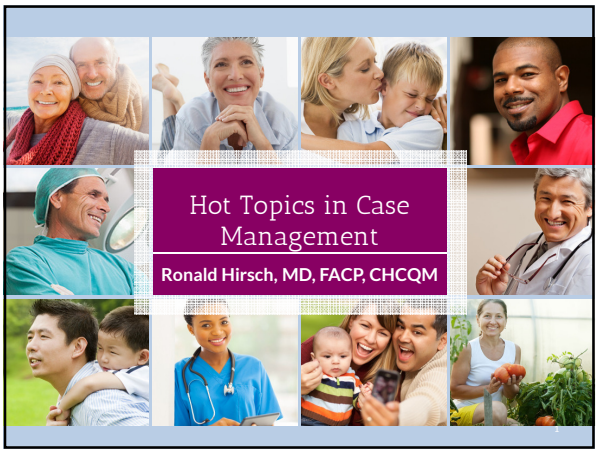


Objectives

- Finally figure out the 2 Midnight Rule
- Realize what observation really is and is not
- Convince doctors that resistance is futile
- You're gonna "Know when to ABN 'em, know when to HINN 'em" (a la Kenny Rogers)

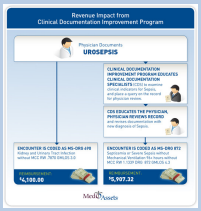
Disclosures/Conflicts of Interest

- None
- (But I am a taxpayer and want my tax money spent on medically necessary, effective treatments and given to cheaters or wasted on ineffective treatments or worthless tests)

It's no Easier for the Doctors

Torn between three lovers, feelin' like a fool, documentin' all of you is breakin' all the rules

2 Midnight Rule | **ICD-10 CC/MCC/DRG** | **E&M coding**



The 2 Midnight Rule

- It's here to stay…for now
- CMS asked for suggestions on a short stay DRG in 2015 IPPS Rule; no action taken
- The real problem is the part A SNF requirement- 3 medically necessary inpatient days, not counting the day of discharge, and terrible payment for observation
- I never thought we'd still be confused about it in 2015

But Observation costs patients a lot

- Medically necessary observation stays cannot exceed two midnights. That's "the law."
- The deductible for an observation stay is $147 and the coinsurance is 20% of the approved payment.
- The inpatient deductible is $1,260, even if they stay only one day. That resets 60 days after discharge.
- Physician charges are the same – in or outpatient

- That means that Observation is cheaper for patients as long as the approved charges during that one day stay do not exceed $5,565.
- The average Observation stay Medicare approved payment is $1,741 (per the OIG report in 2013) and would exceed only $5,565 if they have a major surgery (and then APC limit kicks in)
- $1,741 x 20% = $348 copay + $147 deductible = $495 pt due. That means the patient would have to receive $765 worth of self-administered medications in that one day observation stay in order for their financial obligation as an observation patient to exceed their obligation if admitted as inpatient.
- Therefore, being placed observation is actually the much better financial option for the patient.

The New Medical Necessity

"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." 2014 IPPS Final Rule, p. 50945

Receive Services or Reduce Risk

- Is it medically necessary for the patient to remain in the hospital for their evaluation or treatment?
- Is their needed treatment only safely provided in the hospital? Ventilator, initiation of IV antibiotics with active infection, iv Dilaudid
- Is there a high short-term risk that warrants keeping them in the hospital for testing that could otherwise be done as outpatient? TIA, Chest pain

Applying the Rule

Step 1- Ask: Does patient need to be in hospital for a medically necessary stay as determined by First Level Screening/Secondary Review

No- their stay would be for convenience- no safe discharge plan, wants to stay for medications

-Make alternate arrangements-SNF, home aide, hotel, voucher for meds

-Place in hospital bed as outpatient (G0378)

Give ABN (-GA) or write off costs (-GZ)

Yes- go to step 2

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If they have necessity to stay then

Step 2- Estimate length of expected hospital stay, including any midnights already spent in hospital/ED (clock starts with symptom-related care)

Clearly < 2 midnights- place observation

Clearly ≥ 2 midnights (or exception)- admit as inpatient

Unsure- secondary review/observation first day

Remember: The ED doc determines they need to stay, admitting doctor gets to say how long they think the patient will stay

Symptoms without a Cause

If you don't know the cause, you can't know the course

Acute exacerbation of chronic pain
Abdominal pain
Resolved neurologic findings
Acute back pain
Headache
Nausea and vomiting/dehydration
Syncope
Chest pain

You can always admit if not better after first MN

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Mild Exacerbation of Known Illness

- HF
- Asthma
- COPD

Mild Case of Potentially Serious Illness Will it bloom or will it fade?

- Pneumonia
- Pyelonephritis
- Cellulitis
- pancreatitis

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Exceptions to 2 MN Rule

- Inpatient Only Surgery- can go home whenever stable to go home
- Unexpected mechanical ventilation- even if expectation is less than 2 MN in hospital- drug OD
- Zero or one day stay ok if elects hospice after admission, dies, transfers, has unexpected recovery – **get a note "recovered faster than expected"**

What about weekends?

- If all you are doing is waiting for a test, do not admit; this is hospital convenience.
- If patient is getting active treatment waiting for the test, admit as inpatient. This is convenience with active treatment.

- No patient who **needs** to be in the hospital (medically necessary) should pass two midnights in the building without being admitted as inpatient. Patients who don't need to be in the hospital the second midnight should not be admitted inpatient.
- Medically necessary observation should never cross two midnights or 48 hours. If it does, you are violating beneficiary rights- don't do it.

I want my Criteria!

- IQ and MCG criteria are still important
- View your book as one set of criteria- **needs hospitalization** (pass In or Obs) or **does not need hospitalization** (fails In and Obs)
- If they pass In or Obs (first level review by RN), they **need** to be in the hospital, but they still must be expected to need 2 MN to be admitted inpatient (so you can pass for In by IQ but be placed Obs, as with some TIA patients)
- If they don't pass any criteria, they need secondary physician review to determine if the **need** for hospitalization exists and if there is the expectation of 2 MN.

- The two midnight rule is not perfect but it makes sense- the payment difference between outpatient and inpatient does not. Fix the payment scheme, not the classification scheme. (more on that soon.)
- CMS needs to stop making exceptions; they make it harder to teach the rule.
- Remember we are not telling doctors to treat their patients in the parking lot; it's just the status of how we label some patients has changed.

Observation – What is it?

A service not a status, like ordering iv fluids

Every observation patient is an outpatient

Used to determine if a patient requires hospitalization or can receive care at a lesser setting (home/SNF).

Not appropriate for:

- Waiting for test on weekend
- Waiting for consultant
- Provide routine post-op care
- Find SNF for placement
- The convenience of patients, physicians or hospitals

Observation and Surgery

- Observation can ONLY be used when there is a post-procedure complication or acute unexpected clinical event that complicates and/or prolongs routine recovery after outpatient surgery.
- Routine recovery is that physician's routine recovery period for that surgery if all goes well (2 hours to 2 days).
- Routine overnight recovery is not observation.
- Observation CANNOT be used for pre-op medical clearance, or prep such as hydration, pre-op testing, bowel prep, renal protocol, etc.

Medical Observation

- Always requires an order
- Hour counting begins with order and ends with end of services
- Carve out packaged services- MRI, EGD, stress test, etc.
- Medically necessary observation should never pass the second midnight! Admit as inpatient
  - If second midnight not medically necessary, keep obs and separate hours

Transfers from your facility

"The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility."

Wow this guy is sick, we need to get him to the Mecca ASAP. I have called them already. Stick him in the ICU until they call with a bed--> **Observation** since leaving in less than 2 MN (unless you intubate). If he ends up not going, then the hospital can admit at any time.

Wow this guy is sick, get him to the ICU and if he does not get better, we may need to transfer him to the Mecca in the next day or two--> **Inpatient** since they hope/expect him to stay and can still bill inpatient even if he gets worse and leaves for the Mecca prior to the second midnight.

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Transfers- The Receiving Hospital

- **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 time spent in the hospital for non-medically necessary services shall be excluded from the physician's admission decision

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Certification Woes

- CMS has removed the requirement for certification of every inpatient admission, effective January 1, 2015
- But now they say that outlier certification must occur by day 20 of hospitalization.

So what was Certification in 2014?

- Valid inpatient order from doctor authorized to admit patients, signed prior to discharge
- Reason for inpatient services
- the estimated time the beneficiary requires or required in the hospital
- Discharge plans

And what will every inpatient admission require in 2015?

- Valid inpatient order from provider (NP, PA ok) authorized to admit patients, signed prior to discharge
- An illness that is expected to require at least two midnights of hospital care to treat

What's never been needed?

- A form
- A check box
- An admission certification template
- A crystal ball to predict LOS

New Certification Requirement

- Certification of cost outlier bill submission or by day 20 now required
- Every note should justify why the patient continues to need hospital care that day. If that is present, certification is met.
- Estimated LOS may be needed- would suggest a wild guess by doc on day 18 -19 in notes

How are Hospitals Paid?

- Part A- Inpatient- Diagnosis Related Group- DRG
  Single payment for whole stay and all services 3 days prior to admission date based on primary diagnosis, secondary diagnoses and procedures (CAHs paid differently)
- Part B- Outpatient - Ambulatory Payment Classification- APC
- Payment for each service or grouping of services- xray, lab, surgery, procedure
- What coders and billers do is amazing! It is crazy complex

Why get it right? Laparoscopic Cholecystectomy

- APC 131- ~$4,035 (hospitalized overnight)
- DRG 413- $11,960 (hospitalized at least one more day for medically necessary care)
- Make sense? No
- Do we make the rules? No

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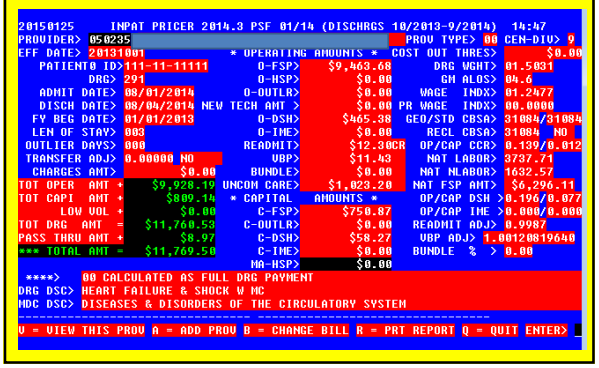
	TIA		HF
Obs-	~$2,200	(1 day)	~$2,000
DRG/In-	$4,985	(2+ days)	$6-12,000

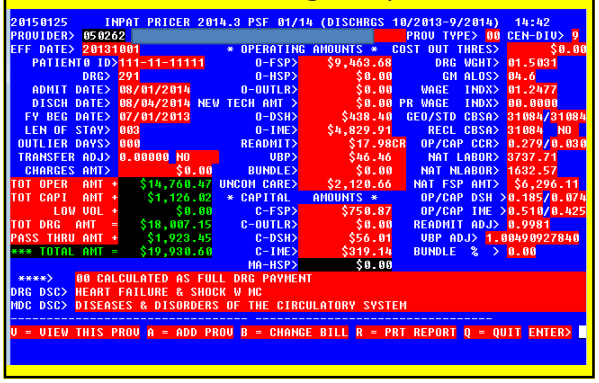
What is a CC or MCC worth?

- DRG 293 "plain" $5,835
- DRG 292 with CC $8,131
- DRG 291 with MCC $11,769

LA Community Hospital



LA Teaching Hospital



Inpatient Only Surgery

- Must be admitted pre-op with an inpatient order- this is not negotiable!!!!! (Unless true emergency) (The lawyers are still arguing about this but ignore them)
- If order is not written until post-op, the admission can be billed but the surgery procedure cannot be on the claim- you get a medical DRG payment, not a surgical DRG

Why do patients get readmitted?

Mrs. Gomez 's Home Medications and her Inpatient Medications

Home Medications	Inpatient Medications
Lisinopril/HCTZ, 20/25 mg/d	Prinivil (lisinopril), 20 mg/d
Metoprolol, 50 mg BID	HCTZ, 25 mg/d
Lantus (insulin glargine), 20 units/d	Coreg (carvedilol), 25 mg BID
Metformin, 500 mg BID	Levemir (insulin detemir), 35 units/d
Aspirin, 325 mg/d	Ecotrin (aspirin), 325 mg/d
Pravastatin, 40 mg/d	Crestor (rosuvastatin), 10 mg/d
	Plavix (clopidogrel), 75 mg/d
	Nexium (esomeprazole), 20 mg/d
	N-acetyl cysteine, 600 mg BID for 1 day

BID = twice daily; HCTZ = hydrochlorothiazide.

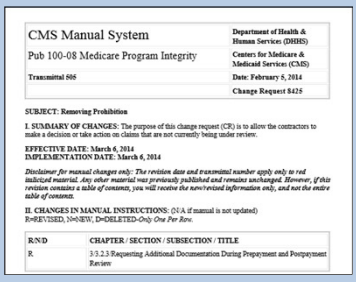
My personal opinion on Readmissions

- Make the hospitalists actually spend >30 minutes with patient on discharge
- Sit down next to bed, on side away from the door
- Do med rec themselves, looking at home meds carefully
- Use generics- no fancy stuff that needs prior auth
- Type out discharge instructions themselves in plain language
- Call a family member on every discharge and explain course
- Do the discharge summary on the day of discharge
- Get a message to the PCP on hospital course and get patient appt
- Follow up on pending tests after discharge
- Watch early discharge programs (out by 10 am)– may incr readmissions

Skin in the Game

Transmittal 505

Issued February 5, 2014



CMS Manual System — Department of Health & Human Services (DHHS)

Pub 100-08 Medicare Program Integrity — Centers for Medicare & Medicaid Services (CMS)

Transmittal 505 — Date: February 5, 2014

Change Request 8425

SUBJECT: Removing Prohibition

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to allow the contractors to make a decision or take action on claims that are not currently being under review.

EFFECTIVE DATE: March 6, 2014
IMPLEMENTATION DATE: March 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2.3 Requesting Additional Documentation During Prepayment and Postpayment Review

Transmittal 534

Issued August 8, 2014

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 534	Date: August 8, 2014
	Change Request 8802

SUBJECT: Claims that are Related

I. SUMMARY OF CHANGES: The purpose of this CR is to allow the MACs and ZPICs the discretion to deny claims that are "related" and provide approved examples of such situations.

EFFECTIVE DATE: September 8, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 8, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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Transmittal 540

Issued September 4, 2014

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 540	Date: September 4, 2014
	Change Request 8802

Transmittal 534, dated August 8, 2014, is being rescinded and replaced by Transmittal 540, dated September 4, 2014, to adhere to CMS Inpatient rescelling policy standards, which was accomplished by removing the rescelling language in section 3.2.3 in the Manual Instructions. All other information remains the same.

SUBJECT: Claims that are Related

I. SUMMARY OF CHANGES: The purpose of this CR is to allow the MACs and ZPICs the discretion to deny claims that are "related" and provide approved examples of such situations.

EFFECTIVE DATE: September 8, 2014
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IMPLEMENTATION DATE: September 8, 2014

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2.3/Requestsa Additional Documentation Duriat Prepayment and Postpayment Review

Transmittal 541

Issued September 12, 2014

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 541	Date: September 12, 2014
	Change Request 8802

Transmittal 540, dated September 4, 2014, is being rescinded and replaced by Transmittal 541, dated September 12, 2014, to provide consistency between the policy section and section 3.2.3 in the Manual Instructions. All other information remains the same.

SUBJECT: Claims that are Related

I. SUMMARY OF CHANGES: The purpose of this CR is to allow the MACs and ZPICs the discretion to deny claims that are "related" and provide approved examples of such situations.

EFFECTIVE DATE: September 8, 2014
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IMPLEMENTATION DATE: September 8, 2014

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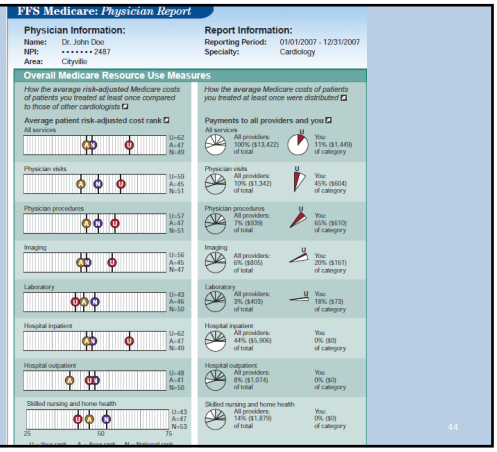
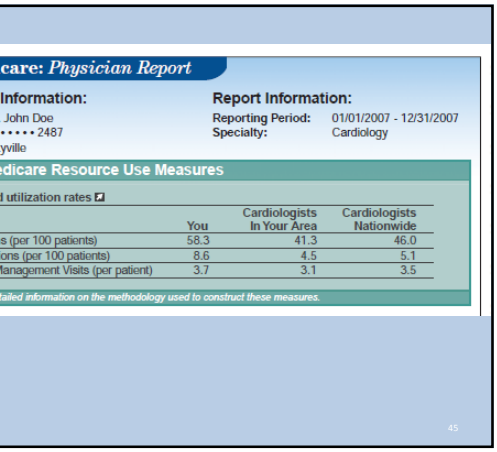
R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2.3/Requesting Additional Documentation During Prepayment and Postpayment Review

What does it mean?

- The only claim at imminent risk of "related" denial is the performing physician claim for a surgery/procedure performed on an inpatient where the MAC or ZPIC denial was for medical necessity of the procedure itself.
- It is a discretionary ability, not a requirement.
- If denied, the physician must appeal on their own, submitting all documentation.





IP by Discharge Disposition	Apr-11	May-11	Jun-11	Total	Percentage
ome	53	50	47	150	45.05%
ursing Home	7	6	5	18	5.41%
illed	8	10	7	25	7.51%
aving	1	2	1	4	1.20%
ome Health	17	22	18	57	17.12%
ospice	14	11	10	35	10.51%
xpired	8	2	7	17	5.11%
ehab	3	3	1	7	2.10%
ansferred	4	2	0	6	1.80%
ther	5	5	4	14	4.20%

Inpatients by Payor	Apr-11	May-11	Jun-11	Total	Percentage
Champus	1	0	1	2	0.60%
Blue Cross	5	2	1	8	2.40%
Commercial	17	18	10	45	13.51%
Indian Health	0	0	2	2	0.60%
Medicaid	9	9	13	31	9.31%
Medicare	79	72	67	218	65.47%
Self Pay	9	12	6	27	8.11%
Worker's Comp	0	0	0	0	0.00%

RG COMPARISON WITH SERVICE

DRGs	DRG DESCRIPTION	MEDIAN CMI	MEDIAN AGE	MEDIAN LOS (JPMC)	MEDIAN EXPT LOS	LOS DIFF	MEDIAN COST (JPMC)	MEDIAN EXPT COSTS	COST DIFF
43	871-SEPTICEMIA OR SEVERE SEPSIS wo MV 96+ HRS w MCC	1.9074	78.00	4.00	4.75	-0.75	$7,669.00	$6,902.00	$767.00
13	872-SEPTICEMIA OR SEVERE SEPSIS wo MV 96+ HRS wo MCC	1.1545	63.00	3.00	4.32	-1.32	$6,416.00	$6,051.00	$365.00
13	378-G.I. HEMORRHAGE W CC	1.0274	75.00	3.00	3.26	-0.26	$3,901.00	$5,267.00	$1,366.00
11	683-RENAL FAILURE W CC	1.0243	76.00	4.00	4.28	-0.28	$5,855.00	$5,013.00	$842.00
10	65-INTRACRAN HEMORRHAGE or CEREBRAL INFARCT w CC	1.1667	76.50	4.00	3.94	0.06	$5,393.00	$5,494.00	$101.00

Don't let the data show them as a doctor that "harms" patients- document accurately and completely

Make them Pay!

- ABN- Outpatient
- HINN- Inpatient
- Use for services that Medicare sometimes covers but will not be covered for this patient in this circumstance.

- ABN- Blood test, xray, outpatient surgery, obs patient who won't leave.
- HINN
  - Pre-admission- inpt not warranted
  - 10- patient stable but doc won't discharge
  - 12- patient won't leave but has been discharged
  - 11- needs to be in hospital but does not need the planned test (can't use for "while you are here")

- Always go to the CMS site for the form
- Fill in every box without abbreviations
- Give the patient time to think, record tme given form and got signature

Ask to be Admitted as Inpatient

- Find out why they insist on it- if financial, see above cost analysis
- Get your PA involved- be sure Obs is correct
- Then two choices-
  - Do not acquiesce- place outpt with observation
  - Get admit order, give pre-admission HINN, let them appeal to QIO, tell them SNF will not be covered even if stay 3 days-- "a medically necessary stay of at least three consecutive calendar days."

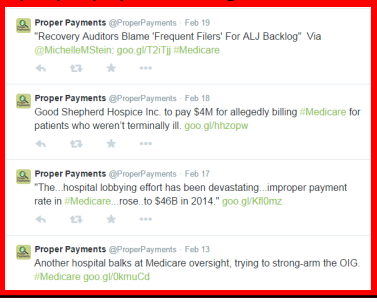
Home Care Face to Face

- Physician narrative no longer needed
- Physician orders home care on eligible patient
- HHA documents homebound and needs
- PCP signs that document and puts in chart
- CMS screwed it all up- proposed 30 question template

The Enemy

American Coalition of Healthcare Claims Integrity

www.properpayments.org



Even the MACs are getting Ugly

Palmetto proposes to deny Home Health payments for visits if patient taking Beers Criteria medication

CGS denying claims for ureteral stents if UA not done

If we have time

- Does a high cholesterol matter? What is the patient-oriented outcome?
- 35% of advanced cancer and 20% of dementia patients still on statin
- Do a medication debridement on your patients
  - What's the benefit? What are the side effects?
  - Is it worth trying a drug holiday?
  - Clinical Intertia – effort to continue med<<< stop med

Billing Interactive Complexity for Use of an Interpreter or Translator

While the use of an interpreter or translator is not generally recognized as a separately payable service, when the patient's pathology requires the use of an interpreter (such as when the patient only communicates with animalistic sounds or speaks an atypical language such as "Klingon"), then use of the interactive complexity code, when reported with certain "primary" procedures, would be appropriate.

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Questions?

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