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CMS IPPS 2014 Final Rule: Overview & Best Practice Recommendations

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PHILADELPHIA BUSINESS JOURNAL 2013 BEST PLACES TO WORK

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Objectives and Agenda

- **Objectives:**
  - Review key points of 2014 IPPS Final Rule
  - Understand best practices for operating under 2014 IPPS
  - Case studies
  - Rebilling

Valid Admissions – What Changed?

OLD "Rules"	NEW "Rules"
• Expectation of 24 hour stay • Physician order a best practice	• Expectation of 2 midnight stay • Physician order required

Medical Necessity

Certification

2014 IPPS: 2 Midnight Rule

CMS states in 2014 IPPS:

- "**Our previous guidance** also **provided for a 24-hour benchmark**, instructing physicians that, in general, beneficiaries who need to stay at the hospital less than 24 hours should be treated as outpatients, while those requiring care greater than 24 hours may usually be treated as inpatients. **Our proposed 2-midnight benchmark**, which we now finalize, **simply modifies our previous guidance to specify that the relevant 24 hours are those encompassed by 2 midnights**. While the complex medical decision is based upon an assessment of the need for continuing treatment at the hospital, the 2-midnight benchmark clarifies when beneficiaries determined to need such continuing treatment are generally appropriate for inpatient admission or outpatient care in the hospital."

Page 50945, 2014 IPPS

Benchmark vs. Presumption

- **"Benchmark of 2 midnights"**
  - "the decision to admit the beneficiary should be based on the **cumulative time spent at the hospital beginning with the initial outpatient service**. In other words, if the physician makes the decision to admit after the beneficiary arrived at the hospital and began receiving services, **he or she should consider the time already spent receiving those services in estimating the beneficiary's total expected length of stay**."

Page 50946, IPPS

- **"Presumption of 2 midnights"**
  - **"**Under the 2-midnight presumption, **inpatient 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**…"

Page 50949, IPPS

Conditions of Participation

COPs Must Be Followed

- "We did not propose and are not finalizing a policy that would allow hospitals to bill Part B following an inpatient reasonable and necessary self-audit determination that does not conform to the requirements for utilization review under the CoPs."

Page 50913, 2014 IPPS

- 482.30 (c)(1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of:
  - (i) Admissions to the institution
  - (ii) Duration of stays
  - (iii) Professional services furnished, including drugs and biologicals

Concurrent UM Still Matters

"Use of **Condition Code 44 or** Part B inpatient billing pursuant to **hospital self-audit is not intended to serve as a substitute** for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols."

Page 50914, 2014 IPPS

Physician Certification

- **Physician Certification** of inpatient services:
  - Authentication of the practitioner order
  - Reason for inpatient services
  - The estimated time the beneficiary requires or required in the hospital
  - The plans for post-hospital care

- **Timing**: The certification must be completed, signed, dated and documented in the medical record prior to discharge

- **Format:**
  - As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form.

Certification - What Changed?

OLD "Rules"

- SOCIAL SECURITY ACT § 1814(a)(3): "…a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment…"
- CFR Subpart B – § 424.10-15:
  - physician certifies the necessity of services
  - reasons for hospitalization, estimated time, post hospital plans

NEW "Rules"

- The physician order constitutes a required component
- Indication that services are provided in accordance with 42 CFR 412.3
- Certification begins with the order of admission
- Certification must be completed and signed prior to discharge
- Sept. 5, 2013 memorandum clarifies who can certify admission

Certification requirement is a mandate for all inpatient admissions

Order and Certification

- "While the **physician order and the physician certification are required** for all inpatient hospital admissions **in order for payment** to be made under Part A, **the physician order and the physician certification are not** considered by CMS to be **conclusive evidence that an inpatient hospital admission or service was medically necessary**. Rather, **the physician order and physician certification are considered along with other documentation in the medical record**."

Page 50940, 2014 IPPS

- In the Medical Review Requirements Section states "(b) Physician's order and certification regarding medical necessity. No presumptive weight shall be assigned to the physician's order under § 412.3 or the physician's certification under Subpart B of Part 424 of the chapter in determining the medical necessity of inpatient hospital services under section 1862(a)(1) of the Act**. A physician's order or certification will be evaluated in the context of the evidence in the medical record**."

Page 50965, 2014 IPPS

December Updates to IPPS

Ventilator Management to be Treated Like Inpatient-Only Procedures

- ***CMS Q and A 4.3 12/23/13***
- *Mechanical Ventilation Initiated During Present Visit: As CMS stated in the preamble to the Final Rule, treatment in an Intensive Care Unit, by itself, does not support an inpatient admission absent an expectation of medically necessary hospital care spanning 2 or more midnights……While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require 1 midnight of hospital care, inpatient admission and Part A payment is nonetheless generally appropriate. NOTE: This exception is not intended to apply to anticipated intubations related to minor surgical procedures or other treatment.*

Code 72 Will Tell CMS When Two Midnights Started With Outpatient

- ***CMS Q and A 5.2 12/23/13***
- *Occurrence Span Code 72 is a voluntary code, but may be evaluated by CMS for medical review purposes. CMS reminds providers that claims for stays of less than 2 midnights after formal inpatient admission may still be subject to complex medical record review, to which Occurrence Span Code 72 may be evaluated and the 2-midnight benchmark applied .*

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Best Practice Recommendations to Comply with 2014 IPPS Requirements

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Admission Review – Key Considerations

- Physician's Order
- Expectation of 2-midnight Stay
- Medical Necessity
- Documentation and Certification

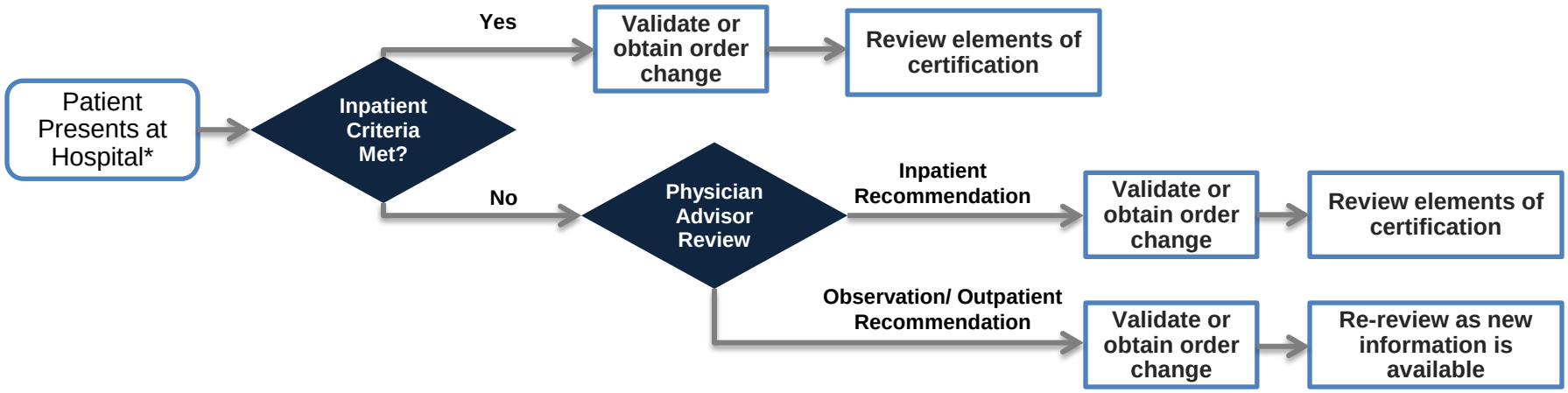
Admission Review – Key Considerations

Initial Review for Expectation of Length of Stay

- Physician documentation of an expectation of 2-midnight stay generally falls into three categories:
  - **Supports expectation of 2 midnight stay**
    - "I expect this patient to remain in the hospital for longer than…"
    - Expected LOS > 2 midnights (in document signed by physician)
  - **No documentation/conflicting documentation**
  - **Clearly conflicts with or fails to support expectation of 2-midnight stay**
    - Order – "Discharge in am" (when care has not already crossed at least one midnight)
    - Progress note – "anticipate d/c in am" (when care has not already crossed at least on midnight)

Recommended Hospital Work Flow

Expected LOS Greater Than Two Midnights or Unclear



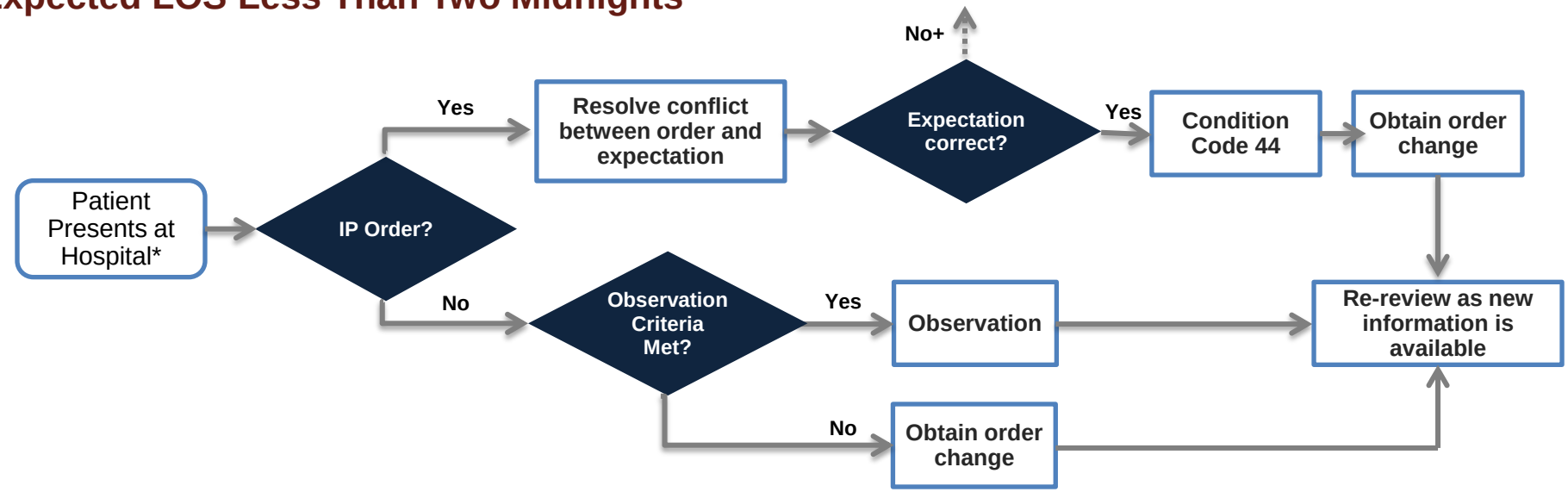
Follow this process when:

- **Physician documentation of expected discharge is greater than 2 midnights; or**
- **There is no documentation of expected discharge**

*** Patient hospitalized for condition other than Inpatient Only Procedure List**

Recommended Hospital Work Flow

Expected LOS Less Than Two Midnights



Follow this process when:

- **Physician documentation of expected discharge is in less than two midnights**

- ***** Patient hospitalized for condition other than Inpatient Only Procedure List.
- **+**If the expectation is not correct, follow the workflow for an expected length of stay of greater than two midnights.

Case 1

Symptoms:	• 80-year-old female admitted with chest pain, positive biomarkers and EKG changes in the emergency room, urgently taken to catheterization lab
Order	• "Admit as inpatient"
Expectation of LOS	• "I expect this patient to remain in the hospital for a time greater than 2 midnights"
Medical Necessity	• Documentation present to support inpatient admission
Certification	• All elements of certification present per document review

Follow up necessary	• Patient does not remain for 2 MN
	  • Was (presumption not met) due to of the exception: death, transfer, AMA, inpatient only procedure or "recovery faster than anticipated"?
	  • Evaluate based on start of service to see if benchmark met

Case 2

Symptoms:	• 65-year-old male, no previous cardiac history, presents with shoulder pain after exertion, physician suspects musculoskeletal, biomarkers below detection threshold, no EKG changes. Monitor overnight if telemetry, enzymes and EKG's remain negative anticipate discharge in am. No planned stress test or further evaluation during hospitalization.
Order	• Admit as inpatient
Expectation of LOS	• 23 hour monitoring
Medical Necessity	• Documentation does not support inpatient admission – observation
Certification	• Order and physician expectation of 2 midnights are in conflict • Order and medical necessity are in conflict
Follow up necessary	• Consider Condition Code 44 if requirements are met • If patient remains in hospital, or new information available re-review for medical necessity at inpatient level • If patient discharged – cannot do Condition Code 44, if within rebilling timeframe, consider for Part B Rebilling

Case 3

Symptoms:	• 78-year-old female admitted for atrial flutter, stabilized in Emergency Room. Although expected to be discharged after medication adjustments, patient developed heart block requiring additional adjustments and possible pacemaker
Order	• Place in observation
Expectation of LOS	• Anticipate short stay, 23 hour monitoring
Medical Necessity	• Delayed review suggests that inpatient may be appropriate
Certification	• All elements of certification would need to be completed prior to discharge
Follow up necessary	• EHR would recommend inpatient level of service • Call with physician to discuss medical necessity in light of order change requirement • Call with Case manager to discuss order change, and expectation documentation with regard to certification requirements • Inpatient order, documentation of expectation and all other elements of certification would need to be addressed prior to discharge

Case 4

Symptoms:	• 76-year-old woman with UTI, treated with intravenous antibiotics. Fevers continue with tachycardia and hypotension requiring fluid support. Immunosuppressed due to post kidney transplant status.
Order	• Admit for inpatient services
Expectation of LOS	• Admission orders include order for “discharge in am”
Medical Necessity	• Would meet for inpatient by criteria, but documentation clearly violates 2 midnight expectation
Certification	• Depending on follow-up activity, if inpatient supported confirm all elements of certification prior to discharge
Follow up necessary	• Although historically inpatient medical necessity would be met, the documentation does not support 2 MN expectation • Resolve conflict between order/medical necessity and expectation • Update documentation if patient not discharged as planned • Consider Condition Code 44 if expectation of discharge remains

Case 5

Symptoms:	• 68-year-old male, with a history of stroke, known carotid stenosis, and previous neck irradiation making carotid end-arterectomy high risk. Patient scheduled for carotid angiography and stent placement.
Order	• Observation
Expectation of LOS	• <2 midnights
Medical Necessity	• Procedure appropriate for inpatient based on inpatient-only status
Certification	• All elements of certification except the 2 MN expectation would be required to be documented prior to discharge to support inpatient claim
Follow up necessary	• Order should be corrected for procedure on CMS inpatient only procedure list • For procedures on the inpatient only list, order must be present on the medical record prior to the initiation of the procedure • Inpatient only procedures are exempted from the 2 midnight expectation, but all other certification requirements remain

Rebilling

- If a case has a physician inpatient order, yet fails "expectation 2 midnight stay" or medical necessity:
  - If patient is still in the hospital, hospital may use **Condition Code 44** to reclassify patient as in the past
  - If patient has been discharged, hospital may use **Self Audit/Rebilling** if within timely filing requirements

- Rebilling:
  - Submit provider-liable Part A claim
  - Summit an inpatient claim for payment under Part B and outpatient claim for Part B appropriate services
  - Status does not change – remains IP
  - Beneficiary responsible for Part B copayments

Rebilling - What Changed?

OLD "Rules"

- Outside of appeals process:
  - If inpatient claim not supported, billing of very limited Part B ancillaries (bill type 12x)
  - Only within timely filing period through appeals process
  - Part B rebilling allowed if Judge determined
  - No regulations
- Beneficiary held harmless

NEW "Rules"

- After Oct 1, allowed to rebill inpatient Part A claims denied as a result of a contractor review or "self-audit"
- Greater number of services eligible for Medicare Part B rebilling (bill type 13x)
- Timely filing requirements is 1 year from the date of service
- Judges prohibited from ordering payment outside of Part A claim under review
- Upon rebilling, requires hospital to adjust beneficiary billing

Rebilling Evolution

	Prior to New Rulings	Interim 1455	CMS Final Rule
Self-Auditing	Bill Part B Ancillaries only. Subject to limitations of CC 44	Allows providers to rebill only for claims denied by a Medicare contractor	Allows providers to rebill inpatient Part A claims denied as a result of a "self-audit"
Part B Rebilling	Only allowed if Judge determined appropriate. No regulations	Rebilling of covered Part B charges when the Part A claim is denied as not medically reasonable and necessary	Part B rebilling to claims for services rendered to beneficiaries enrolled in Medicare Part B
Timeliness for Rebilling	Only if within timely filing (one year) or Judge orders (no time limit)	Allows for rebilling 180 days from denial or lost appeal with date of service before Sept. 30, 2013	Standard timely filing requirements (1 year from the date of service) on rebilled claims
Impact to Beneficiary	To be held harmless	Upon rebilling, requires hospital to adjust beneficiary billing	Upon rebilling, requires hospital to adjust beneficiary billing

Summary

- "Get It Right" while the patient is in the hospital and as early in the stay as possible
- Admission Review – Key Considerations:
  - Order
  - Expectation
  - Medical Necessity
  - Documentation and Certification
- While the time requirement has evolved, the science at the core of medical necessity remains the same

Questions?

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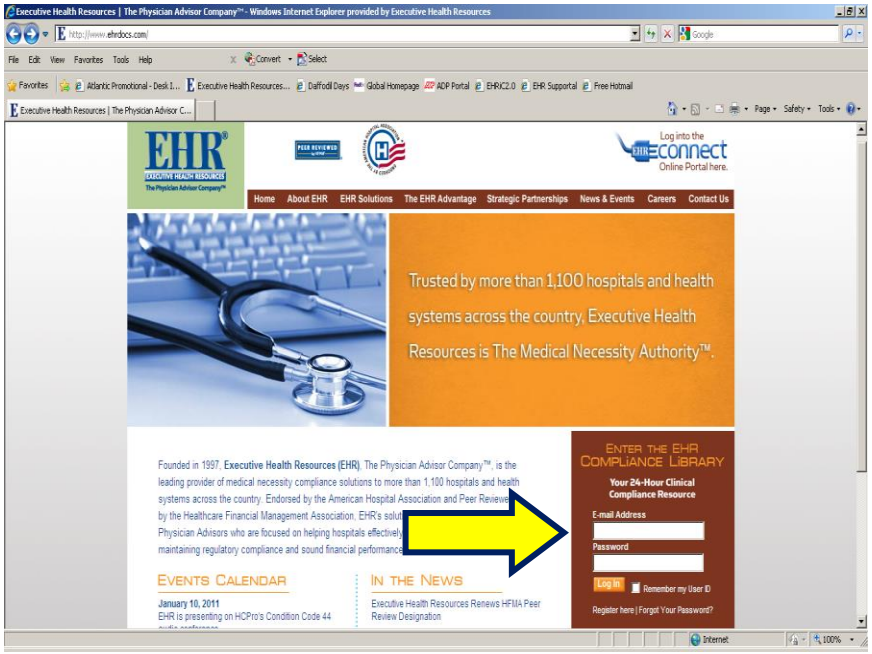

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