Documentation –Inpt vs. Obs- It is all about the patient's story Plus Total Knee Anguish

Presented By:
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From the OIG/ Office of Inspector General

- Currently only the QIOs are auditing 0-1 MN stays –with the limit of 10-25 records per request. Moving to more focused reviews if 'at risk' is identified-referred to RAC. (NOW – HOW TO COORDINATE AUDITING?)

RECOMMENDATIONS FOR CMS TO DO:

1) Conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpt stays that are potentially inappropriate under the 2 MN policy.
2) Identify and target for review the short inpt stays that are potentially inappropriate under the 2 MN policy.
3) Analyze the potential impacts of counting time spent as an outpt toward the 3-night requirement for SNF so that pts receiving similar hospital care have similar access to these services.
4) Explore ways of protecting pts in outpt stays from paying more than they would paid as an inpt. (CMS concurred with all)

Final 2019 "Inpatient Order" CMS Chaos

- Pub 100-02 Medicare Benefit Policy: Transmittal 234, CR 9979, March 10, 2017 "An inpt is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. …an individual becomes an inpatient of a hospital, including a critical access hospital, when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner described in the final regulations."
- 412.3 admissions. "This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpt services under Medicare Part A. "
- Sub-regulatory guidance, not final regulation , regarding signing inpt order prior to discharge. 2019 Final IPPS does not address the 'signed prior to discharge is no longer required." Silent –so no change to sub-regulatory guidance.
- Dr Hu/President/ACPA: In open door call, "CMS does not plan to change Medicare guidance regarding provider responsibilities for the inpt order. They said so in the final rule..change is neglible to CMS."

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More CMS Inpt Challenges

- 2014 IPPS Final Rule– …in the extremely rare circumstances the order to admit is missing or defective, yet the **INTENT,** decision and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpt can CLEARLY be derived from the medical record, **MEDICAL REVIEW CONTRACTORS** are provided discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record."
- **What Changed in 2019? Essentially, nothing**… ASK MAC FOR CLARITY!
- Are inpt orders still expected to be present? Is 'getting paid' that matters or the reason for the admit/tied to the 2 MN rule? What does 'intent' look like?
- What does 'extremely rare circumstances' look like? Is it meant for daily operations of getting an inpt order or just for the external/contracted CMS auditors to use judgement and not deny simply as no inpt order was in the record?
- WHAT ABOUT THE OTHER PAYERS? Are you setting up a 'rare rule' for no order and no signature prior to discharge exceptions for Traditional Medicare ONLY?

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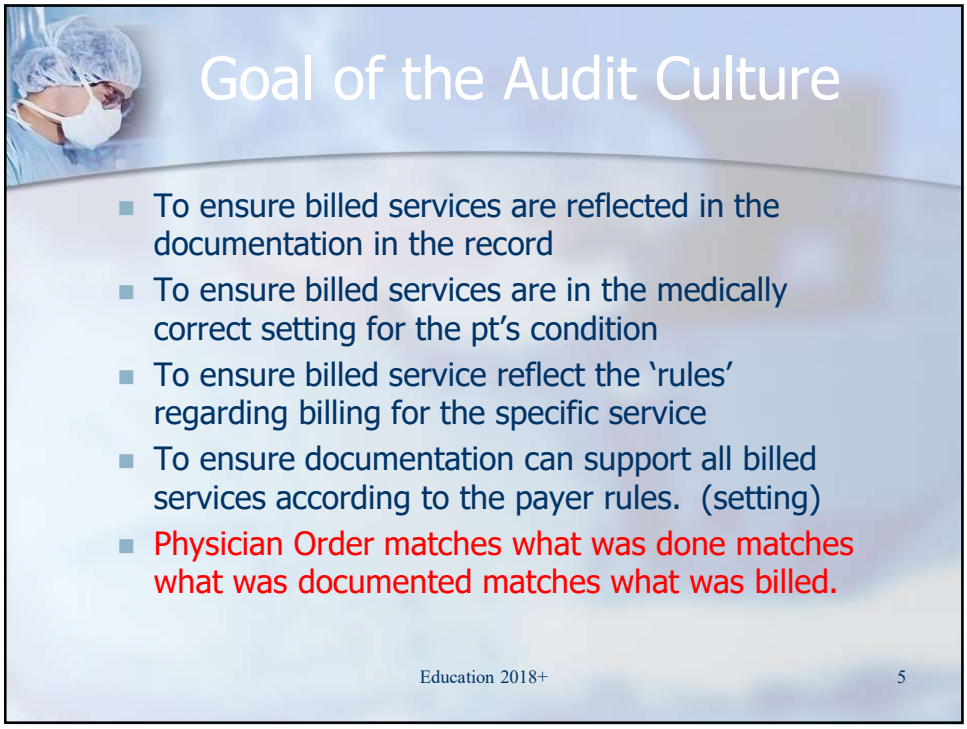
Goal of the Audit Culture
To ensure billed services are reflected in the documentation in the record
To ensure billed services are in the medically correct setting for the pt's condition
To ensure billed service reflect the 'rules' regarding billing for the specific service
To ensure documentation can support all billed services according to the payer rules. (setting)
Physician Order matches what was done matches what was documented matches what was billed.
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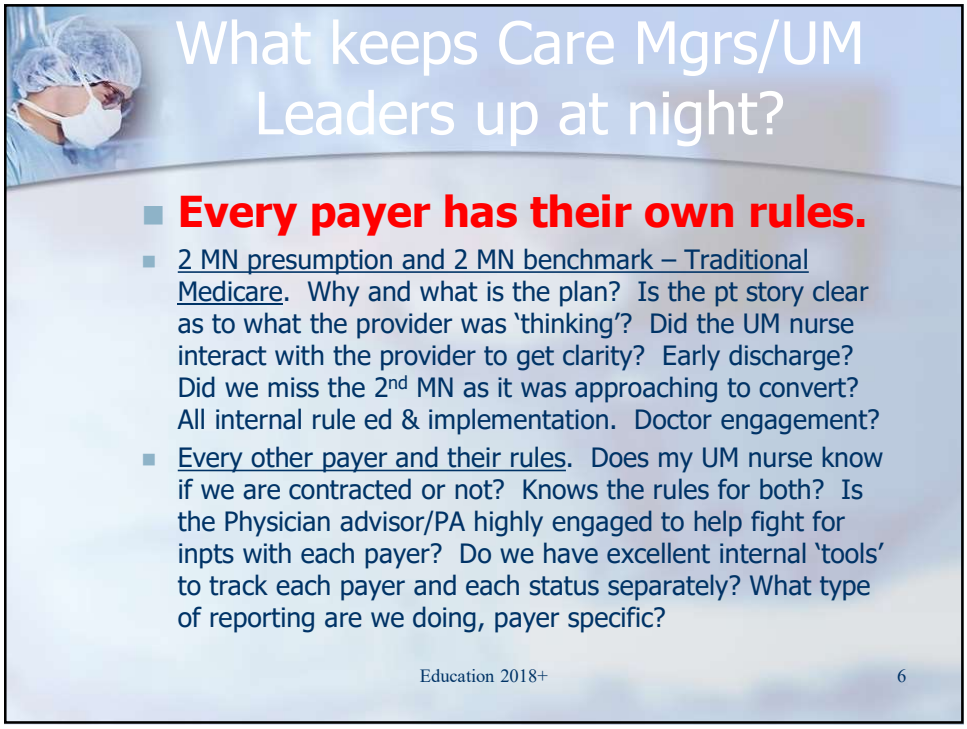
What keeps Care Mgrs/UM Leaders up at night?
Every payer has their own rules.
2 MN presumption and 2 MN benchmark – Traditional Medicare. Why and what is the plan? Is the pt story clear as to what the provider was 'thinking'? Did the UM nurse interact with the provider to get clarity? Early discharge? Did we miss the 2nd MN as it was approaching to convert? All internal rule ed & implementation. Doctor engagement?
Every other payer and their rules. Does my UM nurse know if we are contracted or not? Knows the rules for both? Is the Physician advisor/PA highly engaged to help fight for inpts with each payer? Do we have excellent internal 'tools' to track each payer and each status separately? What type of reporting are we doing, payer specific?
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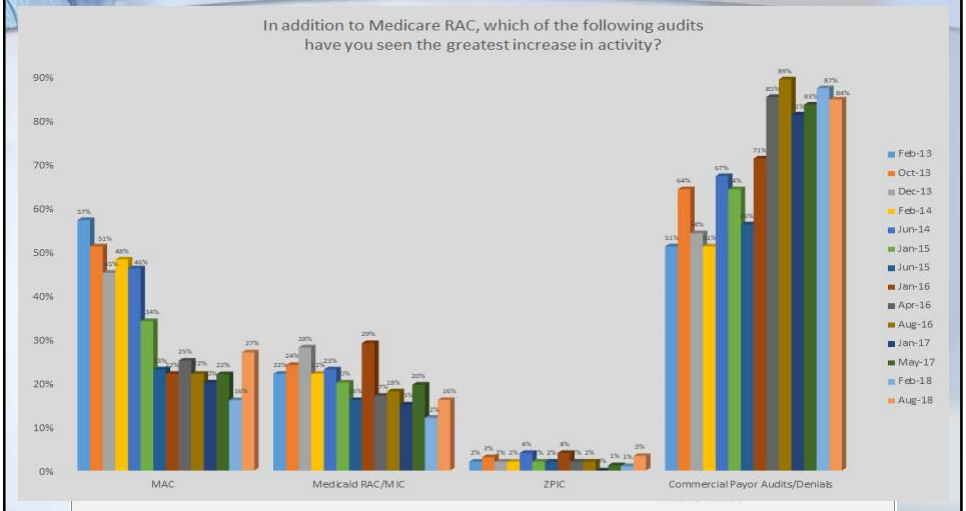
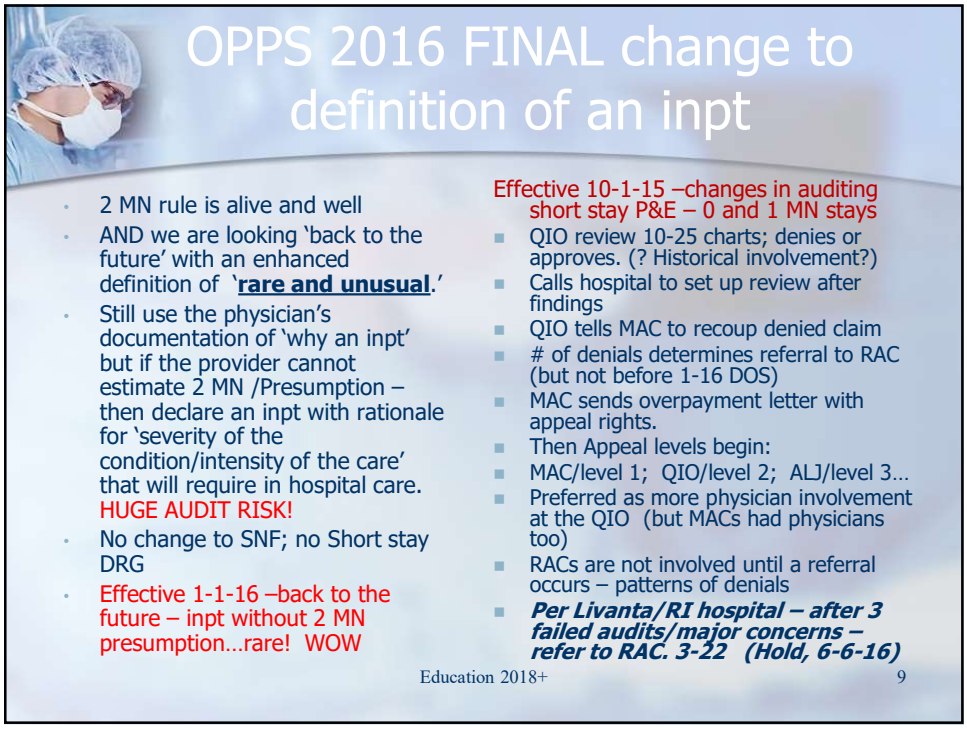
All Payers are auditing…

- Each payer has their own set of 'criteria' for coverage- Milliman/MCG, Interqual, medically necessary stay (?). (United, Blues, Part C Medicare, PEPPER/Traditional Medicare is targeting 1 day surgical, 2 day Surgical, same day medical, and same day surgery, etc.)
- Each payer has their own standards for appeals
- Each payer determines if the documentation supports the service that was billed.
- Documentation to tell a strong pt story – but be aware of the enhanced payer battles..

Compliance 360 Free Webinar 4 yr trend





OPPS 2016 FINAL change to definition of an inpt

- 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…rare! WOW

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

- QIO review 10-25 charts; denies or approves. (? Historical involvement?)
- Calls hospital to set up review after findings
- 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 more physician involvement at the QIO (but MACs had physicians too)
- RACs are not involved until a referral occurs – patterns of denials
- ***Per Livanta/RI hospital – after 3 failed audits/major concerns – refer to RAC. 3-22 (Hold, 6-6-16)***

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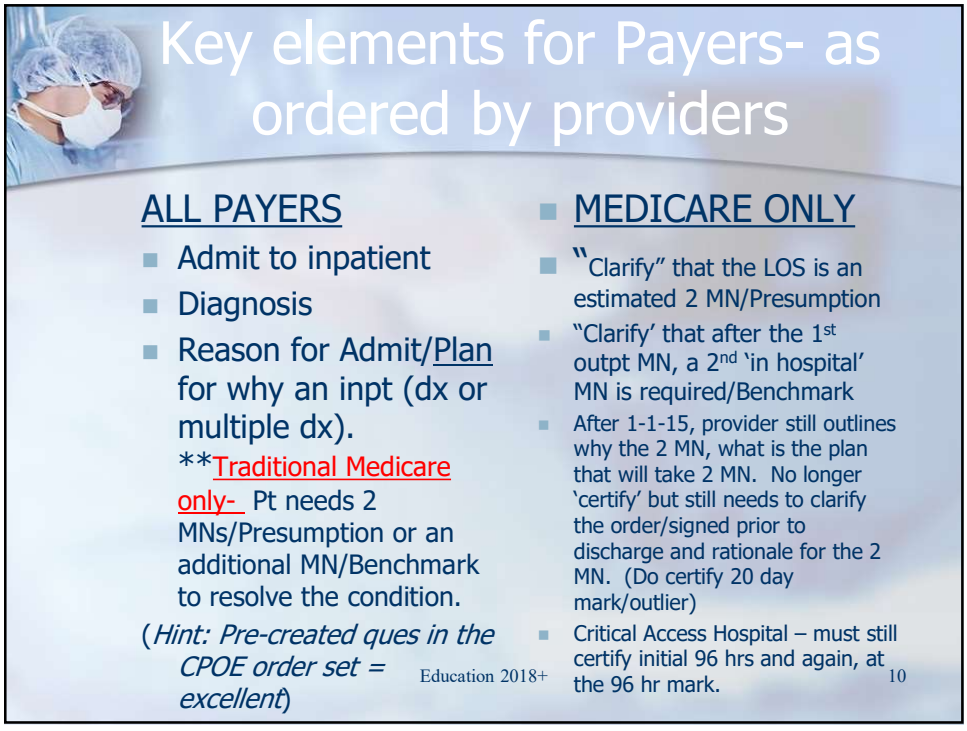

Key elements for Payers- as ordered by providers

ALL PAYERS

- Admit to inpatient
- Diagnosis
- Reason for Admit/Plan for why an inpt (dx or multiple dx). **Traditional Medicare only- Pt needs 2 MNs/Presumption or an additional MN/Benchmark to resolve the condition.

(*Hint: Pre-created ques in the CPOE order set = excellent*)

MEDICARE ONLY

- "Clarify" that the LOS is an estimated 2 MN/Presumption
- "Clarify' that after the 1st outpt MN, a 2nd 'in hospital' MN is required/Benchmark
- After 1-1-15, provider still outlines why the 2 MN, what is the plan that will take 2 MN. No longer 'certify' but still needs to clarify the order/signed prior to discharge and rationale for the 2 MN. (Do certify 20 day mark/outlier)
- Critical Access Hospital – must still certify initial 96 hrs and again, at the 96 hr mark.

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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://3.amazonaws.com/public-inspection.federalregister.gov/2014-26146.pdf)

- **We still need: OPPS FINAL RULE, Nov 2014, effective 1-1-15 – CLARIFICATION (*SOAP*)**
  - 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. (**UPDATE**: ODF call 1-26-16 with CMS- No countersign with inpt mid-level orders. But CMS has not published anything in writing, yet.)
  - 96 hr certification for critical access hospitals – **still required**.

Why we LOVE the 2 MN Rule for Traditional Medicare?

- What is the difference between inpt and obs for Traditional Medicare?
- 2 MN presumption: the provider declaring the estimated need for 2 MN PLUS a plan that will take the 2 MN.
- 2 MN benchmark: the provider declaring the need for a 2nd medically appropriate MN after the 1st MN as an outpt PLUS a plan that will take a 2nd MN.
- EASY ---LOVE IT! (Other payers – not so much!)

Key elements of new Medicare 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.

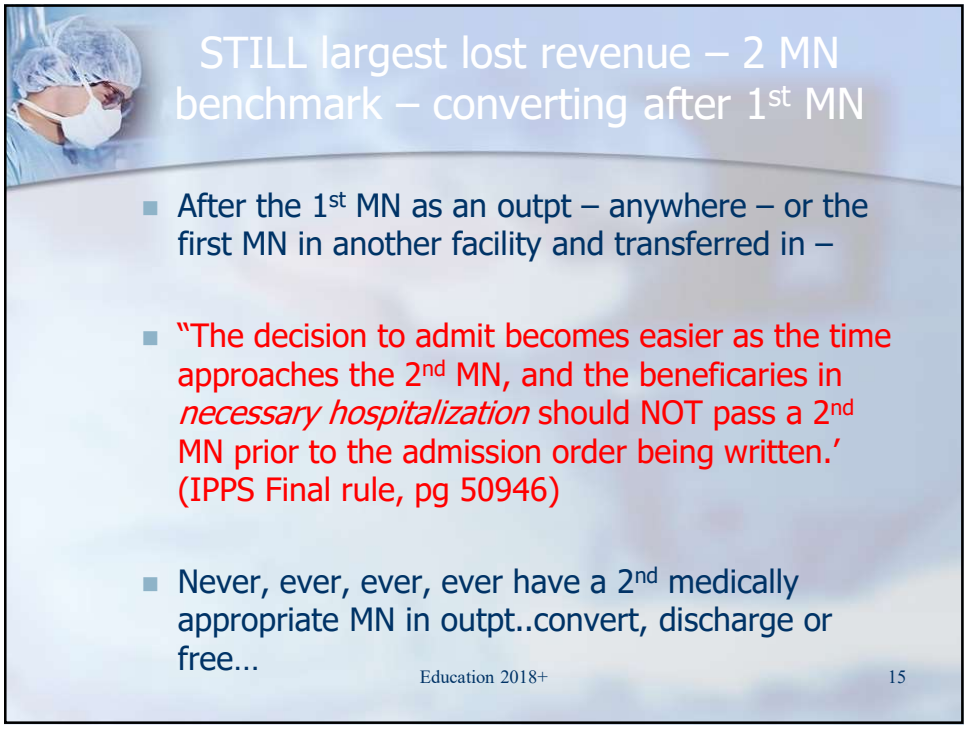
Pg 50959

- **Benchmark of 2 midnights**
- **The new Medicare Inpt**
- "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.

Pg 50956

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. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman/MCG criteria.
- ER, Observation, outpt surgery = all included in the 2 MN Benchmark.
- 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.


STILL largest lost revenue – 2 MN benchmark – converting after 1st MN
After the 1st 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 2nd MN, and the beneficaries in necessary hospitalization should NOT pass a 2nd MN prior to the admission order being written.' (IPPS Final rule, pg 50946)
Never, ever, ever, ever have a 2nd medically appropriate MN in outpt..convert, discharge or free…
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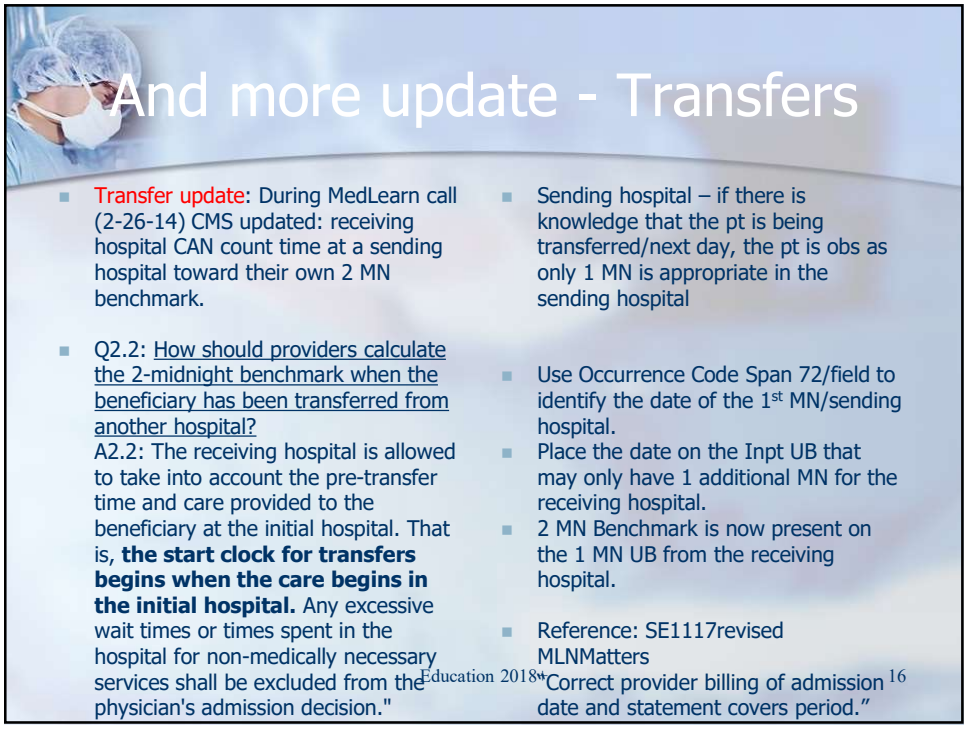
And more update - Transfers
Transfer update: During MedLearn call (2-26-14) CMS updated: receiving hospital CAN count time at a sending hospital toward their own 2 MN benchmark.
Q2.2: How should providers calculate the 2-midnight benchmark when the beneficiary has been transferred from another hospital?
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 1st 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."
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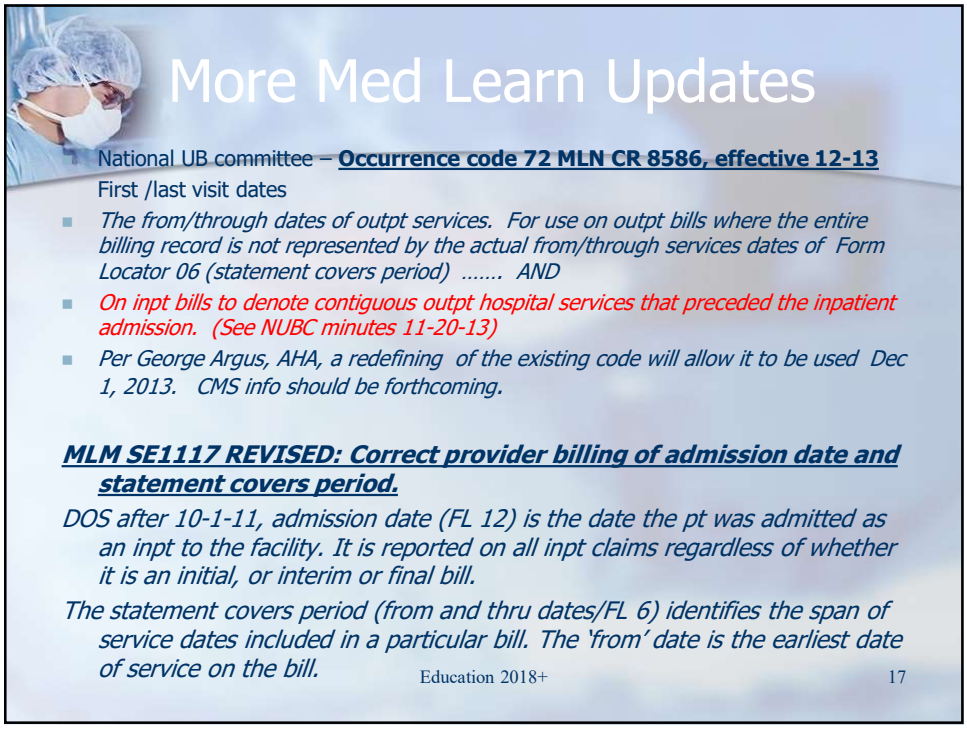
More Med Learn Updates
National UB committee – **Occurrence code 72 MLN CR 8586, effective 12-13**
First /last visit dates
The from/through dates of outpt services. For use on outpt bills where the entire billing record is not represented by the actual from/through services dates of Form Locator 06 (statement 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.
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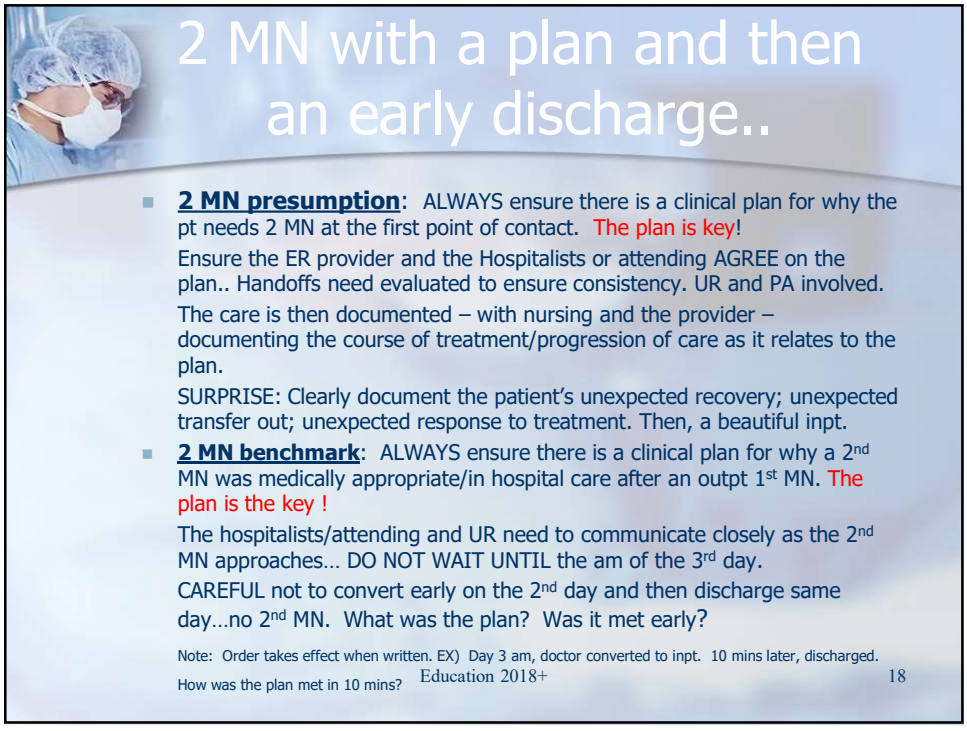
2 MN with a plan and then an early discharge..
2 MN presumption: ALWAYS ensure there is a clinical plan for why the pt needs 2 MN at the first point of contact. The plan is key!
Ensure the ER provider and the Hospitalists or attending AGREE on the plan.. Handoffs need evaluated to ensure consistency. UR and PA involved.
The care is then documented – with nursing and the provider – documenting the course of treatment/progression of care as it relates to the plan.
SURPRISE: Clearly document the patient's unexpected recovery; unexpected transfer out; unexpected response to treatment. Then, a beautiful inpt.
2 MN benchmark: ALWAYS ensure there is a clinical plan for why a 2nd MN was medically appropriate/in hospital care after an outpt 1st MN. The plan is the key !
The hospitalists/attending and UR need to communicate closely as the 2nd MN approaches… DO NOT WAIT UNTIL the am of the 3rd day.
CAREFUL not to convert early on the 2nd day and then discharge same day…no 2nd MN. What was the plan? Was it met early?
Note: Order takes effect when written. EX) Day 3 am, doctor converted to inpt. 10 mins later, discharged. How was the plan met in 10 mins?
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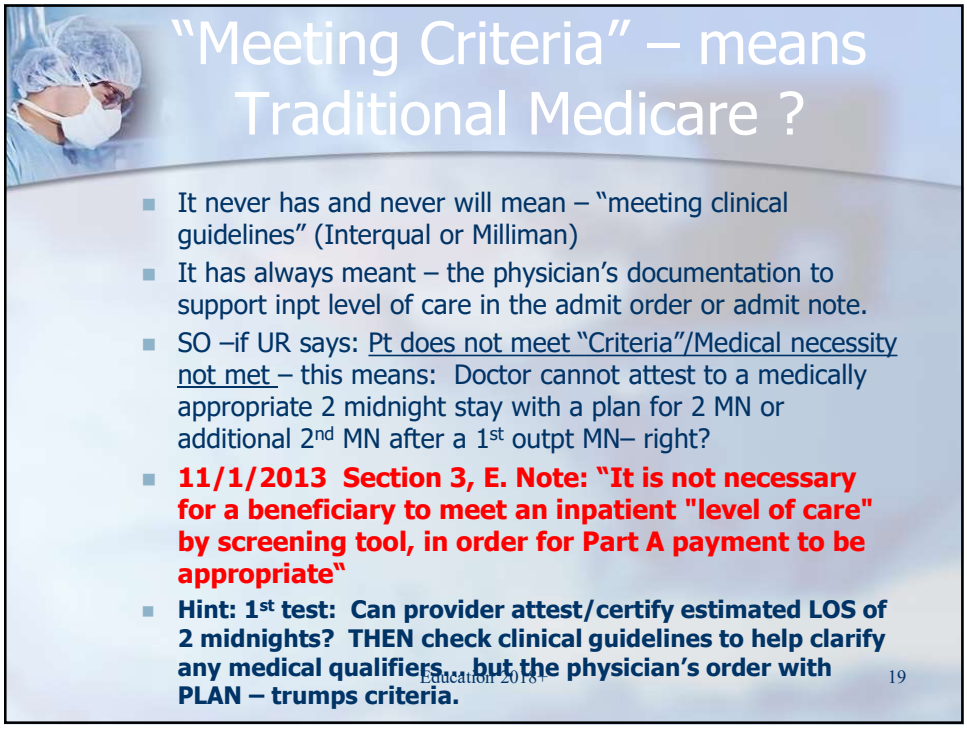
"Meeting Criteria" – means Traditional Medicare ?
It never has and never will mean – "meeting clinical guidelines" (Interqual or Milliman)
It has always meant – the physician's documentation to support inpt level of care in the admit order or admit note.
SO –if UR says: Pt does not meet "Criteria"/Medical necessity not met – this means: Doctor cannot attest to a medically appropriate 2 midnight stay with a plan for 2 MN or additional 2nd MN after a 1st outpt MN– 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: 1st test: Can provider attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers… but the physician's order with PLAN – trumps criteria.
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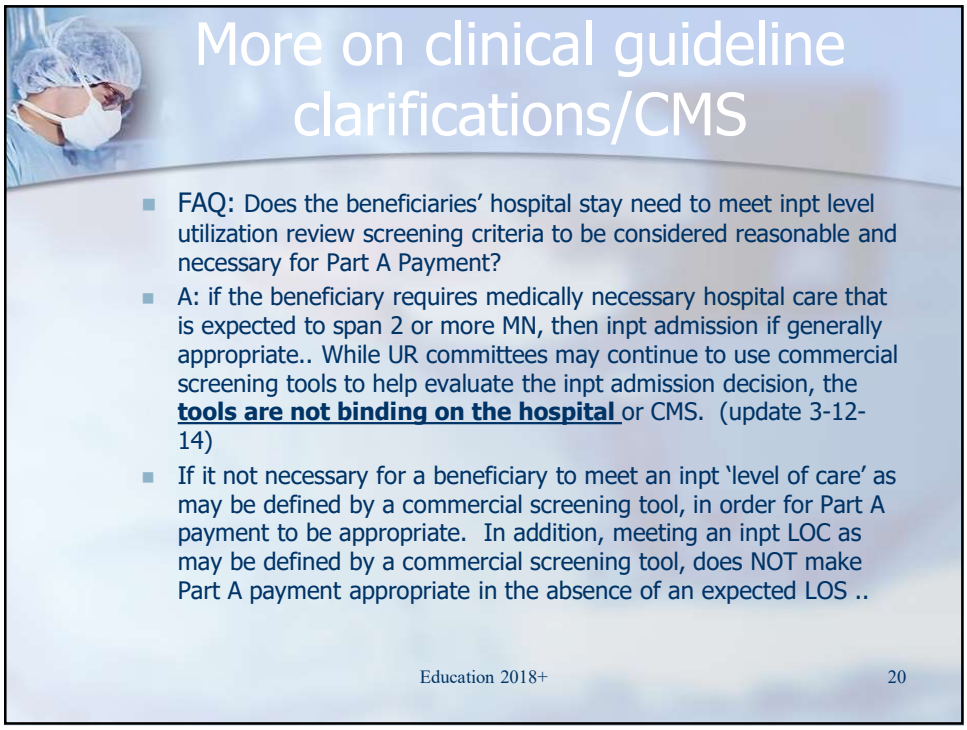
More on clinical guideline clarifications/CMS
FAQ: Does the beneficiaries' hospital stay need to meet inpt level utilization review screening criteria to be considered reasonable and necessary for Part A Payment?
A: if the beneficiary requires medically necessary hospital care that is expected to span 2 or more MN, then inpt admission if generally appropriate.. While UR committees may continue to use commercial screening tools to help evaluate the inpt admission decision, the tools are not binding on the hospital or CMS. (update 3-12-14)
If it not necessary for a beneficiary to meet an inpt 'level of care' as may be defined by a commercial screening tool, in order for Part A payment to be appropriate. In addition, meeting an inpt LOC as may be defined by a commercial screening tool, does NOT make Part A payment appropriate in the absence of an expected LOS ..
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More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd 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 but still an inpt.**
- 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

Still struggling with 2 MN Benchmark- Largest Lost Revenue

- 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.
- Only 1 MN in outpt – then convert or free. (Medicare)
- 1st MN/ER
- 2nd 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/1more MN.
- NO dedicated Ambulatory Outpt Unit
- WAY too many obs hrs!

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."

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.)

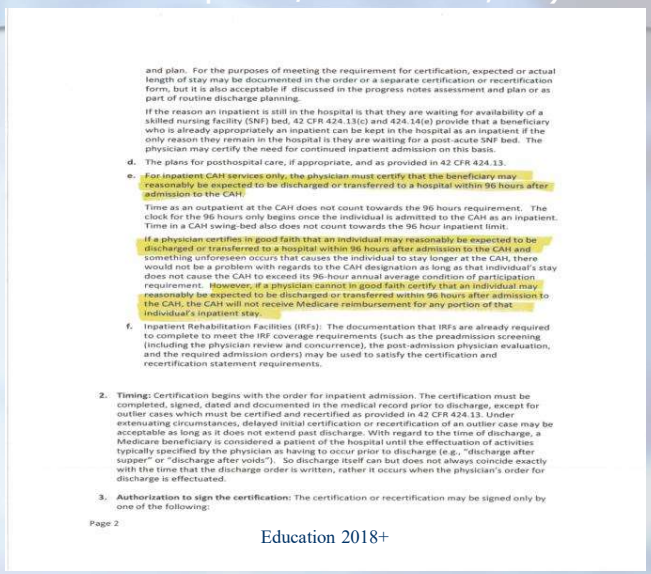
Ex) What if the surgery was delayed because the surgeon was only at the hospital 1 day a week? Is there another hospital where the surgery could occur without the delay?

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

Long obs: Pt in in Obs for 2 midnights. 1st Q: did the pt have 48+ hrs of billable obs or just hrs in a bed?
2nd 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 -2nd MN

96 hr CAH requirement/CMS Physician certification, Jan 31,2014 (still required/OPPS 1-15, 16)



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.

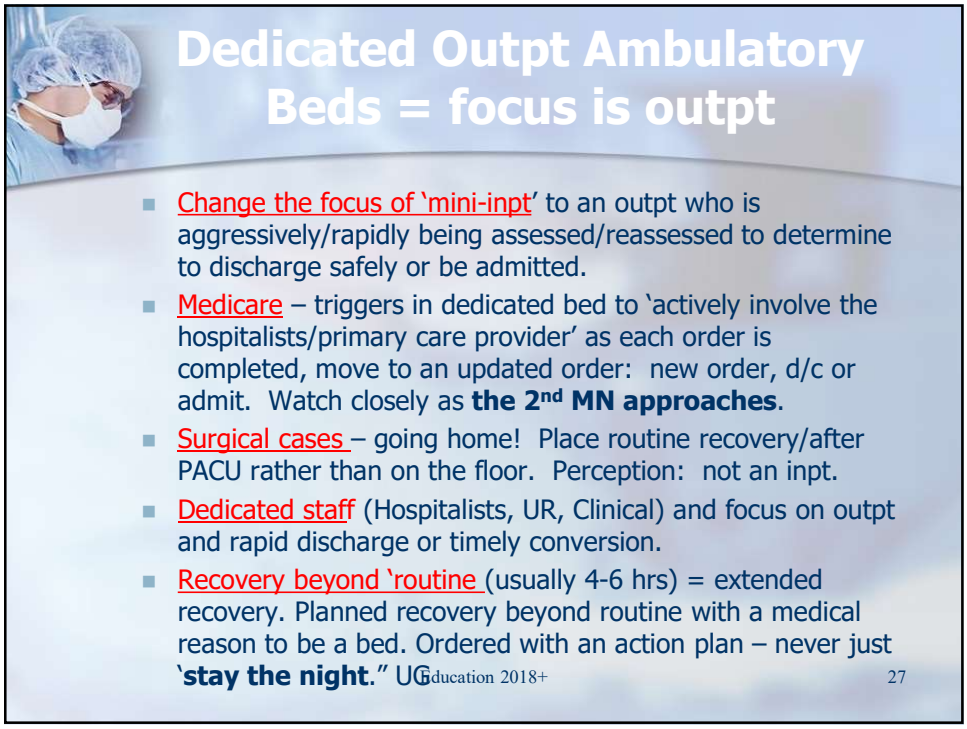
2. **Timing:** Certification begins with the order for inpatient admission. The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, 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:

Page 2

Tell a better, more complete patient story

- Begin with the 1st point of contact – ER, direct or Surgery
- Why is the pt not safe to be discharged/ED?
- Why is the surgery an inpt if the CPT is not on the inpt only list? (Medicare only)
- What provider laid out a plan for why 2 MN for a direct admit to the floor? Did the hospitalist see the pt immediately? Did UR talk to the ordering provider?
- Who is validating status for transfers in? Who is asking both the sending and the receiving the 2 MN question? Count 1st in sending.


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 2nd 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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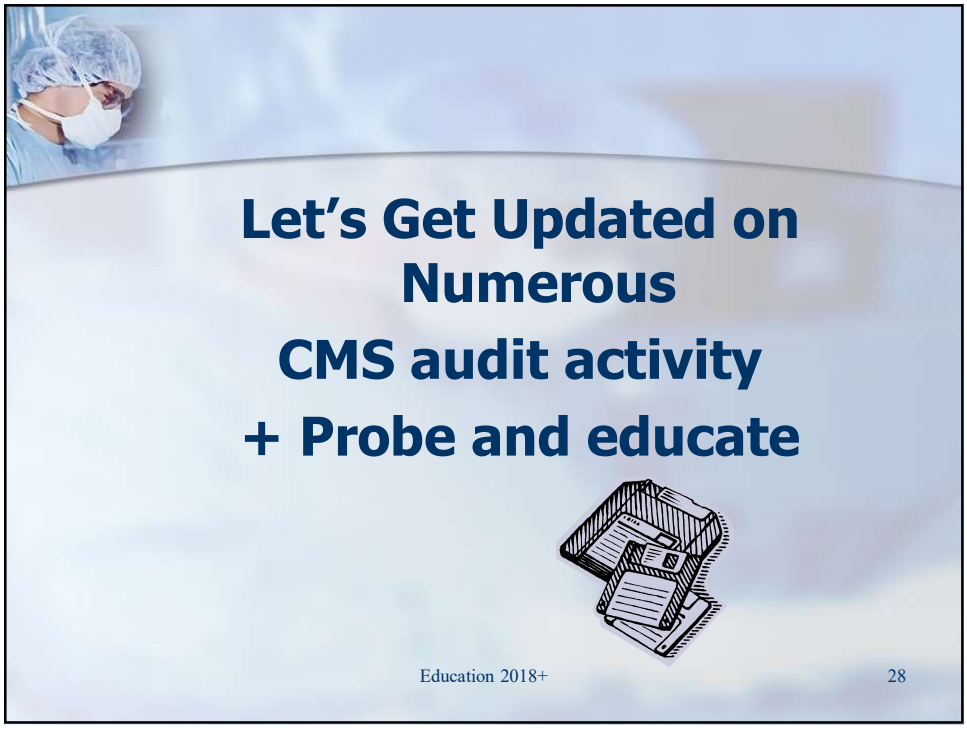
Let's Get Updated on Numerous
CMS audit activity
+ Probe and educate
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Probe & ED Round 1- WPS data- RAC SUMMIT 11-14

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

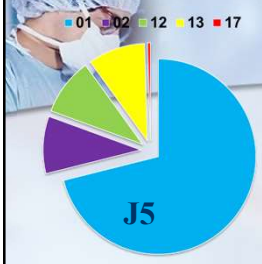
- Approximate number
- J5- NE, IA, KS, MO
- J8- MI, IN

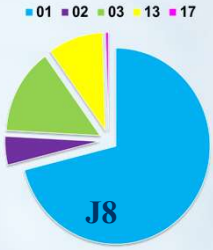
Overall Denial Rate- WPS

J5
27%

J8
26%

Denials by Type - WPS





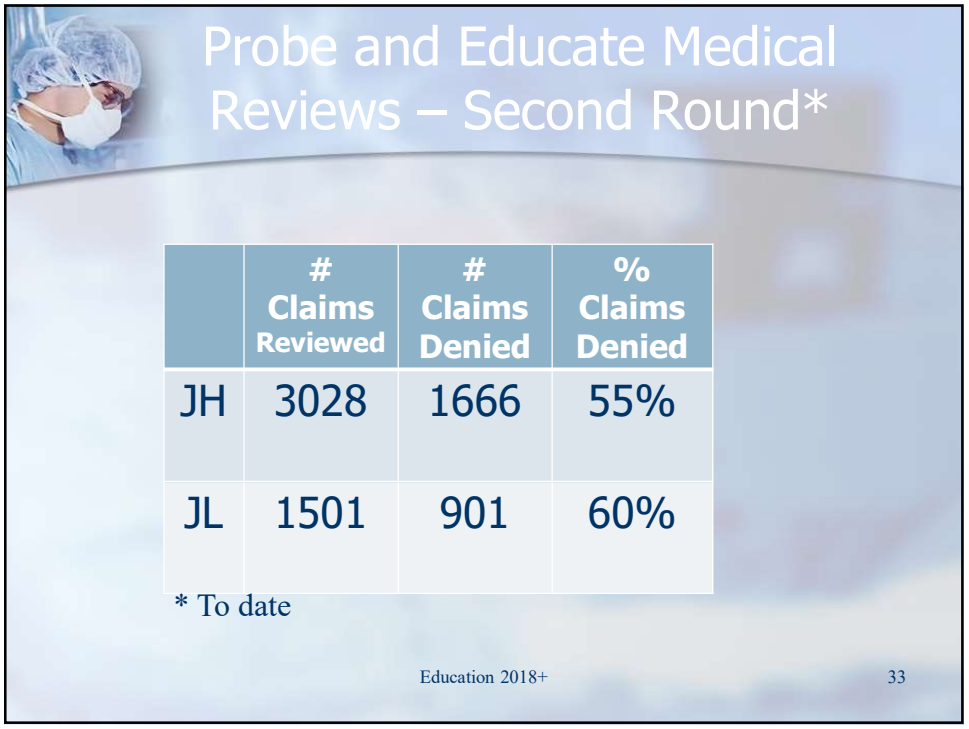
5PC01	Documentation does not support services medically reasonable/necessary (PS PLAN!!)
5PC02	Insufficient documentation
5PC12	Order missing
5PC13	Order unsigned
5PC15	Certification not present
5PC17	No documentation of 2-midnight expectation

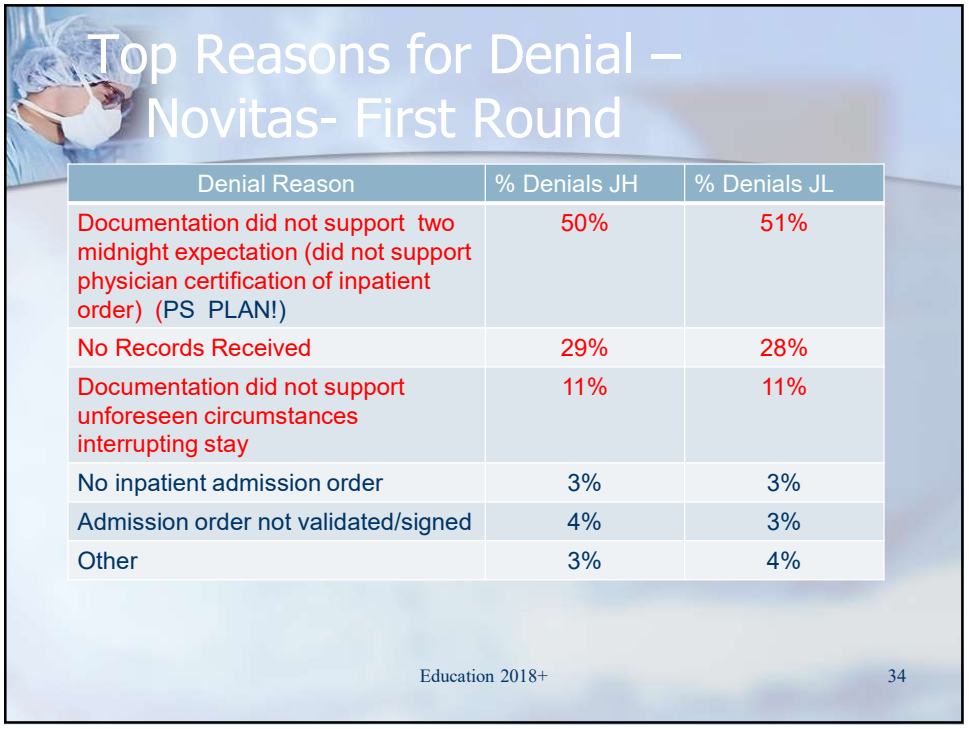
Novitas -Probe and Educate Medical Reviews – First Round

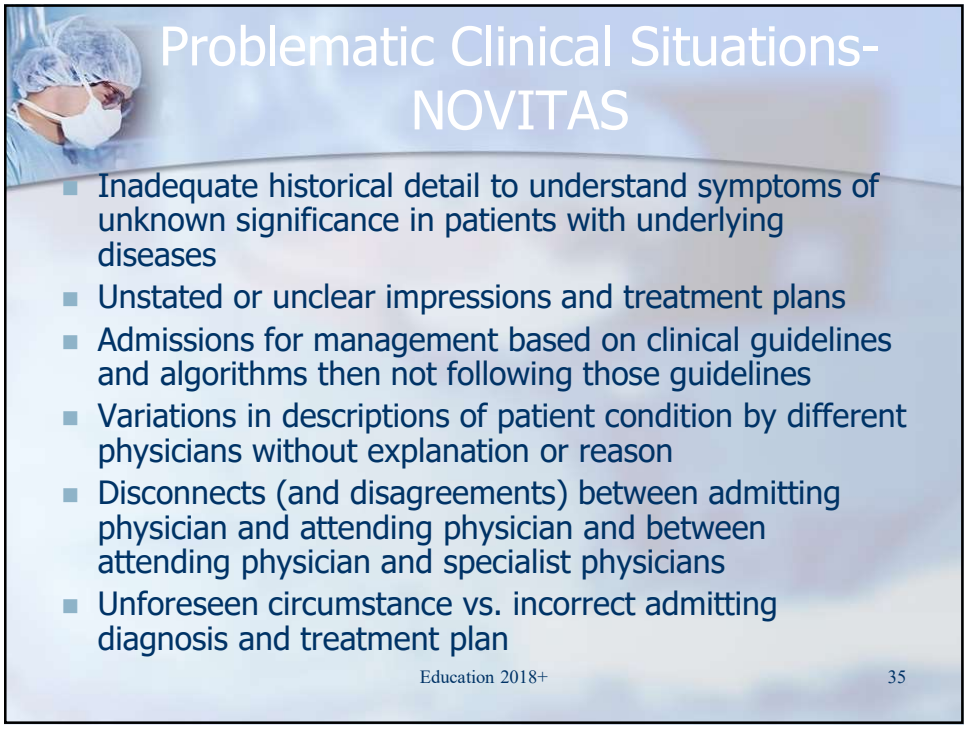
JH: CO, NM, OK, TX, AR, LA, MS JL: PA, NJ, MD, DE, Dist of Co

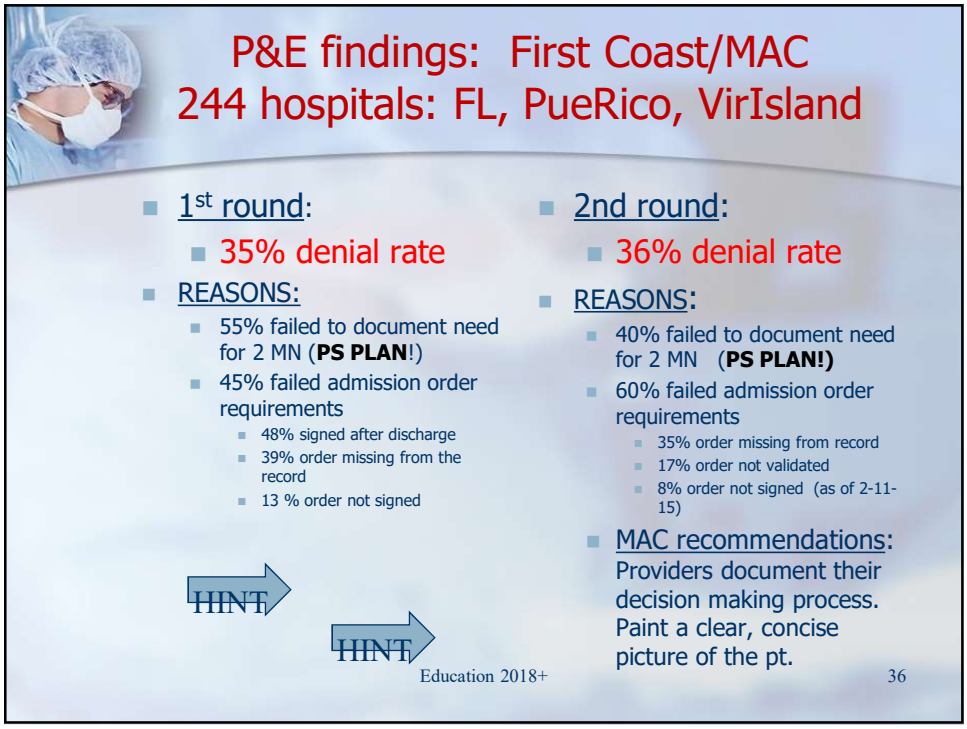
PRESENTED TO THE RAC SUMMIT 11-14/Dr Anderson, Medical Dr

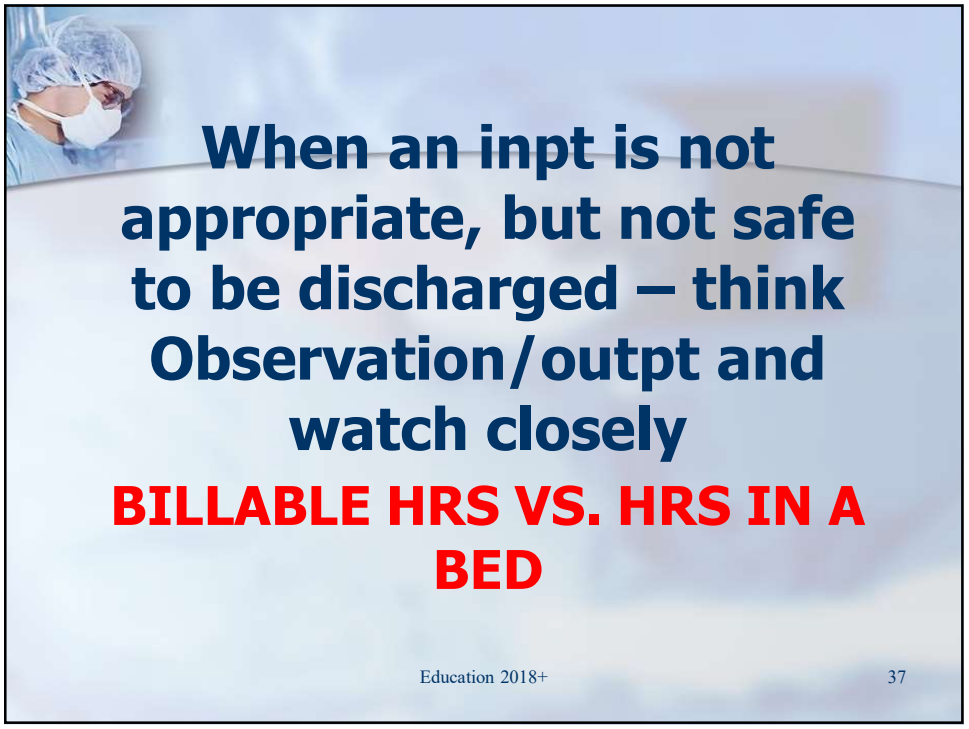
	# Providers	# Claims Reviewed	# Claims Denied	% Claims Denied
JH	1004	3794	2206	58%
JL	586	2712	1720	63%

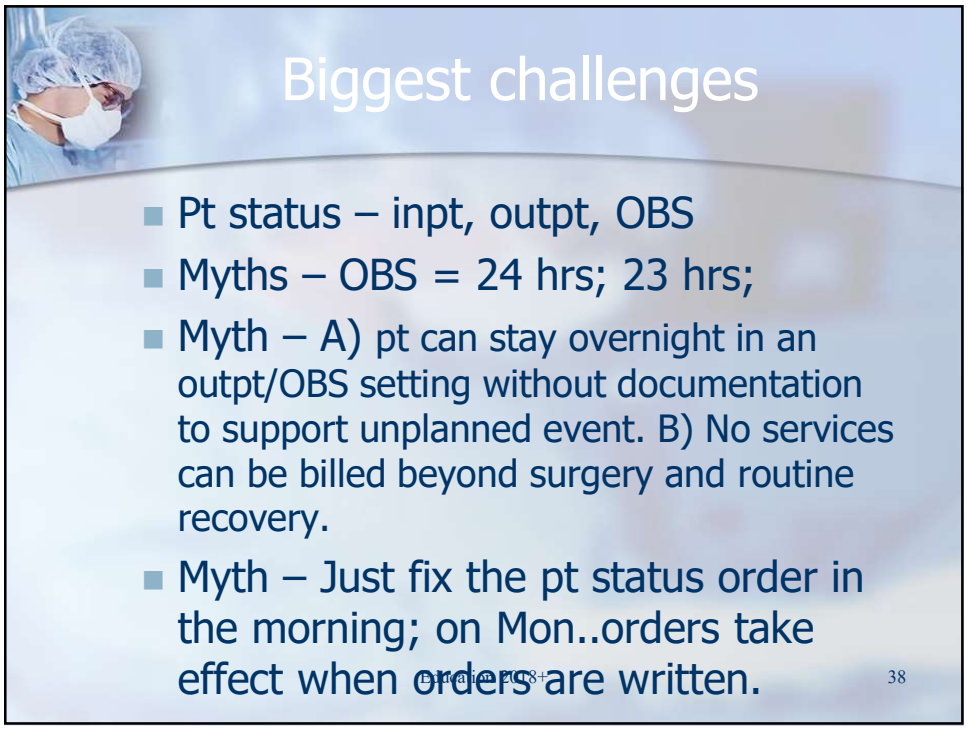

Probe and Educate Medical Reviews – Second Round*
Claims Reviewed
Claims Denied
% Claims Denied
JH
3028
1666
55%
JL
1501
901
60%
* To date
Education 2018+
33


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) (PS PLAN!)
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%
Education 2018+
34


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
Education 2018+
35


P&E findings: First Coast/MAC
244 hospitals: FL, PueRico, VirIsland
1st round:
35% denial rate
REASONS:
55% failed to document need for 2 MN (PS PLAN!)
45% failed admission order requirements
48% signed after discharge
39% order missing from the record
13 % order not signed
HINT
HINT
2nd round:
36% denial rate
REASONS:
40% failed to document need for 2 MN (PS PLAN!)
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.
Education 2018+
36


When an inpt is not appropriate, but not safe to be discharged – think Observation/outpt and watch closely
BILLABLE HRS VS. HRS IN A BED
Education 2018+
37


Biggest challenges
Pt status – inpt, outpt, OBS
Myths – OBS = 24 hrs; 23 hrs;
Myth – A) pt can stay overnight in an outpt/OBS setting without documentation to support unplanned event. B) No services can be billed beyond surgery and routine recovery.
Myth – Just fix the pt status order in the morning; on Mon..orders take effect when orders are written.
Education 2018+
38

And for the Non-Traditional Medicare Pt Status Disputes

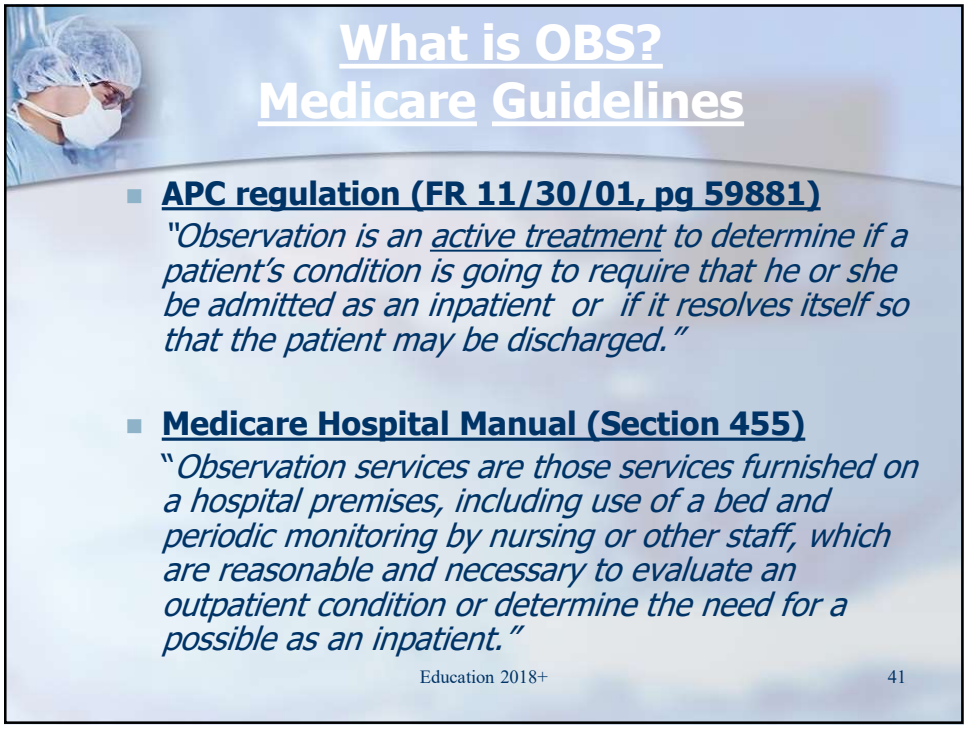
- Non-Traditional Medicare payers – pt status disputes…can continue after discharge.
- The record shows inpt order – but the disputed ended with the hospital agreeing to accept the downcoded status to obs. Messy for the coders, the audit history in the record, the payer follow up and the professional/provider billing must match.
- IDEA: Create a template/form: " **Variation from order for non-Traditional Medicare payers, all commercial, others."**
- **Template could read: " Thru communication with *payer's name*, the inpt order is being changed to observation as the payer will not authorize inpt and the facility agrees not to appeal or challenge the change in status. The account will be changed to OBS for billing purposes."**
- Signed by the UR or Physician Advisor Directors.
- Notify the Physician's office; notify the pt thru a very easy to follow notice that their status is changed = very likely a change in out of pocket expense—include a name and # to call with questions.

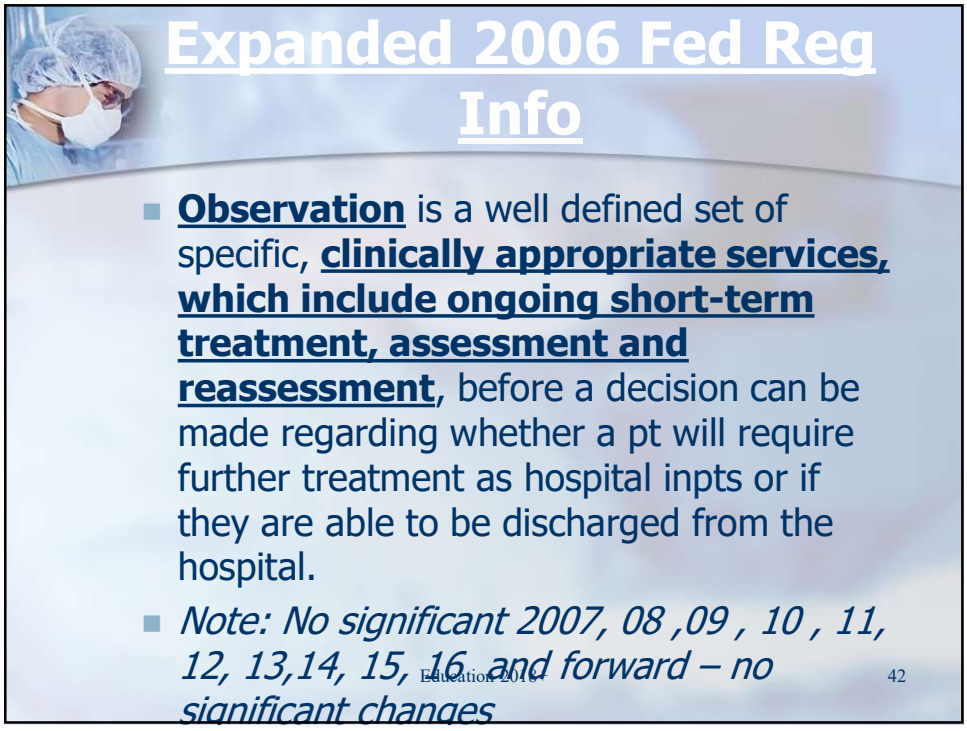
Education 2018+ 39

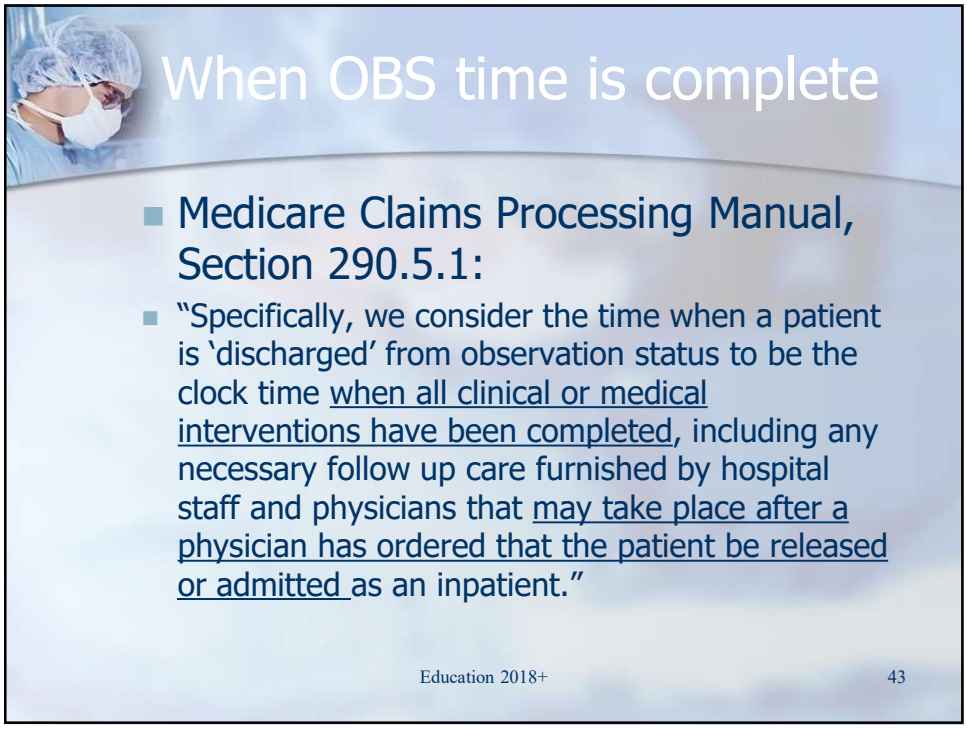
Observation challenges

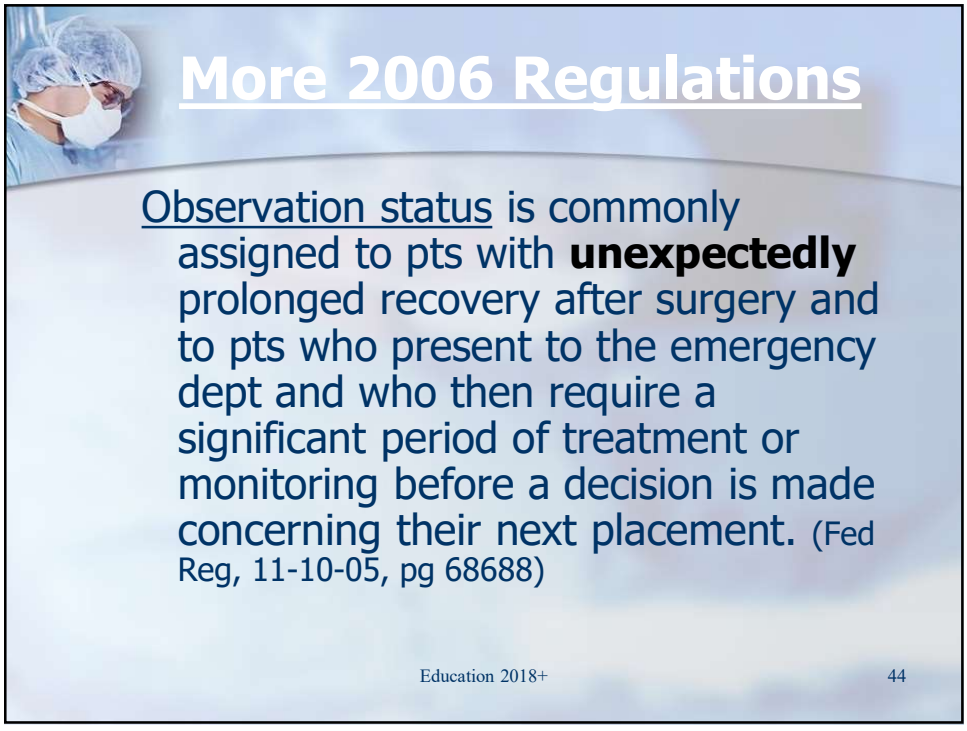
- Medicare – Can the provider declare the pt will need 2 MNs at the onset of care? No, but not safe to go home? Then place in obs with an action plan. Monitor closely. As the 2nd MN approaches, safe to go home? If not, does the pt need a 2nd MN? If yes, CONVERT to inpt. 1st outpt MN does NOT count toward 3 MN SNF.
- Non-Medicare – whatever the payer determines –with some 'help."

Education 2018+ 40


What is OBS?
Medicare Guidelines
APC regulation (FR 11/30/01, pg 59881)
"Observation is an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged."
Medicare Hospital Manual (Section 455)
"Observation services are those services furnished on a hospital premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible as an inpatient."
Education 2018+
41


Expanded 2006 Fed Reg Info
Observation is a well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, before a decision can be made regarding whether a pt will require further treatment as hospital inpts or if they are able to be discharged from the hospital.
Note: No significant 2007, 08 ,09 , 10 , 11, 12, 13,14, 15, 16 and forward – no significant changes
Education 2018+
42

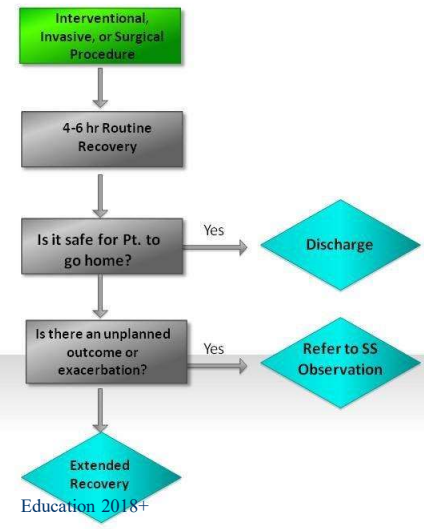

When OBS time is complete
Medicare Claims Processing Manual, Section 290.5.1:
"Specifically, we consider the time when a patient is 'discharged' from observation status to be the clock time when all clinical or medical interventions have been completed, including any necessary follow up care furnished by hospital staff and physicians that may take place after a physician has ordered that the patient be released or admitted as an inpatient."
Education 2018+
43


More 2006 Regulations
Observation status is commonly assigned to pts with **unexpectedly** prolonged recovery after surgery and to pts who present to the emergency dept and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. (Fed Reg, 11-10-05, pg 68688)
Education 2018+
44

Recovery Guidance

- Services that are covered under Part A, such as a medically appropriate inpt admission or as part of another Part B service, such as postoperative monitoring during a standard recovery period (4-6 hrs) which should be billed as recovery room services. Similarly, in the case of pts who under diagnostic testing in a hospital outpt dept, routine preparation services furnished prior to the testing and recovery afterwards are included in the payment for those dx services. Obs should not be billed concurrently with therapeutic services such as chemotherapy. (Pub 100-02, Ch 6, Sec 70.4)

OBSERVATION DECISION TREE



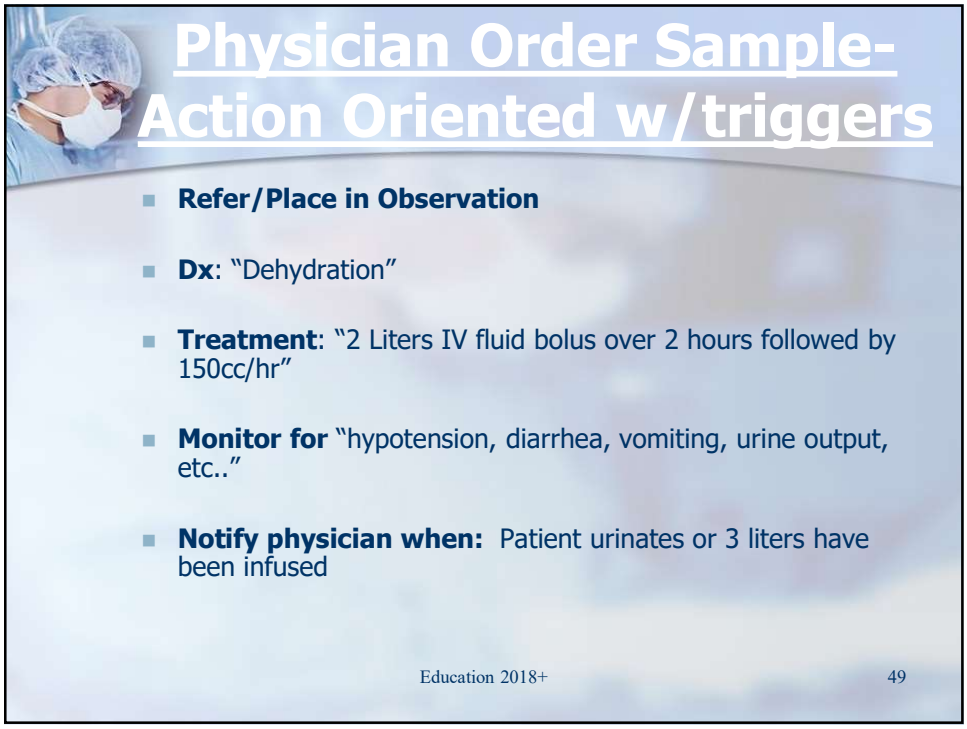
Need an updated order

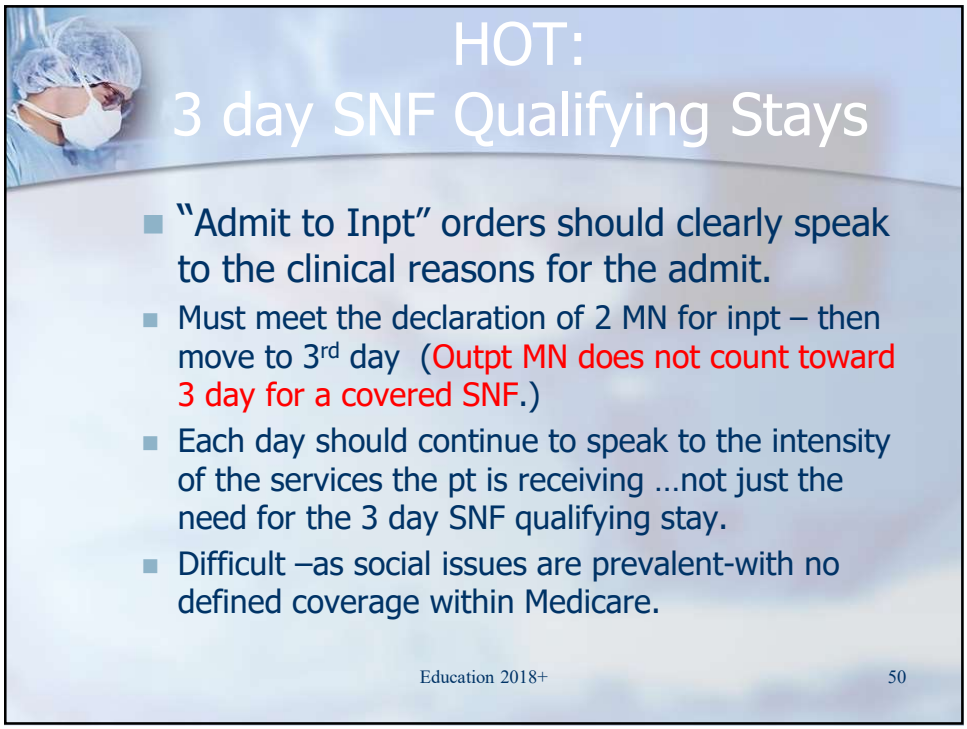
Payment issues- Outpt surgery

- **There is NO additional payment** for extended recovery or observation –pre or post outpt procedures.
- ALL costs are included in the CPT-driven payment/APC rates
- Ensure there is a clinical reason to be a bed beyond the up to 6 hrs routine recovery. Not just 'stay the night.'
- CAH – are paid for all hrs.

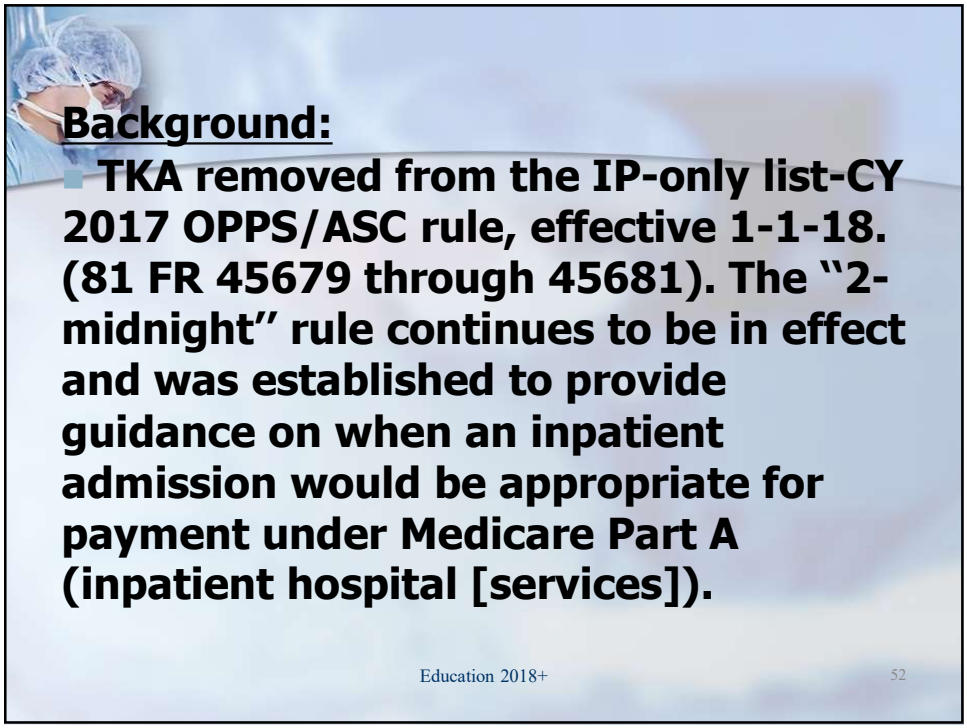
Biggest challenge — OBS billable hrs vs hrs in a bed. Conflict: Providers per day vs Hospitals per hr

- First point of contact- ER, direct – with a plan for placement in obs.
- "Plan" made aware to the nursing team so they can aggressive execute the plan – with active involvement with the attending/hospitalist. (Hint: Assign the hospitalists to all OBS pts for active mgt. Dedicated beds = outpt beds)
- "Lost Hrs' due to orders completed with no new orders, no follow up contact with the provider asking for new orders – or admit – or safely discharge.
- "Recovery outside PACU" – routine recovery = up to 6 hrs anywhere in the hospital as an outpt. EX) 1 hr PACU and 5 hrs on the floor.. An order for obs is not appropriate until the unplanned event has occurred. Then question – is 2 MN necessary to resolve/inpt? If not, default into obs and watch for the 2nd MN.
- "Extended recovery' – beyond up to 6 hrs routine, a planned recovery period ALL pts receive. (EX: all TURP procedures must void as part of the RR process..however long that takes.) Orders required.


Physician Order Sample-
Action Oriented w/triggers
Refer/Place in Observation
Dx: "Dehydration"
Treatment: "2 Liters IV fluid bolus over 2 hours followed by 150cc/hr"
Monitor for "hypotension, diarrhea, vomiting, urine output, etc.."
Notify physician when: Patient urinates or 3 liters have been infused
Education 2018+
49


HOT:
3 day SNF Qualifying Stays
"Admit to Inpt" orders should clearly speak to the clinical reasons for the admit.
Must meet the declaration of 2 MN for inpt – then move to 3rd day (Outpt MN does not count toward 3 day for a covered SNF.)
Each day should continue to speak to the intensity of the services the pt is receiving …not just the need for the 3 day SNF qualifying stay.
Difficult –as social issues are prevalent-with no defined coverage within Medicare.
Education 2018+
50


And now the removal of the Total Knee from the Inpt only list.
Final OPPS 2018 regs: Removal of TKA from IPO list.
CMS stated: "The decision regarding the most appropriate care setting for a given surgical procedure is a complex medical judgement made by the physician." …that Medicare beneficiaries 'who are able to receive this procedure safely on an outpt basis are a subset…and CMS does not expect a significant shift in TKA cases from the hospital inpt setting to the hospital outpt setting."
Opinion: American Association of Hip and Knee Surgeons. *Open door call, did not support*
Education 2018+
51


Background:
TKA removed from the IP-only list-CY 2017 OPPS/ASC rule, effective 1-1-18. (81 FR 45679 through 45681). The "2-midnight" rule continues to be in effect and was established to provide guidance on when an inpatient admission would be appropriate for payment under Medicare Part A (inpatient hospital [services]).
Education 2018+
52

Medically necessary to have a total knee procedure

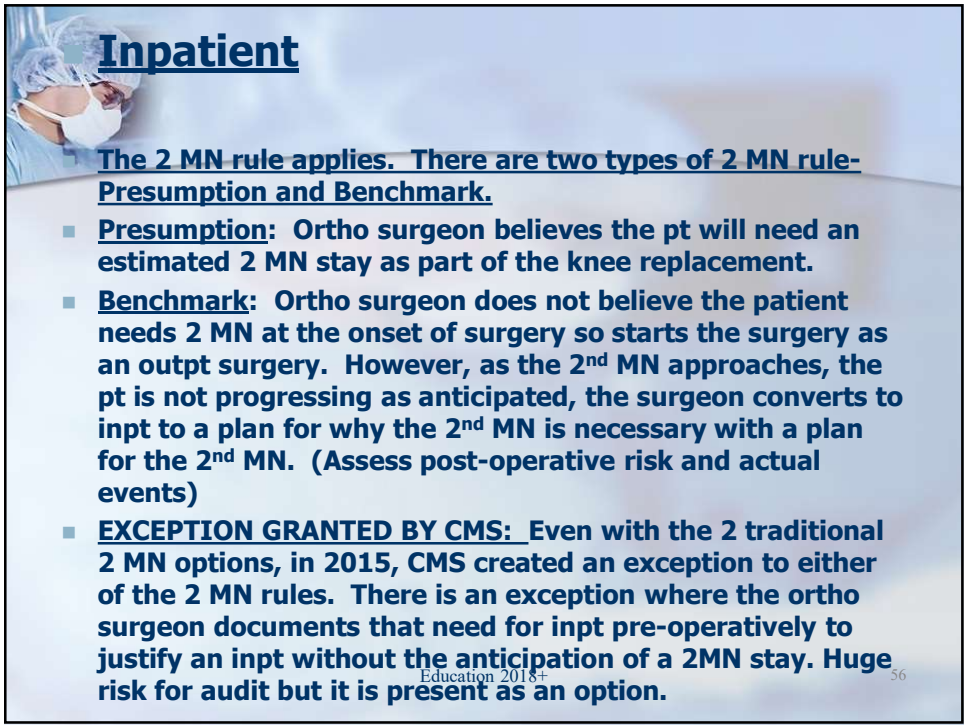
- **Reference "CMS Releases Major Joint Replacement Booklet" Medicare Learning Network ICN 909065 May 2017. CMS prohibited the RAC reviews for patient status for TKA procedures performed in the inpatient setting for a period 2 yrs to allow time and experience for these procedures under this setting." However, these procedures remain 'fair game' for review for medically necessity of the surgical procedure -regardless of patient status.**
- **MLN outlines the required documentation to support the surgical procedure -at all. …medical record supports the determination that major joint replacement surgery was reasonable and necessary for the pt.**
- **Elements to include: Pt history, physical exam/ROM, investigations/xray, pre-op studies, pre-operative findings, limitations with ADLs, contraindications to non-surgical treatments, failed non-surgical treatments, pain, safety issues, reasons for deviating from a stepped-care approach.**

Reference: www.cms.gov/outreach-and-education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1236.pdf.

Next steps= Start as an outpt

- If the initial review/conversation with surgeon does not reveal any 'at risk factors" to support the expectation of 2 MN – default to outpt.
- 2) Outpt surgery, routine recovery (up to 6hrs) and then assess extended recovery IF the pt needs more 'routine' time to recover.
- 3) Outpt surgery/above- but not recovery as expected. Explore observation and watch closely for the 2nd MN = benchmark.


Decision process -TKR
Then make a decision : Inpatient or outpatient – at the time of scheduling.
Outpatient
Medicare beneficiaries who are selected for outpatient TKA would be less medically complex cases with few comorbidities and would not be expected to require SNF care following surgery. Instead, many of these beneficiaries would be appropriate for discharge to home (with outpatient therapy) or home health care.
Patient is expected to stay less than 24 hrs. *Routine recovery up to 6 hrs, then extended recovery until expected 'safe discharge' is met.*
Education 2018+
55


Inpatient
The 2 MN rule applies. There are two types of 2 MN rule- Presumption and Benchmark.
Presumption: Ortho surgeon believes the pt will need an estimated 2 MN stay as part of the knee replacement.
Benchmark: Ortho surgeon does not believe the patient needs 2 MN at the onset of surgery so starts the surgery as an outpt surgery. However, as the 2nd MN approaches, the pt is not progressing as anticipated, the surgeon converts to inpt to a plan for why the 2nd MN is necessary with a plan for the 2nd MN. (Assess post-operative risk and actual events)
EXCEPTION GRANTED BY CMS: Even with the 2 traditional 2 MN options, in 2015, CMS created an exception to either of the 2 MN rules. There is an exception where the ortho surgeon documents that need for inpt pre-operatively to justify an inpt without the anticipation of a 2MN stay. Huge risk for audit but it is present as an option.
Education 2018+
56

- **Basic guidelines to support Inpatient for a TKA-must be documented to answer – 'Why an Inpt?" *If presumption, at the initial order for inpt surgery. *If benchmark, at the 2nd MN as an outpt with post-procedure issues included for the plan for the 2nd MN.**
- **• Document the medical necessity for performing the PROCEDURE *See MLN Matters SE1236***
- **• Next, document the medical justification for an INPATIENT admission . Include in the justification for 'why 2 MNs or the 2nd MN after the 1st outpt MN are required for this patient" or Why only 1 MN is necessary as an inpt when the 2 MN rule was not met/exception.**
- **• History and physical — assessment and plan**
  - **– Suspects**
  - **– Concerns**
  - **– Predictable risk**
- **Patient risk: comorbidities, medications, age, ASA, obesity, living conditions, stairs**
  Procedure risk: anticipated, other medical considerations
- **– Intent for treatment -needs post care of SNF/Inpt rehab, inability to meet benchmark 'safe for discharge criteria due to…**

Education 2018+ 57

Change in UM Work Flow

Change in work flow for Utilization Management:

- **At the point of scheduling ANY Traditional Medicare total knee – read the documentation to support the ordering of 'inpt.' Immediately do intervention with the ortho surgeon if any of the above items are not crystal clear. If 2 MN is expected, the above documentation should be present. If there is no 2 MN expectation/ EXCEPTION – carefully, closely review the 'why this pt needs to be an inpt and does not meet the 2 MN expectation."**
- **As the 2nd MN approaches after the 1st MN as an outpt, why is the patient not safe for discharge? Ortho surgeon & UM nurse discuss the discharge plan to determine if a 2nd MN is medically appropriate. If there is a medical reason to be 'in a hospital', then convert to inpt.**

Education 2018+ 58

Financial Impacts of Change- Traditional Medicare *Critical Access Hospitals are paid differently*

- Facility Payment
- Inpt DRG: 470

  Ave: $10,630 (JJ-Ga, AL, TN/34,777 cases JtoJ2017)

  Ave: $12,010 *

  DRG is wage adjusted+teaching +++
- APC Payment for CPT 27447/APC 5115

  Ave: $10,122 *

  APC is wage adjusted. Higher = higher payment; less than "1" wage factor = lower than base payment

- Patient portion
- Inpt every 60 –day deductible: $1340/2018
- APC frozen amt per CPT: $2024/20% of APC$ -but cannot exceed inpt deductible. So CMS pays the difference to the site.
- Amount due from pt: **Inpt Deductible**

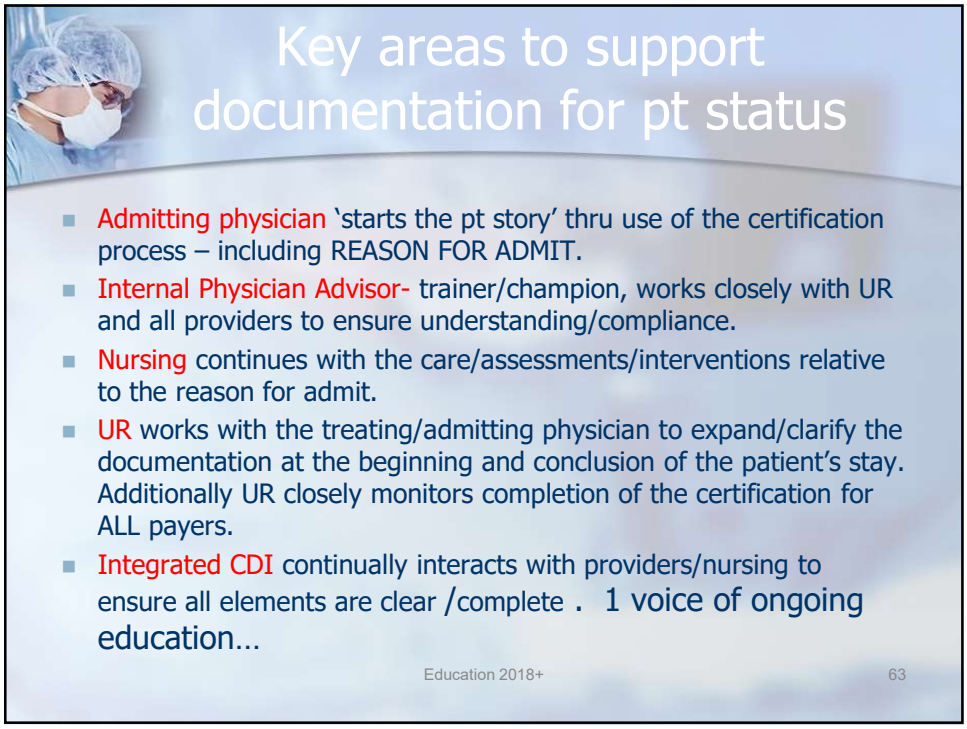
SUMMARY: Key to Total Knee – inpt or outpt

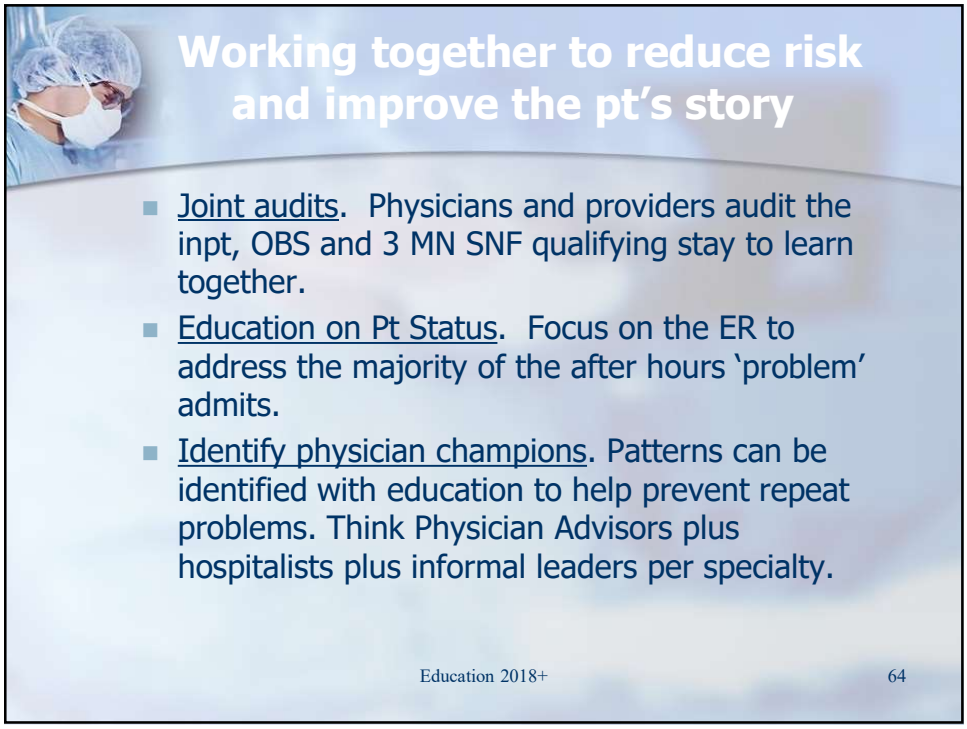
- Evaluate every pt, every time.
- First point of contact – point of scheduling.
- Use the 2 MN rule to justify an inpt: Presumption

  Will the other medical factors support the need for an estimated 2 MN stay? Look at failure to improve after outpt treatments: rehab, weight loss, braces, other. PLUS other joint issues impacting ability to recover rapidly. PLUS ability to ambulate PLUS pain PLUS home situation including care giver, stairs, other medical complications


Going Forward
Track and trend all 1 MN stays for TKAs.
Is there risk that the pt should have begun as an outpt, watched for unplanned recovery events and/or 2nd outpt MN = convert to inpt then with a plan for the 2nd MN = inpt/Benchmark.
Is there a justified inpt with the expectation of 2 MN well documented at the point of surgery with the pt having an unexpected early discharge? = inpt /Presumption
Resource: MLN 9065 Major Joint Replacement Booklet
61


And more chaos on TKA
Future – indicates moving more surgeries to Ambulatory Surgical Clinics/ASC –including all joint replacements, cardiac stents and ablations.
Humana/Medicare Mgd/MA already thinks they can allow inpt only surgeries at ASCs on MA patients.
(* Thanks, Dr Hirsch. www.racmonitor.com/news-alert-is-humana-putting-profits-before-patient-safety.)
62


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…
Education 2018+
63


Working together to reduce risk and improve the pt's story
Joint audits. Physicians and providers audit the inpt, OBS and 3 MN SNF qualifying stay to learn together.
Education on Pt Status. Focus on the ER to address the majority of the after hours 'problem' admits.
Identify physician champions. Patterns can be identified with education to help prevent repeat problems. Think Physician Advisors plus hospitalists plus informal leaders per specialty.
Education 2018+
64

Questions and Answers

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daylee1@mindspring.com
http://Arsystemsdayegusquiza.com

Be watching for our 7th National PA and UR Boot Camp: MEDICARE ADVANTAGE: Building blocks of contracting, provider sponsored MA plans and the new disruptions. July 2019, Washington, DC. Live and webstreaming