



Audit Department

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Angela M. Darragh, CPA, CFE, CISA, Director

September 8, 2014

Mr. Don Burnette
Clark County Manager
500 South Grand Central Parkway, 6th Floor
Las Vegas, Nevada 89106

Dear Mr. Burnette:

In accordance with our annual audit plan, we recently performed a Two Midnight Rule audit at University Medical Center of Southern Nevada. The Two Midnight Rule was issued on August 2, 2013 by the Centers for Medicare and Medicaid Services, 1599-F (Revision of the Medicare Hospital Inpatient Prospective Payment System or IPPS). The final rule, with enforcement to begin March 31, 2015, places increased standards for documentation to support Medicare reimbursement for hospital inpatient stays. The Two Midnight Rule requires the attending physician's signature on the physician certification and the inpatient order. Also, the physician must document the estimated time the patient is to stay in the hospital.

Our objective was to determine whether University Medical Center of Southern Nevada (UMC) is in compliance with the Two Midnight Rule and regulations finalized by the Centers for Medicare and Medicaid Services.

We selected the period of January through March 2014 and reviewed 20 records to ensure that the physician certification and inpatient order were compliant with guidelines set forth by the Centers for Medicare and Medicaid Services. Additionally, we reviewed the selected 20 records to ensure that billing was conducted according to the order documented in the medical record.

We found that ten of 20 (50%) Medicare inpatient records reviewed did not include sufficient documentation to support billing for an inpatient stay.

We conducted the performance audit in accordance with generally accepted government auditing standards. Those standards required that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

A draft report was provided to the Chief Medical Officer, and her response is included.

Sincerely,

A handwritten signature in blue ink that reads "Angela M. Darragh".

Angela-M. Darragh, CPA
Audit Director



AUDIT DEPARTMENT

Audit Report

University Medical Center of
Southern Nevada
Two Midnight Rule

September 2014

Angela M. Darragh, CPA, CISA, CFE
Audit Director

AUDIT COMMITTEE:

Commissioner Steve Sisolak

Commissioner Chris Giunchigliani

Commissioner Lawrence Weekly

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BACKGROUND The Two Midnight Rule was issued on August 2, 2013 by the Centers for Medicare and Medicaid Services, 1599-F (Revision of the Medicare Hospital Inpatient Prospective Payment System or IPPS). The final rule, with enforcement to begin March 31, 2015, places increased standards for documentation to support Medicare reimbursement for hospital inpatient stays. The Two Midnight Rule requires the attending physician's signature on the physician certification and the inpatient order. Also, the physician must document the estimated time the patient is to stay in the hospital. On May 29, 2014, a probe and educate review was conducted by Nordian Healthcare Solutions. The results of the review concluded that 4 out of 8 claims were incorrect (50%) and claims totaling \$47,764.82 were denied. For the calendar year 2013, University Medical Center of Southern Nevada received \$49,567,267 in payments for Medicare inpatients.

OBJECTIVES, SCOPE, AND METHODOLOGY Our objective was to determine whether University Medical Center of Southern Nevada (UMC) is in compliance with the Two Midnight Rule and regulations finalized by the Centers for Medicare and Medicaid Services. Our audit consisted of interviews with management and staff, examination of documentation, and performance of detailed tests and analysis.

In order to test compliance with the Two Midnight Rule, we selected a testing period of January through March 2014. We judgmentally selected a sample of 20 records and reviewed the files to ensure the certification was included in the medical record. We then verified that the physician certification included the following:

- The signature of the certifying physician.
- The reason for inpatient services.
- The estimated time the patient would stay at the hospital.
- Plans for post hospital care.
- Discharge time.
- Physicians' signature of recertification.

Additionally, we ensured the inpatient order was recorded in the medical record that each included the following:

- Signature of the physician who had admitting privileges for the hospital.
- The physician was directly involved with care of the patient.
- The order was furnished at the time of inpatient admission.

Finally, we reviewed the selected 20 records to ensure that billing was conducted according to the order documented in the medical record.

While the sample size is not sufficient to extrapolate to the population as a whole, we believe it gives us sufficient evidence to determine compliance with the Two Midnight Rule.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

RESULTS IN BRIEF Ten of 20 (50%) Medicare inpatient records reviewed did not include sufficient documentation to support billing for an inpatient stay.

DETAILED RESULTS

Insufficient Support for Inpatient Admission (HIGH)

Properly completed inpatient orders and physician certifications are required for compliance with the Two Midnight Rule. During our testing, we found 10 of the 20 records sampled did not meet these requirements (50%). Specifically, we found the following errors (some records contained multiple errors):

- In two instances (10%) the physician certification was not signed.
- In five instances (25%) the physician certification was not included in the medical record.
- In one instance (5%) the inpatient order used for billing was not countersigned prior to discharge, as required.
- In eight instances (40%) the ordering practitioner who signed the order did not have admitting privileges to admit inpatients to the hospital.

Payment received for records with insufficient documentation totaled \$369,014. While we do not believe we can extrapolate the error rate to the entire Medicare population, failure to resolve the insufficient documentation puts UMC at risk for fines from the Office of Inspector General and/or the Medicare Administrative Contractor. Medicare may select a sample and extrapolate when investigating

overpayments. Further, according to the Medicare Program Integrity Manual, Section 8.4.1.2, extrapolation is not subject to administrative or judicial review if a sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error is determined.

Recommendation

1. Develop self-monitoring procedures to ensure that properly completed supporting documentation is included in the medical record to support payment for Medicare inpatient claims.
2. Conduct training with physicians and staff to ensure that physician certifications and orders are completed in accordance with the Centers for Medicare and Medicaid Services guidelines.
3. Correct all incorrect claims identified during the audit and re-bill as allowed.

INTEROFFICE MEMORANDUM

TO: ANGELA DARRAGH, DIRECTOR, CLARK COUNTY, AUDIT DEPARTMENT
FROM: JOAN D. BROOKHYSER, MD, CPE, FCCP, CHCQM, CHIEF MEDICAL OFFICER
SUBJECT: MANAGEMENT RESPONSE TO TWO MIDNIGHT AUDIT
DATE: AUGUST 28, 2014



We respectfully offer the following in response to the Clark County Audit Department's Two Midnight Audit.

Initial Finding:

Insufficient Support for Inpatient Admission

Auditor's Recommendation:

1. Develop self-monitoring procedures to ensure that properly completed supporting documentation is included in the medical record to support payment for Medicare inpatient.

Management Response and Action Plan:

- The unit Case Manager will print and review daily the Medicare census from STAR. Each Medicare admission from the Adult Emergency Department will have a paper certification order placed on the chart. Once the patient is moved to the floor from the Emergency Department, the unit Case Manager will ensure that a physician certification order is present. Patients admitted after hours will be reviewed the next day.
 - If the paper certification order is not signed by the Attending or not found on the record, the unit Case Manager will call the Attending physician and obtain a telephone order for less or more than 2 midnights. The order will be submitted electronically by the Case Manager, via HEO. HEO is the computerized order entry system. This will be sent real time electronically to the Attending physician for co-signature.
 - The Case Manager will recap with the Attending physician to need to co-sign the order prior to discharge.
 - These processes will be documented in the STAR financial record under the graphic user interface [GUI] notes.
 - An electronic Attending co-signature solution for Resident cases is in progress by our IT department. Once completed we will have detailed report of which orders have been co-signed. Outliers will be reported to the Associate Dean for the School of Medicine (if applicable) or to the providers medical director for private Hospitalist, preferably on a daily basis.
 - Dr Miriam Bar-On, Associate Dean for UNSOM
 - Dr Raoul Tamayo, Cogent HMG

- Patient records will be audited for certification and supporting documentation by the Case Management department.
 - Our goal is 100% of the short stay admits to be reviewed. This should be possible when the electronic co-signature process has been finalized and in operation.

Auditor's Recommendation:

2. Conduct training with physicians and staff to ensure that physician certifications and orders are completed in accordance with the Centers for Medicare and Medicaid Services guidelines.

Management Response and Action Plan:

- Case Management utilizes a Physician Advisor to interact and educate physicians regarding the need for supporting documentation. This process is on-going throughout the year and will be reported to the Utilization Management Committee.
 - The Physicians Advisor in conjunction with the Manager and Director for Case Management will review the quality of the documentation on cases presented by the Case Manager.

Auditor's Recommendation:

3. Correct all incorrect claims identified during the audits and re-bill allowed.

Management Response and Action Plan:

- All claims referred to UM Committee will be reviewed with Physician Advisor. Recommendations for appropriate billing will be sent to Patient Accounting.
- This is an on-going process performed in collaboration with Appeals / Denials and Patient Accounting.