CMS IPPS 2014 Final Rule: Overview & Best Practice Recommendations

Stephen Leb, MD, FACS
Senior Medical Director
Audit, Compliance and Education

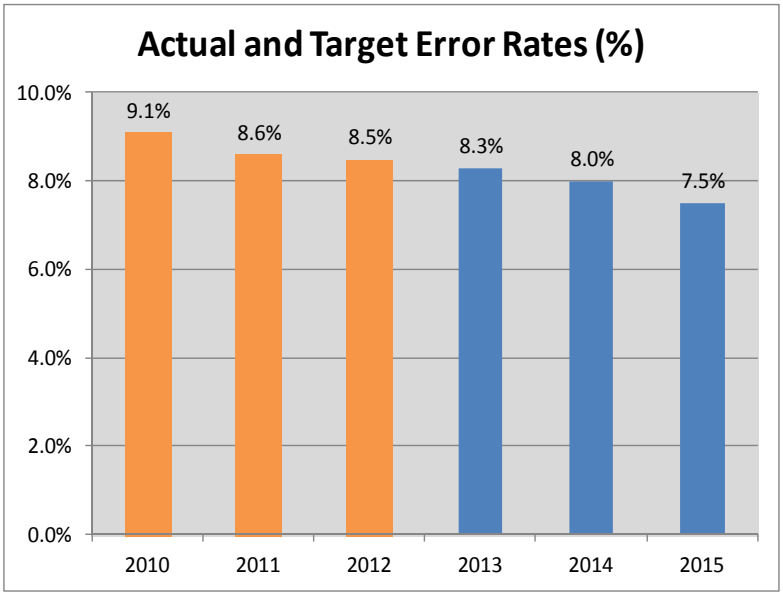
Objectives and Agenda

- **Objectives:**
  - Review key points of 2014 IPPS Final Rule
  - Probe and Educate
  - Best Practices
  - Rebilling

Improper Payment Report

***Estimated $31.2 billion in improper payments in 2013**

"The primary causes of improper payments, as identified in the Medicare FFS Improper Payments reports, are insufficient documentation errors, medically unnecessary services, and to a lesser extent, incorrect coding."



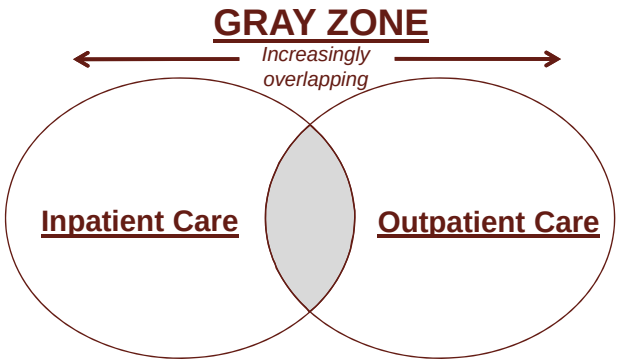
* From the FY 2012 HHS Agency Financial Report (AFR)

The Age of Accountability

Who	What
RAs	Recovery Auditors
MACs	Medicare Administrative Contractors
CERT	Comprehensive Error Rate Testing
MIP	Medicaid Integrity Plan
MIG	CMS Medicaid Integrity Group
MICs	Medicaid Integrity Contractors
MIGs	Medicaid Inspector Generals
PERM	Payment Error Rate Measurement
PSCs	Program Safeguard Contractors
ZPICs	Zone Program Integrity Contractors
OIG	Office of the Inspector General
DOJ	Department of Justice

Auditors Target Gray Area Cases

Potential for Inpatient
(review required):
- Acute MI
- Coronary Artery Bypass Graft
- Open Appendectomy
- Acute Intracranial Bleed
- Valve Transplant
- Respiratory Failure



Potential for Outpatient/OBS
(review required):
- Scheduled Transfusion
- Injection / Chemotherapy
- Lymph Node Biopsy
- Inner Ear Infection
- Dilation & Curettage

"Gray" Area – Cases that require individual assessment due to unclear Medical Necessity:

- Chest Pain
- Anemia
- Dehydration
- Syncope
- Back Pain
- Cardiac Stent, PTCA, ICDs
- Mastectomy
- Prostatectomy
- Laparoscopic Appendectomy

Only A Doctor Can Legally Admit Patients To A Hospital

- **42 CFR 482.12(c)(2)**
  - "Patients are admitted to the hospital *only on a recommendation of a licensed practitioner permitted by the State to admit patients to a hospital."*
- **Medicare State Operations Manual**
  - "In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate."

Importance of Utilization Review

Providers will be judged by their UR Process

- A UM Committee is required by Medicare in the Conditions of Participation
- Medicare does not say ALL cases have to be reviewed but Medicare does say ALL billing claims have to be accurate
- The best way to ensure claims are accurate is by using a compliant and consistent UR process that ensures appropriate review and documentation to support the claim

Best Practices for Compliance Review

- **Best Practices for Admission & Continued Stay Review (HPMP Compliance Workbook pg 38, March 2008)**
  - "Because it is not reasonable to expect that physicians can screen all admissions, continued stays, etc. for appropriateness, screening criteria must be adopted by physicians that can be used by the **UM staff to screen admissions, length of stay, etc**. The criteria used should screen both the **severity of illness (condition) and the intensity of service (treatment).** There are numerous commercial screening criteria available. In addition, some QIOs have developed their own criteria for screening medical necessity of admissions and procedures. CMS does not endorse any one type of screening criteria."
  - "**Cases that fail the criteria should be referred to physicians for review**. For your UM program to screen medical necessity appropriately, the decision to admit, retain, or discharge a patient should be made by a physician, either through the use of physician approved or developed criteria, or through a **physician advisor**."

Inpatient (CMS Medicare Benefit Policy Manual, Chapter 1, §10)

"An ***inpatient*** is

- a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.
- Generally, a patient is considered an inpatient if ***formally admitted as inpatient***
- with the ***expectation*** that he or she will remain at least overnight and occupy a bed even though ***it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight***."

Regulatory Definition of "Inpatient"

"…However, the decision to admit a patient is a ***complex medical judgment…*** Factors to be considered when making the decision to admit include such things as:

- The ***severity*** of the signs and symptoms exhibited by the patient;
- The ***medical predictability*** of something adverse happening to the patient;
- The ***need for diagnostic studies*** that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The ***availability of diagnostic procedures*** at the time when and at the location where the patient presents.

It's all about the physician!!!!!

Admissions of particular patients are ***not covered or non covered solely on the basis of the length of time*** the patient actually spends in the hospital."

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

Outpatient Services Included

CMS FAQs 12/23/13

- "…the Medicare review contractor will consider time the beneficiary spent receiving **outpatient services within the hospital**. This will include services such as observation services, treatments in the emergency department, and procedures provided in the operating room or other treatment area."

- "…the **starting point** for the 2 midnight timeframe for medical review purposes will be **when the beneficiary starts receiving services following arrival at the hospital**. CMS notes that this instruction **excludes** wait times prior to the initiation of care…"

Valid Admissions – What Changed?

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

Medical Necessity Certification

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Physician Certification

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

PEER REVIEWED by HFMA*

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2013 BEST PLACES TO WORK
2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

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

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.

Physician Order

- For payment of hospital inpatient services under Medicare Part A, the order must specify the admitting practitioner's recommendation to admit "to inpatient," "as an inpatient," "for inpatient services," or similar language specifying his or her recommendation for inpatient care

  Page 50942, IPPS

- "Admit to Tower 7" or "Admit to Dr. Smith" are no longer acceptable

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

2-MN Exceptions

- One True Exception
  - Inpatient Only List
- Exceptions after 2 MN Expectation
  - Unexpected Death
  - Unexpected Transfers
  - AMA Sign Out
  - Unexpected Early Recovery

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 .*

Rare and Unusual

CMS FAQs 12/23/13

- "…(T)here may be rare and unusual cases where the physician did not expect a stay lasting 2 or more midnights but nonetheless believes inpatient admission was appropriate and documents such circumstance."
- "**The MACs are being instructed to *deny* these claims** and to submit these records to CMS Central Office for further review."
- CMS will create and update a list for contractors of "rare and unusual situations" in which an inpatient admission of less than 2 midnights may be appropriate.

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Probe and Educate

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

PEER REVIEWED by HFMA*

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2013 BEST PLACES TO WORK
2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

Reasonable Expectation of ≥2 MNs

CMS FAQs (12/23/13)

"Expected length of stay and the determination of the underlying need for medical or surgical care at the hospital must be **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**, which Medicare review contractors will expect to be **documented in the physician assessment and plan of care**."

0-1 Day Stays not Reviewed

CMS FAQs (12/23/13)

- "…CMS will not permit Recovery Auditors to review inpatient admissions of less than 2 midnights after formal inpatient admission that occur between **October 1, 2013 and March 31, 2015**."
- "These reviews **will be disallowed permanently**; that is, the Recovery Auditors **will never be allowed** to conduct patient status reviews for claims with dates of admission during that time period."

Inpatient Stays of <2 MNs

CMS FAQs 12/23/13

"In reviewing stays lasting less than 2 midnights after formal inpatient admission (i.e., those stays not receiving presumption of inpatient medical necessity), **Medicare review contractors will assess the reasonableness of the physician's expectation of the need for and duration of care** based on complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which must be clearly documented."

Gaming, Abuse or Delays

CMS FAQs 12/23/13

- "Medicare review contractors will identify gaming by reviewing stays spanning 2 or more midnights after formal inpatient admission for the purpose of monitoring and responding to patterns of incorrect DRG assignments, inappropriate or systematic delays, and lack of medical necessity for services at the hospital…"

- "CMS and its review contractors may identify such trends through data sources, such as that provided by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and Program for Evaluating Payment Patterns Electronic Report (PEPPER)."

Applicable Hospitals

- Subject to Probe & Educate Program:
  - Acute Care Inpatient Hospital Facilities
  - Long Term Care Hospitals
  - Inpatient Psychiatric Facilities

- Excluded from Probe & Educate Program:
  - Critical Access Hospitals
  - Inpatient Rehab Facilities are excluded from the 2-Midnight inpatient admission and medical review guidelines per CMS-1599-F and therefore excluded from the Probe and Educate program.

Probe & Educate Process

	Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October – March 2014)		
	No or Minor Concern	Moderate to Significant Concerns	Major Concerns
10 Claim Sample	0-1	2-6	7 or more
25 Claim Sample	0-2	3-13	14 or more
Action	• Deny non-compliant claims • Send results letters explaining each denial • No more reviews will be conducted under Probe and Educate Process	• Deny non-compliant claims • Send results letters explaining each denial • Offer 1:1 Phone Call • **REPEAT Probe & Educate process with 10 or 25 claims**	• Deny non-compliant claims • Send results letters explaining each denial • Offer 1:1 Phone Call • Repeat Probe & Educate • If problems continue, **repeat P&E with increased claim volume of 100-250**.

Best Practice Recommendations to Comply with 2014 IPPS Requirements

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

2008 ★ 2009 ★ 2010 ★ 2011 ★ 2012 ★ 2013

Admission Review – Key Considerations

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

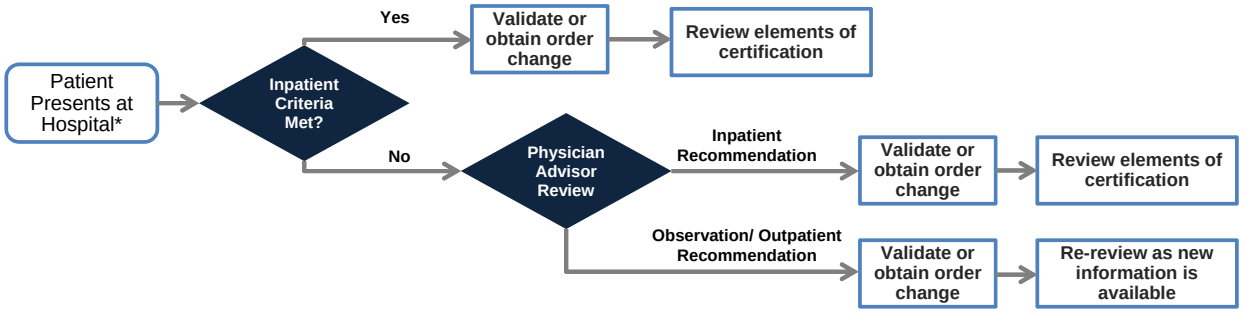
Admission Review – Key Considerations

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



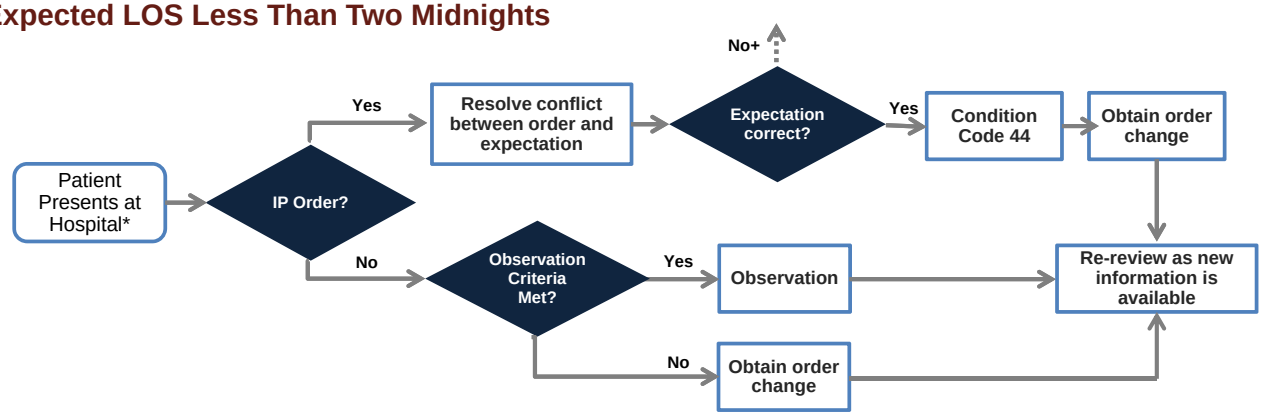
Follow this process when:

- **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.

Transmittal 540

- **Issued on September 4, 2014**
  - **Effective date: September 8, 2014**
- **MACs and ZPICs may deny "related" claims, either after review or automatically**
- **Medicare's example:**
  - **When the Part A Inpatient surgical claim is denied as not reasonable and necessary, the MAC may recoup the surgeon's Part B services. For services where the patient's history and physical (H&P), physician progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment may occur for the performing physician's Part B service.**

Rebilling

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

Settlement Options

- OMHA- sampling and extrapolation
- CMS – 68% settlement for medical necessity

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
- Medical Necessity is not going away
- MAC Probe and Educate
- Rebill when appropriate
- While the time requirement has evolved, the science at the core of medical necessity remains the same

Questions?

Stephen Leb, MD, FACS

Senior Medical Director

Audit, Compliance and Education (ACE)

sleb@ehrdocs.com

877-EHR-DOCS
www.ehrdocs.com
info@EHRDOCS.COM

Get the Latest Industry News & Updates

EHR's Compliance Library
Register today at
www.ehrdocs.com

Follow EHR on Twitter!
@EHRdocs
http://www.twitter.com/EHRdocs

About Executive Health Resources

EHR has been awarded the exclusive endorsement of the American Hospital Association for its leading suite of Clinical Denials Management and Medical Necessity Compliance Solutions Services.

AHA Solutions, Inc., a subsidiary of the American Hospital Association, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

EHR received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of medical necessity compliance solutions, including: Medicare and Medicaid Medical Necessity Compliance Management; Medicare and Medicaid DRG Coding and Medical Necessity Denials and Appeals Management; Managed Care/Commercial Payor Admission Review and Denials Management; and Expert Advisory Services.

* HFMA staff and volunteers determined that this product has met specific criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this product.

EHR was recognized as one of the "Best Places to Work" in the Philadelphia region by Philadelphia Business Journal for the past six consecutive years. The award recognizes EHR's achievements in creating a positive work environment that attracts and retains employees through a combination of benefits, working conditions, and company culture.

2008 • 2009 • 2010 • 2011 • 2012 • 2013