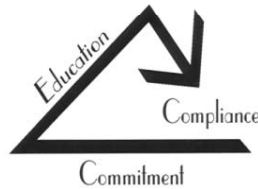


# AR Systems, Inc Training Library Presents

## Mastering the Chaos – Attacking The 2 Midnight Rule ++ Probe & Educate Highlights 3 +++FINDING YOUR LOST INPATIENTS

Instructor:

Day Egusquiza, Pres  
AR Systems, Inc



2015

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## OPPS 2016 FINAL change to definition of an inpt (Budget neutral?)

- 2 MN rule is alive and well
- AND we are looking 'back to the future' with an enhanced definition of '**rare and unusual**.'
- Still use the physician's documentation of 'why an inpt' but if the provider cannot estimate 2 MN /Presumption – then declare an inpt with rationale for 'severity of the condition/intensity of the care' that will require in hospital care. **HUGE AUDIT RISK!**
- No change to SNF; no Short stay DRG
- **Effective 1-1-16 –Back to the future – inpt without 2 MN /presumption. WOW!**

### Effective 10-1-15 –changes in auditing short stay P&E – 0 and 1 MN stays

- QIO (level 2 appeal) review 10-25 charts; denies or approves
- Calls hospital to set up review
- QIO tells MAC to recoup denied claim
- # of denials determines referral to RAC (but not before 1-16 DOS)
- MAC sends overpayment letter with appeal rights.
- Then Appeal levels begin:
- MAC/level 1; QIO/level 2; ALJ/level 3...
- Preferred as some physician involvement at the QIO
- RACs are not involved until a referral occurs – patterns of denials

2

## New RAC Procurement ++ Audits

- **July 10, 2015-** Effective 6-4-15, CMS has withdrawn the requests for quotes for the next round of RA contracts. CMS plans to update the statement of work and release new requests for proposals shortly. In the meantime, the current RA will continue thru at least Dec 2015.
- **Audits:** In mid Jan, 2015, CMS approved the RAC to begin reviewing Outpt Therapy thresholds claims –those over the \$3700 threshold- that were paid March 2, 14 thru Dec 31, 2014. In an effort to minimize provider burden, CMS set restrictions on the # of Additional Documentation Request (ADRs) that could be sent related to these claims.

1<sup>st</sup> ADR: can only request documentation for 1 claim

2<sup>nd</sup> ADR: can request up to 10% of total eligible claims

3<sup>rd</sup> ADR: up to 25% of remaining eligible claims

4<sup>th</sup> ADR: up to 50% of remaining eligible claims

5<sup>th</sup> ADR: up to 100% of remaining eligible claims

[https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent\\_Updates.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html)

2015

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## RAC Program Improvements 12-14-but not effective until new RACS

- **20 new program improvements: Reducing provider burden; Enhancing CMS oversight and Increasing program transparency.**
- ADR limits based on provider's compliance with Medicare rules. If increase denials, increase ADRs. Diversity across all pt types= ADRs ADR limits for new providers
- RAC can only do a 6 month look back for pt status reviews from DOS when the hospital submits the claim within 3 months of DOS
- RAC will have 30 days to complete complex reviews and share findings.
- RAC must have contractor Medical Director with open access to providers to speak to MD.
- RAC must wait 30 days to allow for discussion request before sending the claim to the MAC for adjustment. RAC must confirm receipt of discussion request within 3 b/days.
- RAC will not receive a contingency fee until after the 2<sup>nd</sup> level of appeal is exhausted. Previously RAC was paid immediately upon denial & recoupment of the claim.
- CMS will provide public info regarding data related to appeals.
- RAC must maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims corrected during the appeal process.

2015

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## More Audit changes.....

- RAC will be required to maintain an accuracy rate of at least 95%. Failure to maintain an accuracy rate of at least 95% will result in a progressive reduction in ADR Limits.
- Independent Auditor of the RACS: Performant/Region A 99.1% CGI/B 96.8% Connolly 92.8% (which just received the HH/DME/Hospice Region 5 contract/on hold now due to Performant's challenge) and HDI 97.0%
- CMS establishes a provider relations coordinator to offer more efficient resolutions
- CMS will post provider compliance tips on CMS's website.
- CMS will require the RACs to post more detailed review information concerning new issues to their websites.
- CMS will consider developing a provider satisfaction survey.
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf>

### **MORE AND MORE**

Med Learn CR8583, Effective April 1, 2015 Providers will not be granted additional time to submit records beyond the 45 day period. Failure to respond by day 45 will result in a denial. (Note: Some MACs are requiring pre-payment in 30 days...vs post payment with the RACs.)

2<sup>nd</sup> Round of Probe and Educate/Jan 2015. Question additional auditing before March 31, 2015.

## More Med Learn Updates

- National UB committee – **Occurrence code 72 MLN CR 8586, effective 12-13**  
First /last visit dates
- *The from/through dates of outpt services. For use on outpt bills where the entire billing record is not represented by the actual from/through services dates of Form Locator 06 (statement covers period) ..... AND*
- *On inpt bills to denote contiguous outpt hospital services that preceded the inpatient admission. (See NUBC minutes 11-20-13)*
- *Per George Argus, AHA, a redefining of the existing code will allow it to be used Dec 1, 2013. CMS info should be forthcoming.*

### **MLM SE1117 REVISED: Correct provider billing of admission date and statement covers period.**

*DOS after 10-1-11, admission date (FL 12) is the date the pt was admitted as an inpt to the facility. It is reported on all inpt claims regardless of whether it is an initial, or interim or final bill.*

*The statement covers period (from and thru dates/FL 6) identifies the span of service dates included in a particular bill. The 'from' date is the earliest date of service on the bill.*

# Let's Get Updated on Numerous CMS audit activity + Probe and educate & Recommendations

2015

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## RAC Activity – they are back! 9-14

- New referrals for audit-
- Medical necessity of the procedure, not if 2 MN was met
- MS – DRG 004- Tracheostomy with mechanical ventilation 96+ hrs
- Trastuzumab (Herceptin)- multi vial waste
- Blepharoplasty (eyelid lifts and repairs)
- Intensity Modulated Radiation Therapy
- Cancelled Inpt surgeries -OIG-100 records/80 without justification 'why an inpt.'
- **Guidance:** if cancelled during the pre-op process of an inpt ordered surgery, reasons for cancellation were identified, change to outpt as no inpt surgery was able to be done – known prior to beginning. **Create a reduced charge/pre-op** chg/prior to anesthesia.
- **Guidance:** if cancelled after the surgery has started/cost has started, ensure the record indicates 'why', **create a reduced charge/after anesthesia** and bill as inpt.

2015

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## Subcontracting Arrangement

- “Cahaba has entered a subcontracting arrangement with National Government Services (NGS) to provide Audit and Reimbursement (A&R) services. Cahaba serves as the primary contractor/MAC for the Jurisdiction J A/B and provides direction to all of subcontractors in the completion of the A&R workload. NGS will be requesting information from providers at desk review, reopening and for all audits. “ PER NGS, July 2015

2015

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## Error rate...and new focused audit results – LCD/Cataracts

- Health and Human Services/HHS – released end of Nov, 2014. (Agency Financial Report/\$42.7B improper payments)
- **Error rate: rose from 10.1 2013 to 11.8% 2014**
- **CGS/a MAC – released their probe of their LCD for Cataracts (2 states) Note: highest outpt procedure for Medicare. ALL states should use this guideline**
- **Kentucky 85.6% Ohio 88.7%**
- **HINT: At the first point of contact/scheduling – ensure all elements are met. (Maturity of the cataract disease process, visual acuity and ability to perform activities of daily living.) All documented, signed by the surgeon – yes!**

2015

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## FINAL change to Certification (Effective 1-1-15)

- “In CY 2014, IPPS Final Rule, CMS adopted revised certification requirements for all inpt admissions. Because all elements of the new certification had to be signed by the physician prior to discharge, this requirement has created a great deal of difficulty for hospitals and arguably required the most changes to computerized documentation systems of all changes in 2014. **The proposal would modify the regulation on certification to ONLY require the certification for OUTLIER cases and long stays, defined as 20 days or longer.** CMS is careful to note that the **order requirements from the Final Rule are not proposed to change and an order complying with the new order requirements is still necessary to demonstrate the patient is considered an input during the stay.**” (Final: pg 901-912; <http://s3.amazonaws.com/public-inspection.federalregister.gov/2014-26146.pdf>)
- **We still need: OPSS FINAL RULE, Nov 2014, effective 1-1-15 -CLARIFICATION**
  - An order to admit to “inpt” (beginning of the pt story)- **STILL REQUIRED** and signed prior to discharge.
  - A reason for admit/WHY the pt needs 2 MN in a ‘hospital’ (middle)
  - A discharge note/plan (ending/wrap up)
  - The full medical record must support the REASON/plan demonstrated
  - Just no longer a statement: “I Certify..by provider directing care/mid levels .”
  - PLUS if mid levels have admitting privileges – MD does not have to countersign.
  - 96 hr certification for critical access hospitals – **still required.**

2015

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## And more updates- Part C

- Managed Medicare Plans/Part C = HUGE
- They do not have to adapt Traditional coverage rules.
- Treat them like a Commercial Payers – get pre-certs, determine if they are using ‘2 MN’ rule methodology and/or clinical guidelines.
- Update contracts to CLEARLY outline the tools used to determine: what is an inpt.
- Always use: Physician order with rationale for why? (Sound familiar??)
- Big increase in denials...

2015

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## Huge Managed Care /Part C/Advantage Issues

- USA July 27<sup>th</sup> reported 2 huge potential purchases:  
Anthem BX purchase of Cigna  
Aetna purchase of Humana  
Making United the last of the 3 powerhouse companies.  
WATCH: Denial for the catch phrase: not medically necessary! MEANS?  
  
Negotiating will be more difficult.  
Ensure there is arbitration in all contracts.  
Define an inpt-with no ability to do retro denials 'after discharge.'  
Timelines to certify inpt status.
- Hot issues with denials or lack of inpt certifications:
  - Long LOS in obs with no 'rules' for conversion to inpt
  - Each payer gets to define their own coverage rules
  - Following the 2 MN Medicare Traditional rule AND clinical guidelines. (EITHER Interqual or Milliman.)
  - Levels of appeal clearly included – clarify why not following the 5 levels within CMS's process. Timelines for each and who does what.
  - Denials of coverage 'after discharge' as the pt ended up getting better faster/not as sick as presented on 1<sup>st</sup> contact/ other
  - HAVE AN ATTORNEY READY !!

2015

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Clean up the records– Prior to submission. Can you find the pt story? 2 & 1EMR copied



2015

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# What's New In the World of Audit?



2015

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## HOT: Related Claims Denials Effective 9-8-14 Transmittal 534/now 540/now 541

- **"Claims that are related"**
- **Purpose:** to allow the MAC and ZPIC/Audit groups within Medicare to have discretion to deny other 'related' claims submitted before or after the claim in question. If documentation associated with one claim can be used to validate another claim, those claims may be considered 'related.' **MAC MUST POST BEGINNING OF THIS PROCESS.**
- **Situations:** The MAC performs pre or post-payment review/recoupment of the admitting physician's and/or **Surgeon's Part B services.**
- For services related to inpt admissions that are denied, the MAC reviews the hospital records and if the physician services were reasonable and necessary, the service will be re-coded to the appropriate outpt E&M.
- **540/changed- HOLD - For services where the H&P, physician progress notes or other hospital record documentation does not support for medical necessity of the procedure, post payment recoupment will occur for the Part B service.**

2015

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## More Transmittal 534/now 540/now 541

- If Documentation associated with one claim can be used to validate another claim, those claims may be considered related.
- Upon CMS approval, the MAC shall post the intent to conduct 'related' claims reviews on their website.
- If 'related' claims are denied automatically- shall be an 'automated' review. If 'related' claims are denied after manual intervention, MACs shall count these as denials as routine review.
- The RAC shall utilize the review approval process as outlined in their Statement of work when performing reviews of 'related' claims. (Note: New RACs = new SOW. Pending)
- Contractors shall process appeals of the 'related' claims **separately**.
- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R541PI.pdf>

2015

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## And more update - Transfers

- **Transfer update:** During MedLearn call (2-26-14) CMS updated: receiving hospital CAN count time at a sending hospital toward their own 2 MN benchmark.
- Q2.2: How should providers calculate the 2-midnight benchmark when the beneficiary has been transferred from another hospital?  
A2.2: The receiving hospital is allowed to take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, **the start clock for transfers begins when the care begins in the initial hospital**. Any excessive wait times or times spent in the hospital for non-medically necessary services shall be excluded from the physician's admission decision.
- Sending hospital – if there is knowledge that the pt is being transferred/next day, the pt is obs as only 1 MN is appropriate in the sending hospital
- Use Occurrence Code Span 72/field to identify the date of the 1<sup>st</sup> MN/sending hospital.
- Place the date on the Inpt UB that may only have 1 additional MN for the receiving hospital.
- 2 MN Benchmark is now present on the 1 MN UB from the receiving hospital.
- Reference: SE1117revised MLNMatters "Correct provider billing of admission date and statement covers period."

2015

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## Tough Limitation –document

### Delays in the Provision of Care.: FAQ 12-23-13 CMS

- Q3.1: *If a Part A claim is selected for Medical review and it is determined that the beneficiary remained in the hospital for 2 or more MN but was expected to be discharged before 2 MN absent a delay in a provision of care, such as when a certain test or procedure is not available on the weekend, will this claim be considered appropriate for payment under Medicare Part A as an inpt under the 2 MN benchmark?*

*A3.1: Section 1862 a 1 A of the SS Act statutory limits Medicare payment to the provision of services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body. As such CMS' longstanding instruction has been and continues to be that hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment. Accordingly, CMS expects Medicare review contractors will exclude excessive delays in the provision of medically necessary services from the 2 MN benchmark. Medicare review contractors will only count the time in which the beneficiary received medically necessary hospital services."*

*HINT: If being delayed 'to Mon'- ensure there is clear documentation of the clinical assessments/plan/other services BESIDES the delay for the test/service. Unfortunately, the record usually shows 'ready for discharge except waiting for Mon to do the final test.' What is clinically appropriate about "MONDAY?"  
HINT: Critical access hospital challenges..*

2015

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## More "Related Claims" audits-MAC Probes

- NGS – 1-15
- "In 2015, NGS/MMR team will review up to 10 claims/medical records 3-5 inpt stays since 2 MN implementation."
- Previous probe/CERT found LOS beyond 2 MN with an upward trend in 3-5 day LOS. (Think referrals to SNF)
- HINT: Always chart the reason why the pt still needed 'in hospital care' = all care givers –not just details regarding the discharge plan.

2015

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## What is a Medicare Inpt?

- Per WPS-MAC/Medicare claims processor/auditor (July 23, 2014)
- “If there is one place I would recommend beefing up the documentation, **it is the plan**. There are many patients who present in very acute , life threatening ways, who do not require 2 MNs of care. (think CHF) **The plan, along with the diagnosis/clinical data** on the claim are the 2 biggest supporters of the physician’s reasonable expectation especially if that expectation isn’t met. If all you have is *‘monitor overnight and check in the morning’* – you are going to have a hard time supporting a part A/inpt payment, regardless of the symptomology. You could also add an unexpected recovery note at the end of the record, if they get well faster than the doctor thought at the time of the inpt order and expectation of 2 MN. But in this ex, you’ll have to explain what you expected and what actually happened. **It would be less charting if you actually just had a good plan up front.”**

2015

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## Probe and Educate: Probe 1 Results (Shared at RAC/MAC Summit 9, Nov, 2014) WPS /MAC

2015

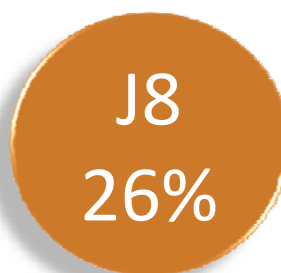
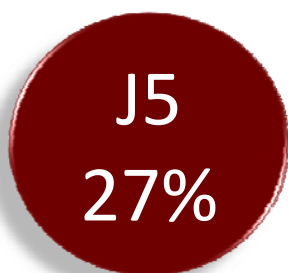
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## Probe 1- WPS data

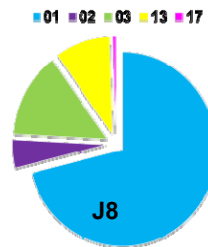
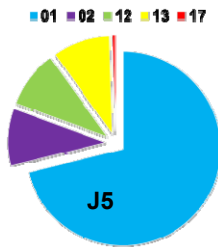
	J5	J8
Part A Hospital Provider Count	800*	300*
# of Providers Sampled	412	151
# of Claims Reviewed	3,625	1,328

- Approximate number
- J5- NE, IA, KS, MO
- J8- MI, IN

## Overall Denial Rate- WPS



## Denials by Type - WPS



5PC01	Documentation does not support services medically reasonable/necessary
5PC02	Insufficient documentation
5PC12	Order missing
5PC13	Order unsigned
5PC15	Certification not present
5PC17	No documentation of 2-midnight expectation

2015

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## Probe 2- WPS (Failed or not 10 in first sweep or had 1/0 now)

	J5	J8
Part A Hospital Provider Count	736	253
% of Claims Completed	32%	35%
Top Denial Code	5PC01	5PC01



### New in Probe 2

- 5PC11 - Procedure not reasonable and necessary

2015

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## Tips- WPS

- Verify your procedures for inclusion on the inpatient-only list
- Include the signed admission order
- Compare physician notes to orders
- Document changes in expected patient care
  
- NOTE: If the site 'failed 2<sup>nd</sup> round' – MAC will continue to audit 10-25 until 3-15/revised 11-14.
  
- ROUND 3: 5PRB3 = means the care is not supported in the record – more 1 day or zero days. WPS reported the denial rate dropping to 19% overall. (July 2015)

2015

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## Per WPS's Ask the Contractor 7-14 4 top reasons for denials with P&E

- 1) Missed or flawed orders. (EX: a) Order states observe and discharge in the am. Billed as inpt. b) multiple 'check boxes' to pick from. Pick "obs", billed inpt.
- 2) Surgery not on inpt only list. (EX: a) multiple outpt surgeries does not equal an inpt/spinal b) MAC has to flag for audit/CPT code the file and confirm if on the list.
- 3) Uncertain Course. (EX: a) symptoms/no dx b) no plan for why 2 MN.
- 4) Attestation/Certification process. (EX: Box marked without a reason/"I certify' ...what the regulation stated with no further justification. Does use H&P but needs tied to why the 2 MN . (Eliminated 1-1-15)
- REMEMBER – the 1<sup>st</sup> MN as an outpt does not count toward the 3 MN for SNF or Swing bed coverage.

2015

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## Novitas -Probe and Educate Medical Reviews – First Round

JH: CO, NM, OK, TX, AR, LA, MS

JL: PA, NJ, MD, DE, Dist of Co

PRESENTED TO THE RAC SUMMIT 11-14

	# Providers	# Claims Reviewed	# Claims Denied	% Claims Denied
JH	1004	3794	2206	58%
JL	586	2712	1720	63%

2015

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## Probe and Educate Medical Reviews – Second Round\*

	# Claims Reviewed	# Claims Denied	% Claims Denied
JH	3028	1666	55%
JL	1501	901	60%

\* To date

2015

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## Top Reasons for Denial – Novitas First Round

Denial Reason	% Denials JH	% Denials JL
Documentation did not support two midnight expectation (did not support physician certification of inpatient order)	50%	51%
No Records Received	29%	28%
Documentation did not support unforeseen circumstances interrupting stay	11%	11%
No inpatient admission order	3%	3%
Admission order not validated/signed	4%	3%
Other	3%	4%

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## Top Reasons for Denial – Second Round

Denial Reason	% Denials JH	% Denials JL
Documentation did not support two midnight expectation (did not support physician certification of inpatient order)	56%	53%
No Records Received	16%	17%
Documentation did not support unforeseen circumstances interrupting stay	4%	3%
No inpatient admission order	9%	15%
Admission order not validated/signed	11%	11%
Other	4%	1%

2015

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## Problematic Clinical Situations- NOVITAS

- Inadequate historical detail to understand symptoms of unknown significance in patients with underlying diseases
- Unstated or unclear impressions and treatment plans
- Admissions for management based on clinical guidelines and algorithms then not following those guidelines
- Variations in descriptions of patient condition by different physicians without explanation or reason
- Disconnects (and disagreements) between admitting physician and attending physician and between attending physician and specialist physicians
- Unforeseen circumstance vs. incorrect admitting diagnosis and treatment plan

2015

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## Examples- Novitas

- Transient Cerebral Ischemia
- Vague neurologic changes, altered mentation, uncomplicated syncope
- Gastrointestinal bleeding
- Cardiac arrhythmias (atrial fibrillation)
- Tube replacements
- Volume depletion
- Same day outpatient procedures
- Psychiatric problems, suicidal ideation, patient non-compliance, alcohol inebriation

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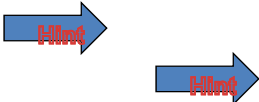
## What's Missing?

- Solid documentation of the nature of an illness, the physician's impression (differential diagnoses), and a clear statement of diagnostic/therapeutic choices along with their stated or implied rationale

2015

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## P&E findings: First Coast/MAC 244 hospitals: FL, PueRico, VirIsland

- 1<sup>st</sup> round:
    - 35% denial rate
  - REASONS:
    - 55% failed to document need for 2 MN
    - 45% failed admission order requirements
      - 48% signed after discharge
      - 39% order missing from the record
      - 13 % order not signed
- 
- 2nd round:
    - 36% denial rate
  - REASONS:
    - 40% failed to document need for 2 MN
    - 60% failed admission order requirements
      - 35% order missing from record
      - 17% order not validated
      - 8% order not signed (as of 2-11-15)
    - MAC recommendations:  
Providers document their decision making process. Paint a clear, concise picture of the pt.

2015

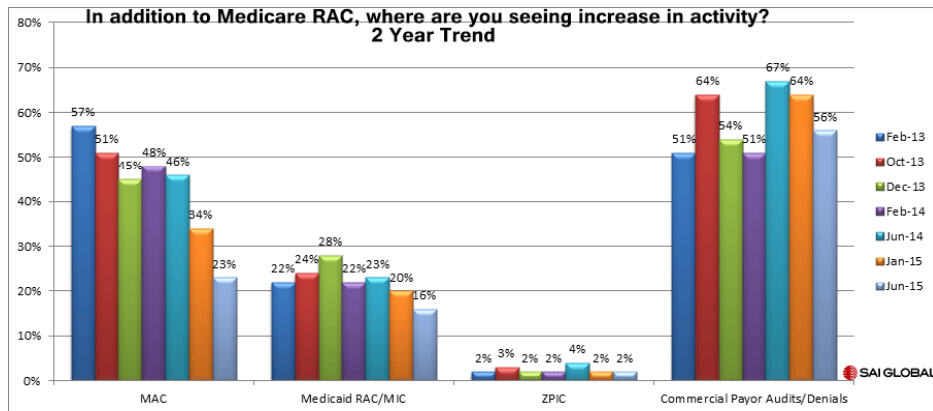
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## Every payer is looking for – why an inpt?

- Enhanced documentation at the beginning of care- ER/direct admit. First point of contact.
- Admit to inpt with the dx and the reason for inpt admission...
- ALL payers, every time.
- Embedded in the EMR 'que' questions to prompt the provider.
- Medicare – add the 2 MN or 1/1 MN question

2015

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RAC 2013

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# HOT AS A PISTOL – New Inpt ruling PLUS Billing for denied hospital inpt claims

## “VALUE ADDED INFORMATION

**FEAR OF AUDIT IS NOT JUSTIFICATION TO VIOLATE BENEFICIARIES RIGHTS OR DEPRIVE THE HOSPITAL OF COMPLIANTLY EARNED REIMBURSEMENT. (Physician advisors on RAC RELIEF 11-13)**

## It never changed... Documentation to support the level of care...

- “No Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness of injury or to improve the functioning of a malformed body member.” Title XVIII of the Social Security Act, Section 1862 (a) (1) (A)
- “Observation services must also be reasonable and necessary to be covered by Medicare.” (Medicare claims processing manual, Chapter 4, 290.1) Obs did not change.
- “The factors that lead a physician to admit a particular patient based on the physician’s clinical expectation are significant clinical considerations and must be clearly and completely documented in the medical record.” (IPPS CMS 1559-F, p 50944)
- Only a physician can direct care ...and...Patient Status....

## Key elements of new inpt regulations – 2 methods

- **2midnight presumption**
- “Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.  
Pg 50959
- **Benchmark of 2 midnights/NEW INPTS**
- “the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt’s total expected LOS. **HUGE LOST INPTS!**  
Pg 50956

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## Understanding 2 MN Benchmark – 72 Occurrence Span MM8586 1-24-14

- EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under the expectation the pt will require medically necessary hospital services for an additional midnight. Pt is discharged on 12-3 at 8am.
- Impacts ER, Observation and Outpt Surgery.
- 1 MN out + 1 MN inpt expectations = 2 MN benchmark inpt.
- EX) Pt is an outpt surgical encounter at 6 pm on 12-21-13 is still in the outpt encounter at 1 min past midnight on 12-22-13 and continues as a outpt until admission. Pt is admitted as an inpt on 12-22 at 1am under the expectation that the pt will required medically necessary hospital services for an additional midnight. Pt is discharged on 12-23-13 at 8am. Total time in the hospital meets the 2 MN benchmark..**regardless of Interqual or Milliman criteria.**

2015

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## STILL largest lost revenue – 2 MN benchmark – converting after 1<sup>st</sup> MN

- After the 1<sup>st</sup> MN as an outpt – anywhere – or the first MN in another facility and transferred in –
- “The decision to admit becomes easier as the time approaches the 2<sup>nd</sup> MN, and the beneficiaries in *necessary hospitalization* should NOT pass a 2<sup>nd</sup> MN prior to the admission order being written.’ (IPPS Final rule, pg 50946)
- Never, ever, ever, ever have a 2<sup>nd</sup> medically appropriate MN in outpt..convert, discharge or free...

2015

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## “Meeting Criteria” – means?

- It never has and never will mean – “meeting clinical guidelines” (Interqual or Milliman)
- It has always meant – the physician’s documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet Criteria – this means: Doctor cannot certify/attest to a medically appropriate 2 midnight stay – right?
- **11/1/2013 Section 3, E. Note: “It is not necessary for a beneficiary to meet an inpatient “level of care” by screening tool, in order for Part A payment to be appropriate”**
- **Hint: 1<sup>st</sup> test: Can attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers... but the physician’s order with ROA – trumps criteria.**

2015

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## Let's get started-new language

### Certification process- It is the 'why..because'

- Lots of 'chatter' but evaluate this process flow.
- 1<sup>st</sup> question: **Can the pt go home safely** from the ER? Assess the reasons the provider (ER doc consults with the provider directing care) and document same. (Risk factors, history of like condition with outcome, presenting factors, plan )
- 2<sup>nd</sup> question: **Can the ER physician** (after consulting with the admitting) attest/certify that the pt needs to 'be in the hospital' **for an estimated 2 midnights** to resolve the condition?
- 3<sup>rd</sup> question: If no, move to OBS and evaluate closely. If yes, move to inpt with other elements of the inpt certification.

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## Where do the patients come from? Two hot spots for referrals into "a bed"

- ER & Inpt surgery (& Direct Admits?-SUPER HOT)
- Attack these places with a pro-pt status focus, not placing and chasing.
- Develop internal flows to attack:
  - ER - how much UR coverage ? 24/7? or utilize ER lead RNs or house supervisors. No pt is given a bed without pt status 'blessed.' Integrated CDI program will help with cross training.
  - Inpt surgery – all daily inpt surgery schedules are reviewed by UR to review outpt being scheduled as outpt.
  - Direct – House supervisors or/& UR clarify PRIOR to placement.
  - Involve the internal UR leaders and PA for patterns.
  - Sr leadership will have to be prepared to push thru the regulation with any problematic providers.

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## Still struggling with Certification of 2 MN Presumption and old language.

- Case: ER doctor admits the pt on Sat am. Facility is not using a certification form/tool . The ER doc does not have admitting privileges, so bridge/transitional. Did not document conversation with the admitting or hospitalist.
- Mon am UR comes in.
- Determines the case does not meet clinical guidelines/Interqual.
- Asks Admitting to convert back to Obs.
- Pt was discharged home prior to having the UR provider agree.
- What is broken?

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## Still struggling with 2 MN Benchmark

- EX) Pt came to ER on Fri night/1900. ER provider, after discussing with the hospitalist, determines the pt is not safe to go home.
- They agree that the pt does not need 2 MN , at this time, and places in obs.
- **No UR coverage in the ER or weekends.**
- 1<sup>st</sup> MN/ER
- 2<sup>nd</sup> MN/Sat – does the pt need additional services/ care to resolve the condition?
- UR discusses with admitting provider and converts to INPT with the PLAN clearly outlined in the Reason for Admit for the 2 MN.
- **NO dedicated Ambulatory Outpt Unit**

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## Dedicated Outpt Ambulatory Beds = focus is outpt

- Change the focus of 'mini-inpt' to an outpt who is aggressively/rapidly being assessed/reassessed to determine to discharge safely or be admitted.
- Medicare – triggers in dedicated bed to 'actively involve the hospitalists/primary care provider' as each order is completed, move to an updated order: new order, d/c or admit. Watch closely as **the 2<sup>nd</sup> MN approaches**.
- Surgical cases – going home! Place routine recovery/after PACU rather than on the floor. Perception: not an inpt.
- Dedicated staff (Hospitalists, UR, Clinical) and focus on outpt and rapid discharge or timely conversion.
- Recovery beyond 'routine' (usually 4-6 hrs) = extended recovery. Planned recovery beyond routine with a medical reason to be a bed. Ordered with an action plan – never just 'stay the night." UG

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## Surgery scheduling joins the UR team

- Inpt only – scheduling gets CPT code/HIM codes, researches, notifies UR if problems.
- Outpt surgeries being scheduled as inpt – scheduling notifies UR of a potential problem. Surgeon is immediately contacted.
- PATTERNS – UR tracks and trends concerns/non-compliant surgeons.
- Physician advisor – involved as needed for peer to peer intervention, education, etc.
- UR committee – patterns are presented with assistance/intervention requested.

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# Bad habits – Attack them

- After an uneventful, but late outpt invasive procedure, physician orders to **‘stay the night’**. This is a FREE service as the pt has no medical reason to be in a bed. Time to discharge .
- Liability risk for having a non billable pt in the hospital.
- **Have the pt stay the night** and do the test in the am or Mon/wkd.
- What is the clinical reason to ‘stay the night?’ If not an unplanned event leading to OBS, a FREE service.
- Is there another clinical reason to be in a bed? Document it well with correct status...

Date/Time	Patient Name	INPATIENT ADMISSION CERTIFICATION (Medicare only)
		<p><b>Check appropriate box for patient status:</b></p> <p><b>Place in Outpatient Observation</b></p> <p><b>Admit to Inpatient Services (Initial)</b></p> <p><b>Level of Care</b></p> <p>Acute Care</p> <p>Tertiary</p> <p>Reason for Admission</p> <p>ICD-9-CM Procedure</p> <p>ICD-9-CM Diagnosis</p> <p>Physician Signature</p> <p>Date/Time</p>
		<p><b>INPATIENT ADMISSION CERTIFICATION (Medicare only)</b></p> <p>Box A This patient is admitted for inpatient services. The patient is medically appropriate and meets medical necessity criteria.</p> <p>1 Medically Necessary Inpatient</p> <p>2 Medically Necessary Inpatient</p> <p>3 Medically Necessary (ICD-9-CM) Inpatient</p> <p>For Initial Certification (ICM only)</p> <p>10 Days for Length of Stay in Outpatient Observation</p> <p>For Re-Certification</p> <p>The Length of Stay is Exceeding 90 days</p> <p>Place for Post-Hospital Care: See Discharge Summary</p> <p>Supportive Findings to Primary Diagnosis (optional): see certification, observed findings, diagnostic observations, procedures, see notes of those with (date/time/location)</p> <p>Physician Signature (Date/Time)</p>

**SAMPLE “CLARIFICATION OF ORDER” FORM (Form is not required)**  
 Use for both OBS and Inpt – clarification of order and intent  
 And remember – it is not just a ‘form’ but the beginning of the pt story.  
**Key elements:** Reason for admit/what is the plan for the estimated 2 MN stay or 1 additional MN after 1 outpt MN.

## A form is just a form...

- If it doesn't tell the reason for admit, why the dx will take an estimated 2 MN/presumption or a 2<sup>nd</sup> MN /benchmark.
- If it doesn't outline the plan for treatment with the treatment done and wrapped up in the discharge note.
- Medically necessary? If it isn't addressed thru the Reason for Admit/Plan, action attached to the RFA, then clinical guidelines won't 'bail' out the inpt.
- SO....It is all about the story told by the provider- beginning, middle, end with a beautiful wrap up.

## More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2<sup>nd</sup> midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)
- Note: presumption = 2 midnights AFTER obs. 1 midnight after 1 midnight OBS = at risk for inpt **audit**
- Pg 50946
- ..the judgment of the physician and the physician's order for inpt admission should be based on the expectation of care surpassing the 2 midnights with **BOTH** the expectation of time and the underlying need for medical care supported by complex medical factors **such as history and comorbidities, the severity of signs and symptoms, current medical needs and the risk of an adverse event.** Pg 50944

## And the “what if’s”

- 412.3 (e) (2) (see p. 50965 of Final Rule) – “If an unforeseen circumstance, such as a beneficiary’s death or transfer, results in a shorter beneficiary stay than the physician’s expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and hospital inpatient payment may be made under Medicare Part A.” (Thx, Accretive)”
- **Can 1 day stay inpts still occur?**
- YES -but as the regs clearly state, anticipate an audit as it should be a highly uncommon occurrence.
- 1 MN as outpt or OBS and 1 MN as inpt = inpt
- Just because a patient dies, is transferred for tertiary care, or leaves AMA, (paraphrased from LCD L27548) it does not change the *presentation of clinical factors/criteria* that went into the physician’s complex medical decision to admit to an inpatient status. (Thx, Appeals Masters)

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## With unusual cases... Rare and unusual = ordered as a 1 day stay

- Lots of discussion on : *“My patient is very sick, at risk but I don’t think they will need 2 midnights. I checked with Interqual/UR and it meets their definition of an inpt. I am admitting and highly anticipate they will only need 1 midnight.” (nope, not an inpt/obs and monitor closely)*
- **CMS has stated**: Rare and unusual. 2 outlined definitions at this time: inpt only surgeries and initiation of mechanical ventilator with 1 midnight. They are still working on how to address transfers out & hospice referral.. (RAC Summit/12-13)
- DIFFICULT to prove –but part of P&E concerns.
- Stay tuned for more if the proposed 2016 regulation is approved.

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# More examples of coverage

CAH: must use the 2 MN presumption/benchmark PLUS certification to reasonably expect the pt to transfer or discharge within 96 hrs. If longer, re-do but should be unusual cases. (Watch HR 3991/slim chance to pass.)

Ex) What if the surgery was delayed because the surgeon was only at the hospital 1 day a week? Is there another hospital where the surgery could occur without the delay?

EX) Is the stay beyond 96 hrs within the scope of the CAH?

Long obs: Pt in in Obs for 2 midnights. 1<sup>st</sup> Q: did the pt have 48+ hrs of billable obs or just hrs in a bed?  
2<sup>nd</sup> Q: Was the regulation for OBS met? (OBS is: Active physician involvement/ongoing assessment.)

If MET- then the pt was eligible to convert to INP after the first midnight with the physician 'attesting' of the need for medically appropriate care -2<sup>nd</sup> MN

## 96 hr CAH requirement/CMS Physician certification, Jan 31,2014 (still required/OPPS 1-15)

and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, 42 CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

d. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.

e. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Time as an outpatient at the CAH does not count towards the 96 hours requirement. The clock for the 96 hours only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour inpatient limit.

If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH and something unforeseen occurs that causes the individual to stay longer at the CAH, there would not be a problem with regards to the CAH designation as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay.

f. Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

2. **Timing:** Certification begins with the order for inpatient admission. The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. With regard to the time of discharge, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the physician as having to occur prior to discharge (e.g., "discharge after supper" or "discharge after voids"). So discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the physician's order for discharge is effectuated.

3. **Authorization to sign the certification:** The certification or recertification may be signed only by one of the following:

## Key areas to support documentation for pt status

- **Admitting physician** 'starts the pt story' thru use of the certification process – including REASON FOR ADMIT.
- **Internal Physician Advisor**- trainer/champion, works closely with UR and all providers to ensure understanding/compliance.
- **Nursing** continues with the care/assessments/interventions relative to the reason for admit.
- **UR** works with the treating/admitting physician to expand/clarify the documentation at the beginning and conclusion of the patient's stay. Additionally UR closely monitors completion of the certification for ALL payers.
- **Integrated CDI** continually interacts with providers/nursing to ensure all elements are clear /complete . 1 voice of ongoing education...

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## WINS with the 2 midnight rule- Don't be afraid of your inpt...

- Clarification of order form – always. Consistently start and clarify the pt story.
- UR in the ER – always involved prior to placement.
- Hospitalist – always see the pt rapidly/less than 2 hrs from referral to inpt.
- Integrated CDI program – one ongoing audit, one voice for ed
- Dedicated beds for OBS. OBS hasn't changed at all. UR assigned to closely monitor every OBS that exceeds the first midnight.
- Grow an internal physician advisor—NOW! Ongoing education, UR support/intervention = effective change
- Actively involve nursing as the eyes of the pt story 24/7.
- Actively involve surgery scheduling to 'spot' any common outpt surgeries being scheduled as inpt.
- Beef up the UR committee
- Beef up the UR 's role, separate from case mgt. Front end...

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- Services unavailable
- Weekends & Holidays
- Patient safety
- Consultants unavailable
- Equipment down
- Patient & family issue

(Thanks, Dr Salvador, DE hospital & PA/UR bootcamp faculty)

## HFMA's HFM article 2-14 issue- "8 Critical Steps for 2 MN Compliance"

- 1) Embed questions from the optional certification form within the electronic orders or use the manual form.
- 2) Empower UR staff to assist with compliance
- 3) Know which procedures are riskiest, such as cath lab procedures and outpt surgeries that 'stay the night'.
- 4) Target physicians in the ED.
- 5) Hire internal physician advisors to assist with education.
- 6) Understand the implications for transfers
- 7) Use internal audits to identify problem areas
- 8) Learn from the probes and hammer the message home

## AR Systems' Contact Info

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Free info line available.

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