

PHYSICIAN ADVISOR ON-CALL

a Med Metrix Company

Complex Challenges/Financial Impact Medical Necessity Compliance Two Mid-Night Rule

HFMA South Carolina Chapter
October 13, 2016

Complex Challenges

- ▶ Declining Inpatient Admissions
- ▶ Defensive over-use of Observation
- ▶ Clinical Documentation Improvement (ICD-10)
- ▶ Ever-changing Regulations - 2 Midnight Rule
- ▶ Number of Chart Audits Increasing (MAC, RAC, QIO)
- ▶ Audits impacting revenue
- ▶ Pre-Payment Review Denials
- ▶ Readmission Penalties

Financial Impact

The Inpatient vs. Observation Delta

Avg. Medicare Inpatient Claim \$9,100*

Avg. Medicare Observation Claim \$1,200*
(Bundled 1/1/16) \$2,375

Delta - \$6,750

**CMS.GOV*

Readmission Penalties

- ▶ Fiscal Year 2014 \$227 million
- ▶ Fiscal Year 2015 \$428 Million
- ▶ Fiscal Year 2016 \$418 million
- ▶ Fiscal Year 2017 \$528 million

Readmission Penalties FY 2016: % of Hospitals with Penalty by Region*

1	Washington DC	100.0%
2	New Jersey	98.4%
3	West Virginia	96.6%
4	Kentucky	95.4%
5	Connecticut	93.5%
6	Arkansas	91.3%
7	Florida	91.2%
8	New York	90.4%
9	Massachusetts	90.2%
10	Illinois	89.8%

Readmission Penalties FY 2016: Average Penalty Per Hospital

1	New Jersey	\$373,233
2	Virginia	\$309,540
3	Connecticut	\$298,094
4	Michigan	\$286,349
5	New York	\$284,845
6	Washington DC	\$266,721
7	Massachusetts	\$255,266
8	Florida	\$251,435
9	Illinois	\$230,688
10	Rhode Island	\$182,639

RAC \$stats

- ▶ RACs recouped \$2.4 billion in improper payments in 2014, down from \$3.7 billion in 2013.
- ▶ RACs received \$301.7 million in contingency fees in 2013 and \$274.6 million in 2014. (2 MN, Probe and Educate impact)
- ▶ CMS made \$58 billion in improper payments to medical providers and health plans in 2014 (*PaymentAccuracy.gov*, a federal website that tracks agencies' estimates of waste).

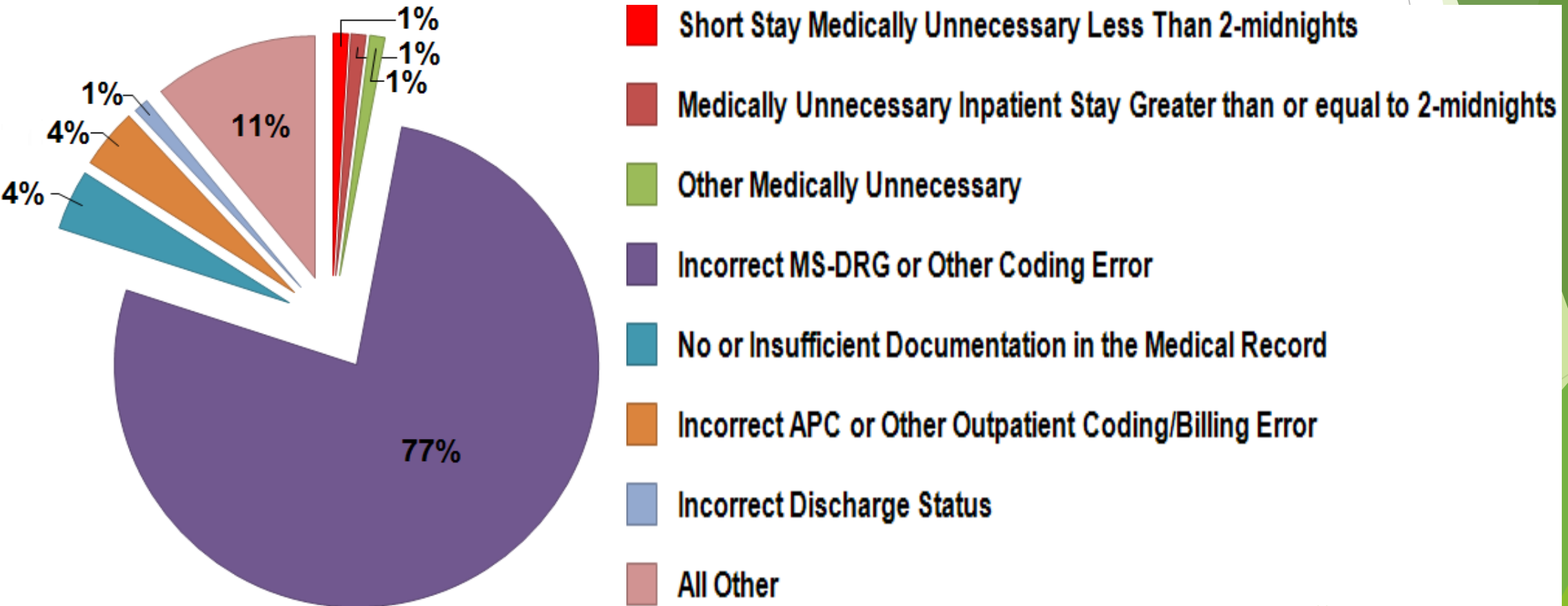
RAC Audits 2015/Q1 2016

- ▶ Number of medical record requests per hospital has increased steadily since inception of program. (Region A had the highest - 2,148 charts/hospital since inception of program)
- ▶ 60% of claims in Q1 2016 were found not to have an overpayment.
- ▶ Hospitals report appealing 47% of all RAC denials
- ▶ 37% of hospitals report having a denial reversed in the discussion period.
- ▶ 44% of all cumulative appealed claims are still sitting in the appeals process
- ▶ 43% of all hospitals reported spending more than \$10,000 managing the RAC process during the Q1 of 2016, 26% spent more than \$25,000 and 8% spent over \$100,000.

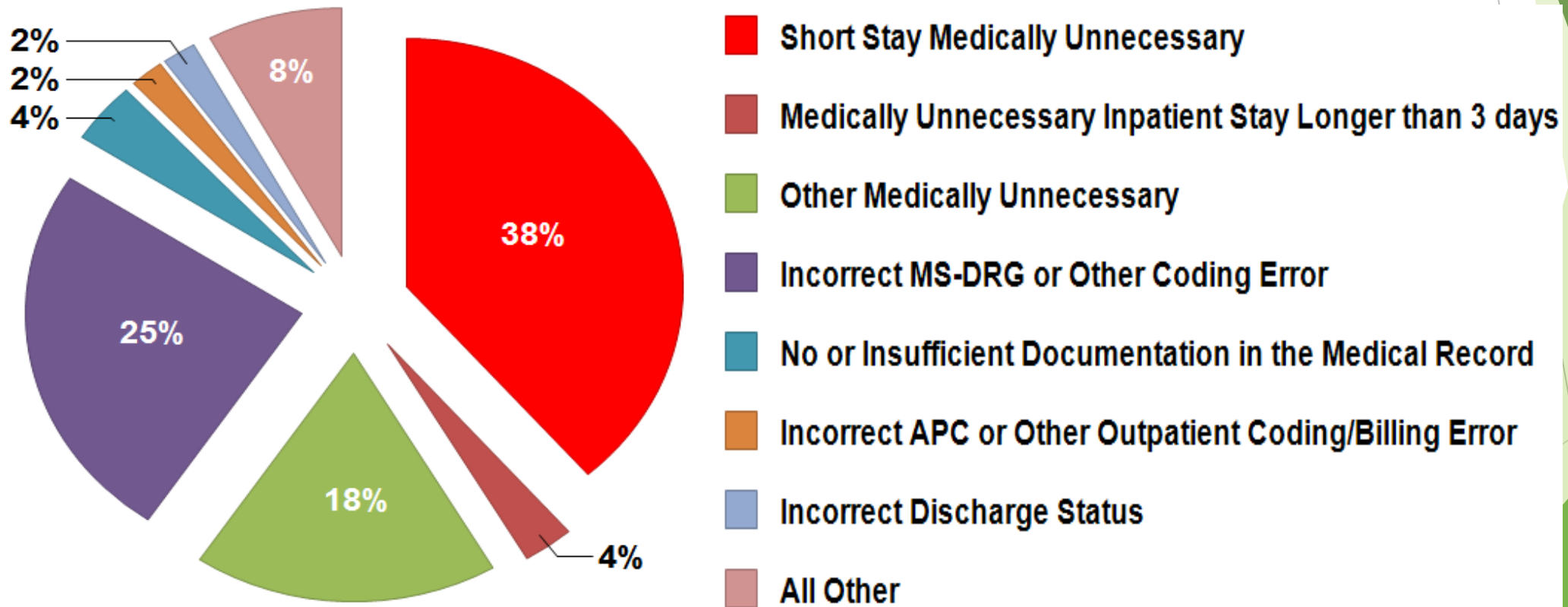
Average RAC Denial Payment Through Q1 2016 (AHA “RacTrac”)

<u>RAC Region</u>	<u>Automated</u>	<u>Complex</u>
NATIONAL	\$867	\$5,451
Region A	\$604	\$5,322
Region B	\$1,756	\$4,562
Region C	\$818	\$5,759
Region D	\$605	\$5,645

Complex Denials Q1 2016



Complex Denials Q1 2014



There is a Trend Here...

- ▶ Q1-Q4 2013 - “The most commonly cited reason for a complex denial was short-stay medically unnecessary.”
- ▶ Q1 2014 - “64% of short-stay denials for medical necessity were because the care was provided in the wrong setting, not because the care was medically unnecessary.”
- ▶ Q3 2014 - “The most commonly cited reasons for a complex denial are outpatient coding and inpatient coding.”
- ▶ Q4 2014 - “Nationally, hospitals reported a higher percentage of denials on incorrect outpatient coding/billing error.”
- ▶ Q12015 - Q1 2016 - “The most commonly cited reasons for a complex denial are inpatient coding error”

*AHA “*RacTrac*”

What's behind this transition from
“medical necessity” to “coding
errors” in complex denials...

... The 2 Mid-Night Rule

Observation Stays Got Longer

Table 2: Number and Percentage of Observation Stays by Length of Stay, 2012

Length of Stay	Number of Observation Stays	Percentage of All Observation Stays
0 nights (1 calendar day)	126,264	8%
1 night	833,583	55%
2 nights	385,830	26%
At least 3 nights	166,198	11%
Total	1,511,875	100%

Source: OIG analysis of CMS data, 2013.

2 MN Summary

Date	Guidance	Comments
8/19/13	IPPS Final Rule CMS-1599-F for FY 2014	2 Midnight Rule effective with admissions on or after 10/1/13.
9/26/13	CMS Special Open Door Forum	Conference call and transcript of call outlining responses to provider questions and probe & educate by the MACs for dates of admission 10/1/13 to 12/31/13. MAC to focus on one inpatient midnight claims. Recovery Auditors not to review claims for this issue for same dates of admission. (exception for pre-payment reviews of therapy in pre-payment demonstration states).
1/24/14	CR # 8586 Occurrence Span Code 72 Identification of Outpatient Time Associate with an Inpatient Hospital Admission and Inpatient Claim for Payment	Guidance to account for total hospital time, including outpatient time that directly precedes the inpatient admission when determining if an inpatient order should be written, based upon the expectation that the beneficiary will stay in the hospital for 2 or more midnights receiving medically necessary care.
1/30/14	CMS guidance to clarify physician order & certification for Hospital inpatient admission	Content of physician certification outlined, timing, authorization to sign the certification, inpatient order and specificity of orders.
10/1/13 to 1/31/14	MAC Probe & Educate	Probe & educate time period 10/1/13 to 9/30/14. MAC requested to re-review claims to ensure claim decision and subsequent education consistent with most recent clarifications. Appeal timelines clarified.

2MN Summary

Date	Guidance	Comments
4/1/14	President signed the Protecting Access to Medicare Act of 2014	Extends MAC probe & educate to 3/31/15. Recovery Auditors prohibited to conduct inpatient status review of claims 10/1/13 to 3/31/15.
5/12/14	CMS UPDATE: MACs completed most of first round probe reviews (10 or 25 claims, volume dependent) and beginning provider education	CMS conduct pre-payment patient status probe reviews for dates of admission 10/1/13 to 3/31/15. MACs conduct patient status reviews using probe & educate strategy for claims 10/1/13 to 3/31/15. MAC education and repeat process, when necessary.
5/15/14	CMS, HHS Proposed IPPS Rule for FY 2015. Final Rule to be published 8/22/14.	Suggested Exceptions for the 2 Midnight Benchmark; inviting further feedback in rare and unusual circumstances that were not identified to justify inpatient admission for Part A payment, absent an expectation of care spanning at least 2 midnights.
7/14/14	CMS, HHS Proposed OPPI rule for CY 2015	Inpatient admission order is necessary for all inpatient admissions and proposing to require such orders as a condition of payment, rather than as an element of the physician certification. Medical necessity documentation for inpatient stay still required. Proposing, for non-outlier cases, 20 days as the appropriate minimum threshold for physician certification and define long stay cases as cases with stays 20 days or longer.

Summary of Inpatient Status Reviews*

<u>Date of Admission</u>	Contractor Type(s)
Through September 30, 2015	MACs conducting probe and educate.
October 1, 2015 through December 31, 2015	QIOs conducting reviews. MACs completing some remaining provider education.
January 1, 2016 and beyond *QIOs “re-start” August 1 st , 2016	QIOs conducting initial reviews. RACs conducting further reviews upon referral by QIOs. *CMS Update 10/26/2015

RAC 2016

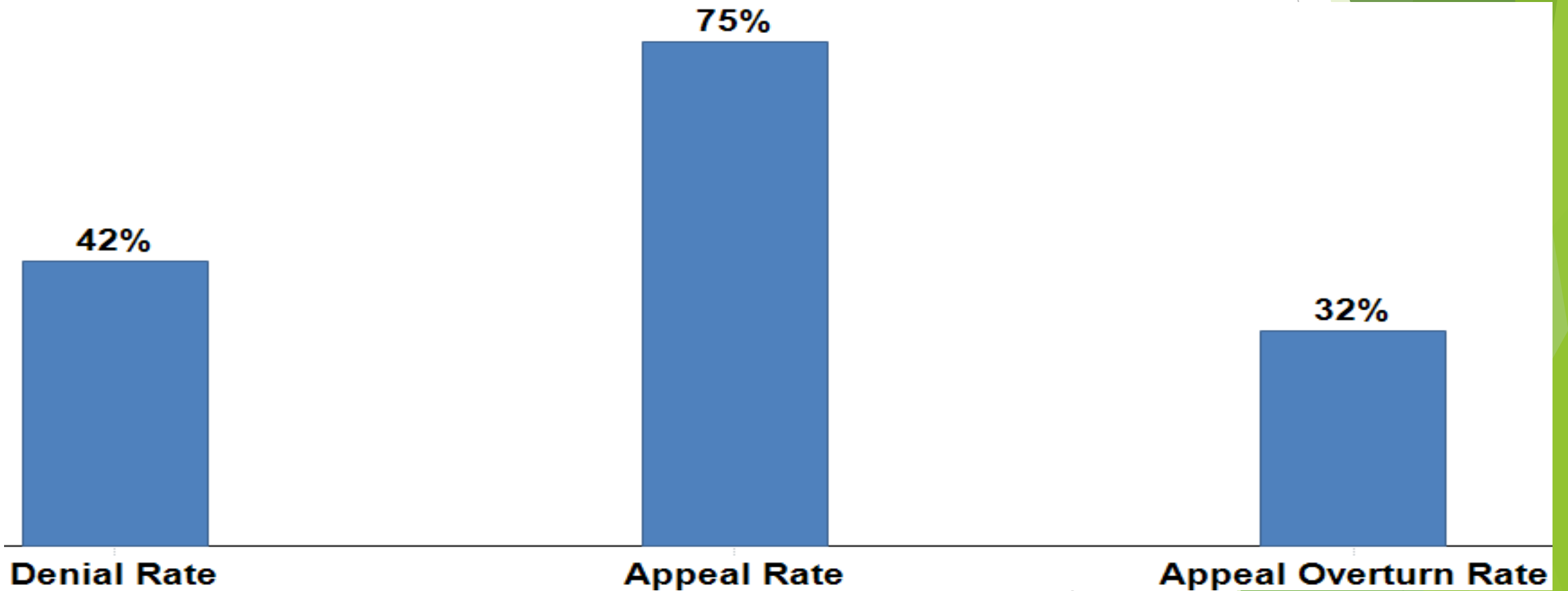
- ▶ “The CMS is sharply cutting back the work of auditors that review hospital claims and seek to recoup improper payments for the government, according to a letter reviewed by The Wall Street Journal.”*
- ▶ “Starting in January, the auditors will be able to review only 0.5% of the claims CMS pays to each hospital or provider every 45 days, according to an Oct. 28 letter to the RAC contractors. (currently 2% of claims are eligible for review every 45 days)”*.
- ▶ CMS has now contracted with QIOs, in addition to RAC, to review Medicare claims.

*WSJ 10/30/2015

Pre-Payment Review Denials

Hospitals experiencing prepayment denials report similar average dollar amounts associated with reviewed and denied claims, when compared to retrospective denials.*

*AHA *RacTrac*



These are the challenges...

...What's the Solution ?

***“The Single Most Important Factor
In Successfully Dealing With These
Challenges Is Placing The Patient
In The Appropriate Level of Care
At The Time Of Admission.”***

Medical Necessity Compliance

Medical Necessity Compliance

Medical Necessity Documentation

+

2 Mid-Nights

=

COMPLIANCE

The 2 Mid-Night Rule: “2 Step Process”*

- ▶ Step 1. Centers for Medicare & Medicaid Services (CMS) only expects to pay for patients who require hospital care; hence, we should only expect payment for those patients who require hospital care. (***Medical Necessity Compliance***)
- ▶ Step 2. CMS only wants hospitals to admit as inpatients those who have an expectation of a total of two midnights of care or meet one of the few exceptions. (***2 Midnight Compliance***)

The 2 Mid-Night Rule

Pursuant to 42 C.F.R. § 412.3:

- ▶ Medicare Part A payment (i.e., an inpatient hospital admission) is generally appropriate where the physician expects a beneficiary to require hospital care that crosses 2 midnights and admits a beneficiary based on that expectation;
- ▶ (d) (1): The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event...
- ▶ If an unforeseen circumstance occurs (e.g., beneficiary's death, election of hospice, transfer, departure AMA), payment may be made under Medicare Part A.

Medical Necessity for Admission

“In our existing guidance, we stated that the decision to admit a patient as an inpatient is a complex medical decision based on many factors, including the risk of an adverse event during the period considered for hospitalization, and an assessment of the services that the beneficiary will need during the hospital stay.

The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care.”

IPPS Final Rule CMS-1599-F, Federal Register, p. 50944-50945

“Reasonable and Necessary Rule”

- ▶ “Satisfying the requirements regarding the physician order and certification alone does not guarantee Medicare payment. Rather, in order for payment to be provided under Medicare Part A, the care must also be “reasonable and necessary...”

i.e. - Clinical Documentation must support “*Medical Necessity*”

CMS Transmittal 534, Effective 9/8/14, “Claims that are Related”

2-Midnight Presumption

CMS-1599-F

- ▶ Hospital stay, 2 or more midnights after admission
- ▶ Inpatient admission order
- ▶ “Presumed” reasonable and necessary for inpatient with medical necessity
- ▶ MACs not to focus reviews on stays spanning at least 2 midnights after admission, BUT
- ▶ MACs may review these claims as part of routine monitoring, i.e. possible system gaming.
- ▶ Oct. 2015 CMS proposal - *“Rare and Unusual exceptions”- Physician must determine and document patient requires “reasonable and necessary” inpatient admission when episode does not cross 2-MN.*

Two Midnights Billed as “Inpatient” Helps Prevent Denials

Day 1	Day 2	Final Bill	Denial/Audit Risk	
IP	IP	IP	LOW*	
OBS	IP	IP	HIGH	
IP	Discharge	IP	VERY HIGH**	** (Exceptions)
OBS	OBS	IP	EXTREMELY HIGH	
OBS	OBS	OBS	LOW*	*with appropriate documentation

One *Midnight Inpatients*

- ▶ Unexpected Rapid Recovery
- ▶ Unexpected Discharge, Transfer or Death
 - The patient died
 - The patient was transferred to inpatient hospice on comfort measures
 - The patient was transferred to another acute care facility for continued treatment
 - The patient signed out against medical advice (AMA)

Back to the Future...

- ▶ Starting January 1st, 2016, Medicare short stays will again be the target for Medical Necessity Reviews.
- ▶ The QIOs, along with the RACs will be reviewing these records
- ▶ The challenge will again be Medical Necessity Compliance.
- ▶ The hospital's first line of defense against audit contractors for Medicare (and other payers) is a strong CM/UR process.
- ▶ Vital to the CM/UR process is the PHYSICIAN ADVISOR.

ROLE OF PHYSICIAN ADVISOR

“The physician serves the hospital through teaching, consulting, and advising both the case management department and the hospital on matters regarding physician practice patterns, over and under-utilization of resources, medical necessity, compliance rules and regulations, collaborative and relationships with payers and the community. The Physician Advisor is a key member of the organization’s leadership team charged with meeting goals of cost and quality”.

Collaborative Case Management, Summer 2007

ROLE OF PHYSICIAN ADVISOR

- ▶ ADVISORY ROLE
- ▶ EDUCATIONAL ROLE
- ▶ ADMINISTRATIVE ROLE

ROLE OF PHYSICIAN ADVISOR

- ▶ Critical to the success of the Case Management/Utilization Management Program
- ▶ Rapidly gaining national recognition as a “Medical Sub-Specialty”
- ▶ National Association of Physician Advisors
- ▶ American College of Physician Advisors (founded 2014)
- ▶ ROI can be substantial

ROI

- ▶ Revenue “Protected”
- ▶ Revenue Gained
- ▶ Revenue Denials Avoided
- ▶ Compliance Enhanced
- ▶ Pre-Payment Review Status Avoided

Some Examples...

You place the patient on Observation Status prior to Midnight #1 for Asthma Exacerbation. During the first full day of hospitalization, the patient does not improve as expected and requires a second medically necessary midnight. What should you do?

1. Keep the patient a second midnight at the Observation Level of Care.
2. “Admit to Inpatient” if you expect the patient to stay two more midnights.
3. Admit the patient to Inpatient prior to Midnight #2 by writing “Admit to Inpatient.”

Some Examples...

A patient is admitted to inpatient at the time of hospitalization and the attending clearly documents the expectation of two medically necessary midnights as well as WHY he/she expects two midnights. The patient is a 90 year old male with severe baseline COPD who has a significant exacerbation. The patient is unexpectedly much better the next day and is discharged after only one midnight in the hospital. How should the hospital bill this case?

1. Bill as “Observation” since the patient only stayed one midnight
2. Bill as “Inpatient Part B” since the patient was at the inpatient level of care but only stayed one midnight and never had an “Observation Order”
3. Bill as “Inpatient” after the Attending Physician documents that the patient had an “Unexpected Rapid Recovery”

Some Examples...

A patient is admitted to inpatient at the time of hospitalization and the attending documents the expectation of two medically necessary midnights as well as WHY he/she expects two midnights. The next day the patient is much better. The CM/UM/PA review the case and, after discussing with the attending, all agree the pt. should have been placed in OBSERVATION. The patient has not been discharged yet and is still physically in the hospital. What should be done at this point?

1. It is too late to change anything. Discharge the patient at the Inpatient Level of Care and expect a denial from the MAC or RAC.
2. Do not submit a Bill and Write Off the Hospitalization.
3. Change the patient to Observation and complete the steps necessary to accomplish a Condition Code 44.
4. Discharge the Patient at the Inpatient Status and then Bill Medicare using “Inpatient Part B”.

Some Examples...

You admit the patient to Inpatient prior to Midnight #1 and the patient does not remain in the hospital Midnight #2. What could have happened? Choose all that apply.

1. The patient made an unexpected rapid recovery.
2. You made a mistake on the day of hospitalization and you should have placed the patient at the observation level of care.
3. The patient was transferred to inpatient hospice with comfort measures.
4. The patient was transferred to another hospital because your hospital does not provide an advanced treatment option like CABG or Valve Replacement Surgery.
5. The patient died.

SUMMARY

- ▶ Many Complex Challenges
- ▶ Significant Financial Impact
- ▶ Medical Necessity/Regulatory Compliance critical
- ▶ A sound CM/UM /PA Process needs to be in place
- ▶ Medical Staff Awareness/Education - ***A MUST***
- ▶ Enterprise Initiative

BEST DVT-PREVENTION PRACTICES • MAKING NIGHT WORK SUSTAINABLE
ID PEARLS • THE POTENTIAL DOWNSIDE OF NEW TECHNOLOGY

Today's Hospitalist

www.todayshospitalist.com

August 2013



PHYSICIAN ADVISOR ON-CALL

a Med Metrix Company

Thank You!

Edward J. Niewiadomski, MD

President

doctored@med-metrix.com

732-597-3035 (c)

201-450-9078 (o)