditation, 4 year program, 4 new fellowships, combined programs
- Increased publication (x5), NIH grants (x10)
- New Revenue management system
- Leaders of the institution in quality

New CMS Guidelines

Conditions of Participation (CoP)

- First published in 1966
- There were four recent anesthesia revisions
  - December 11, 2009
  - February 5, 2010
  - May 21, 2010 (transmittal)
  - February 14, 2011

CMS CoP: The Basics

- If hospital furnishes anesthesia services, they must be provided in a **well organized** manner under the direction of a qualified MD or DO
- The **service is responsible** for all anesthesia administered in the hospital
  - Includes general anesthesia, regional anesthesia, MAC including deep sedation/analgesia in ANY LOCATION by ANY SERVICE
  - Does not include topical/local anesthesia, minimal sedation/analgesia or moderate sedation/analgesia
  - Must ensure that procedures are in place to rescue patients who inadvertently enter a state of deep sedation/analgesia when a level of moderate sedation/analgesia was intended

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Anesthesia Survey Procedure A-1000

- Will review job or position of director
- Surveyor is suppose to request and review all of the anesthesia policies and procedures
- Will make sure privileges and qualifications are consistent with the criteria and compare to charts
- Will confirm directors responsibilities include:
  - **Planning, directing, and supervision of all activities**
  - **Removed section on staffing schedules**
  - **Evaluate the quality and appropriateness of anesthesia services provided to patients as part of PI process**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Anesthesia Survey Procedure A-1000

- Surveyor is suppose to ask for a copy of the organizational chart for anesthesia
- Make sure MD or DO has authority and responsibility for directing anesthesia services throughout the hospital
- Anesthesia & analgesia must be integrated into the QA/PI program
- Will make sure the same anesthesia standards apply to every where in the hospital where anesthesia services are provided

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

IG and Sedation: Reminders

- One Anesthesia Service still required with "qualified" MD/DO leader
- Now required to monitor data and re-evaluate
- "Nationally recognized guidelines"
- CMS:
  - National organization
  - Consensus-setting process with appropriate expertise in guideline development
- CMS examples: ASA, ACEP, ADA, ASGE

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

IG and Sedation: SWOT

- An opportunity to take control
  - Medical director
  - NP coordinator
  - credentialing
  - QA process
  - Pyxis
- Sedation module for AIMS
- NP & CRNA now want to supervise sedation (FL, NV) and the RN therat

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Labor Epidurals: THEN & NOW

- Labor epidurals were considered analgesia. Thus, no longer subject to supervision requirements (2010).

- Hospital establishes policies *based on nationally recognized guidelines* that address whether specific clinical situations involve anesthesia versus analgesia (2011).

American Society of Anesthesiologists

Pre-anesthesia Evaluation : THEN & NOW

- Review of complete medical history
- Interview and exam of patient
- Note anesthesia risk
- ID potential anesthesia problems
  - e.g., difficult airway, infection, intravascular access
- Additional pre-anesthesia eval if needed
  - e.g., stress tests, consult
- Plan for anesthesia care
  - Including type of meds, discuss risks

Within 48 hours

Up to 30 Days in advance

American Society of Anesthesiologists

Post anesthesia evaluations: THEN & NOW

- **48-hour requirement loosened**
- **Outpatient requirements – can complete after (vs. before) patient discharge if within 48 hours**
- **ICU patients – document within 48 hours**
- **Long-lasting regional blocks – document within 48 hours**
  - **Note that patient not fully recovered from anesthesia and reason**

American Society of Anesthesiologists

Supervision Requirements: Oct 24, 2011

- **CMS released two proposed rules in October aimed at reforming existing Medicare and Medicaid regulations.**

- **The rules contain no change to the long-standing physician supervision patient safety standard, according to an ASA release.**

American Society of Anesthesiologists

Proposed: Medical staffing provisions (482.22)

- As proposed, hospital would be able to grant privileges to physicians and non-physicians to practice within their State scope of practice, regardless of whether they are also appointed to the hospital's medical staff.
- CMS is proposing to require that they adhere to medical staff provisions, bylaws and medical staff oversight
- Avenue to circumvent the review and approval process afforded to physicians through the medical staffing requirements.
- CMS proposes to allow hospitals to use standing orders for prep and administration of drugs and biologicals for specific areas, including postoperative recovery areas.

American Society of Anesthesiologists

The 60K View

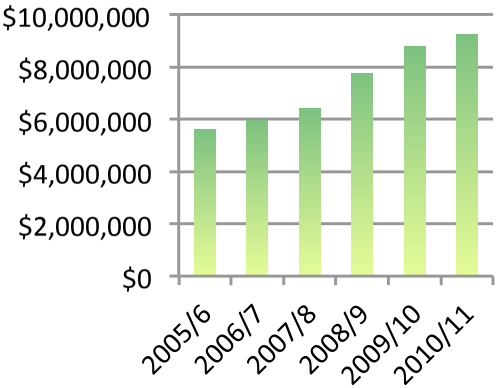
- **Perceived Federal Government control of health care – CMS took a big step back**
- **One Anesthesia Service and leader still empowered to determine policies**
- **Hospitals given additional flexibility:**
  - **Meet patient needs**
  - **Ensure quality and patient safety**
  - **Deal with limited resources (fiscal and staff)**

Thank You to Jason Byrd

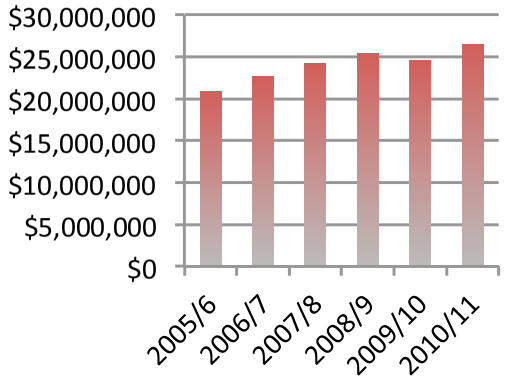
Smile, we are done!

HEAL: FINANCIAL

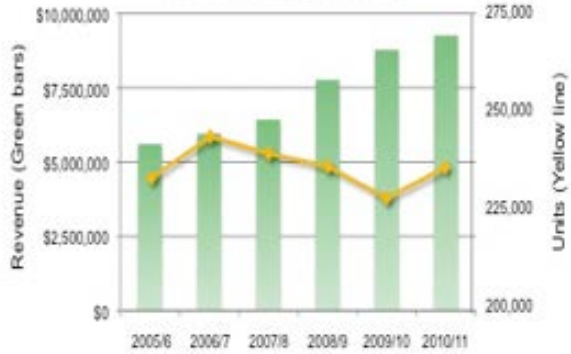
REVENUE



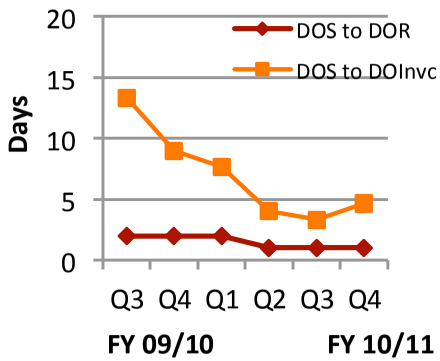
CHARGES



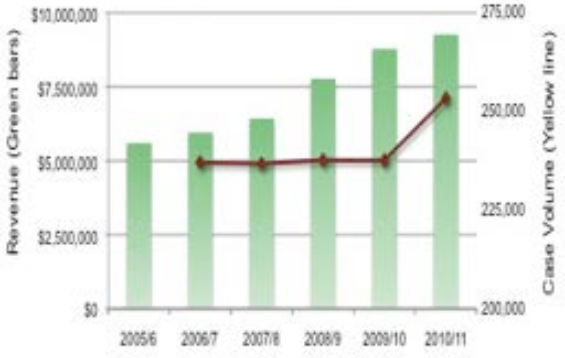
REVENUE and UNITS



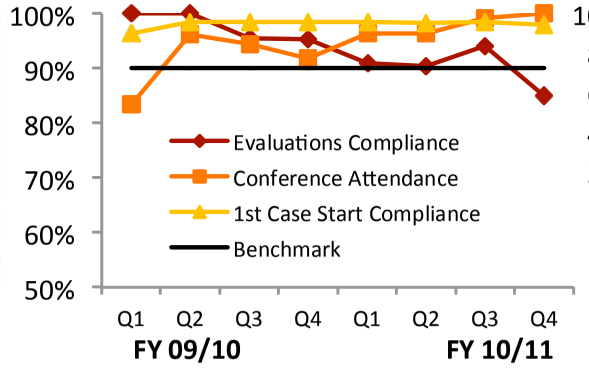
Dept Billing Lag Days



REVENUE and CASE VOLUME

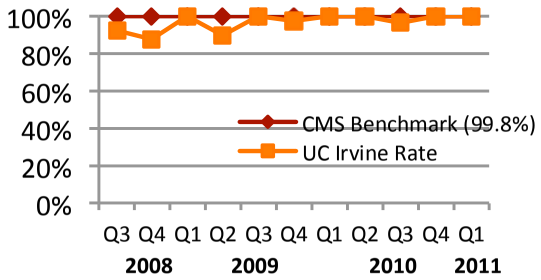


At Risk/Incentive Plan Bench Marks

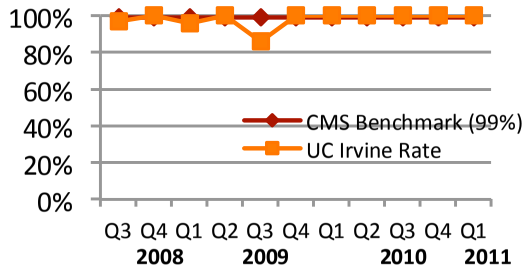


HEAL:QUALTIY

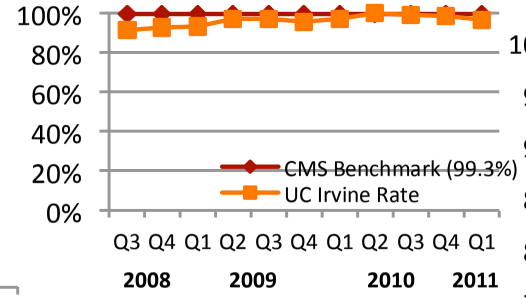
SCIP - Periop Beta Blocker, % Compliance



SCIP - Normothermia % Compliance

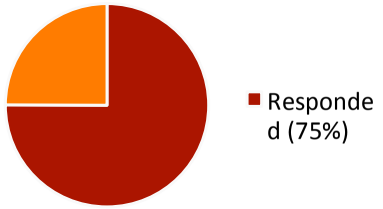


SCIP- Antibiotics, % Compliance



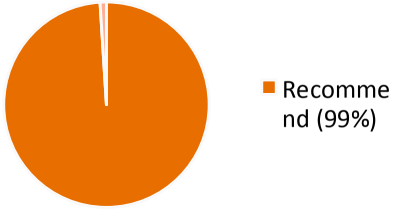
Outpatient Survey:

Survey Response Rate

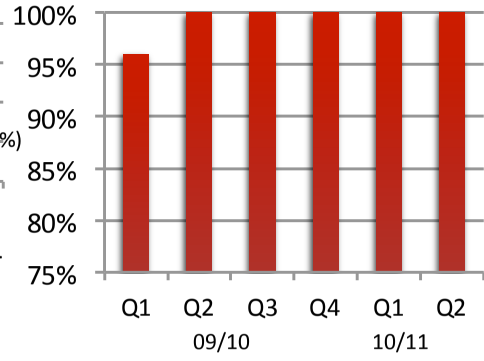


Satisfaction

Recommendation

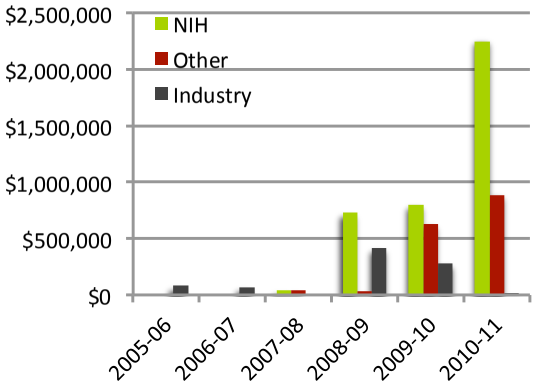


CLIP, % Compliance

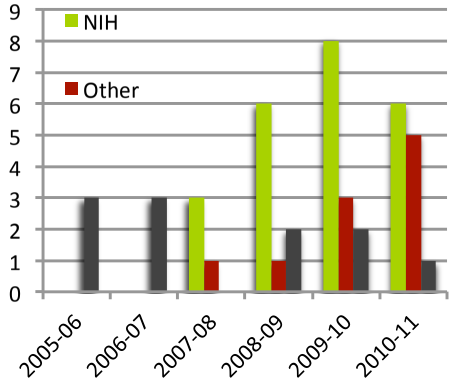


DISCOVER

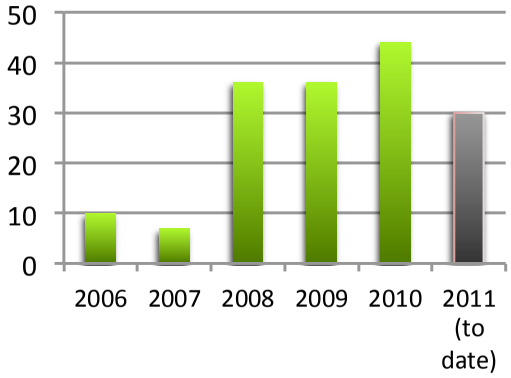
Exsiting Grant Dollars



Number of Grants

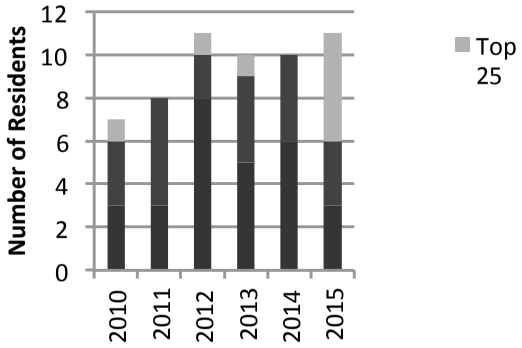


Publications

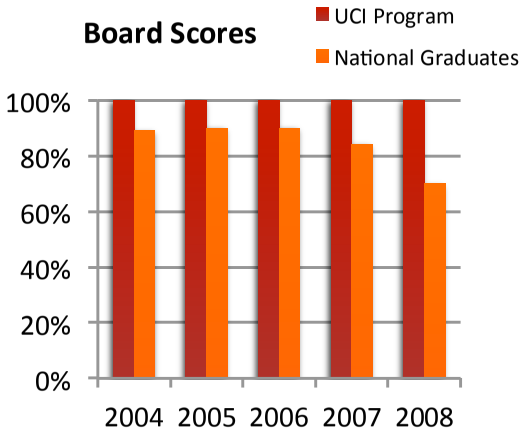


TEACH

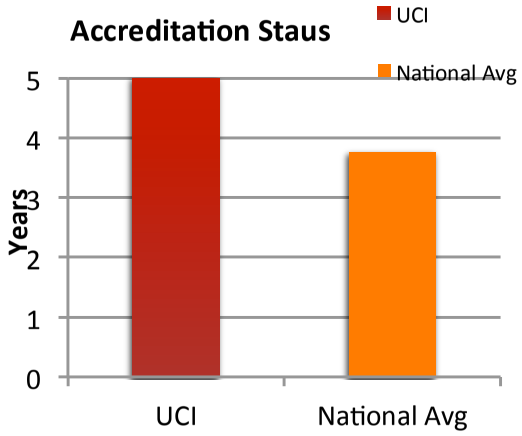
US News & World Report Medical School Rank



Board Scores

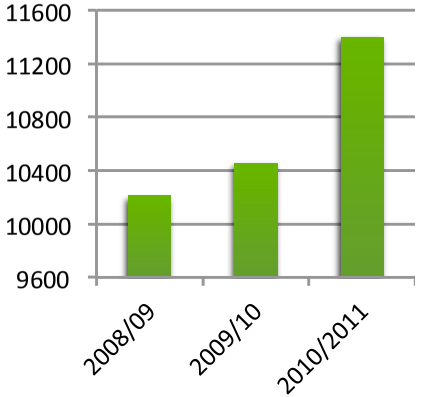


Accreditation Staus

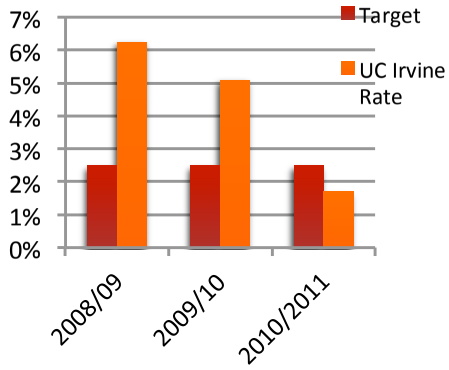


HEAL: CLINICAL

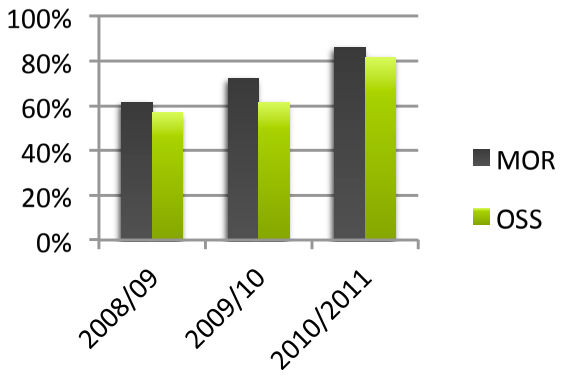
Total Surgical Case Volume



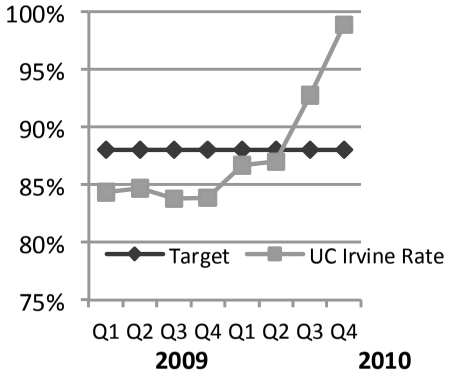
Day of Surgery Cancelation



1st Case On Time



OSS Treatment of Pain



FY	Case Volume	ASA Units
2006/7	10232	259,574
2007/8	10158	248,932
2008/9	10397	240,720
2009/10	10381	220,850
2010/11	10812	230,000