Hey all, thanks for attending the Accretive PA Symposium

I am truly sorry for throwing so much information at you in a day and a half. It is overwhelming for us too! But what could we cut out????

Here are the slides from the beginning of day 2

You were all great; the questions were great (and sorry for messing up the cancer surgery question- bill inpatient with V code for cancelled surgery)

I also owe you the address for CMS for egregious MAC errors

Send them to:

MedicareMedicalReview@cms.hhs.gov

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

The rule applies to FFS Medicare and any insurer that adopts it. Others can do whatever they want. You have to ask them what to do.

But Observation costs 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 $1,216, 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 $5,345. ($147 + [$5345 x 20%])

The average Observation stay Medicare approved payment is $1,741 (patient copay = $495) and would exceed only $5,345 if they have a major surgery.

That means the patient would have to receive $721 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

You must ask this every single day of 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." 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

Step 1- Ask: Does patient need to be in hospital for a medically necessary stay?

- First level screening, secondary review

  Needs to be kept in the hospital is different than **wants** to be in the hospital. "Need" means not a convenience to the patient, doctor, or hospital.

  - No- send home or place outpatient in a bed with ABN
  - Yes- go to step 2

Step 2- Estimate length of expected hospital stay, including any midnights already spent in hospital/ED and doctor documentation

- < 2 midnights- place observation
- ≥ 2 midnights- admit as inpatient

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

AMA, unexpected rapid recovery, hospice, death

No patient who needs to be in the hospital should pass two midnights in the building without being admitted as inpatient. Patients who don't need to be in the hospital should not be admitted inpatient.

Medically necessary observation should never cross two midnights or 48 hours

The Three Clocks

Midnight counting clock starts when symptom-related care or testing begins in ED (for deciding if I 2 midnights will be met for admission)

Inpatient clock begins when the order is written and stops when the discharge is effectuated (for counting inpatient days for part A SNF eligibility)

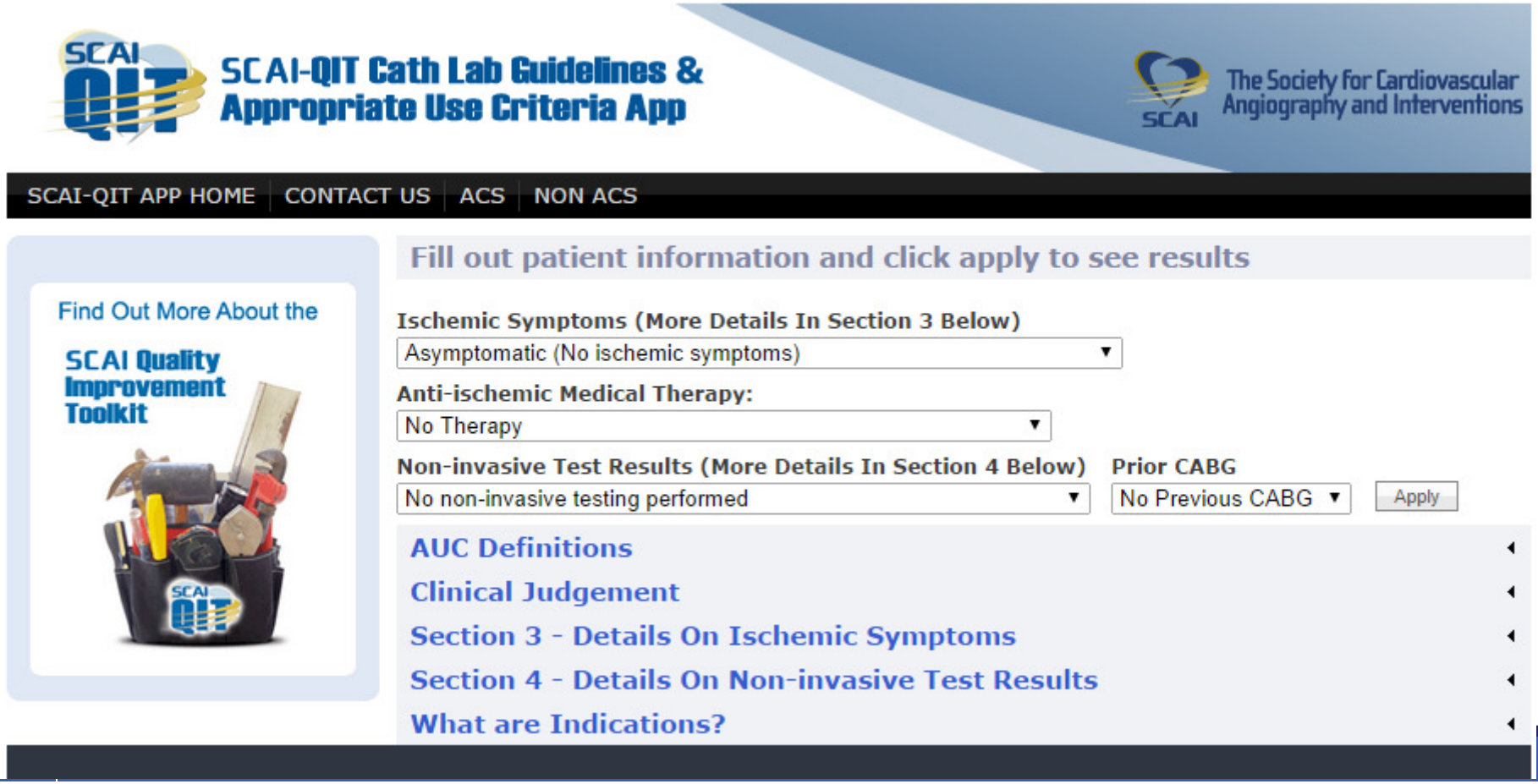
Observation hour clock starts when the order for observation is written and ends when the observation services cease (for billing for observation APC)

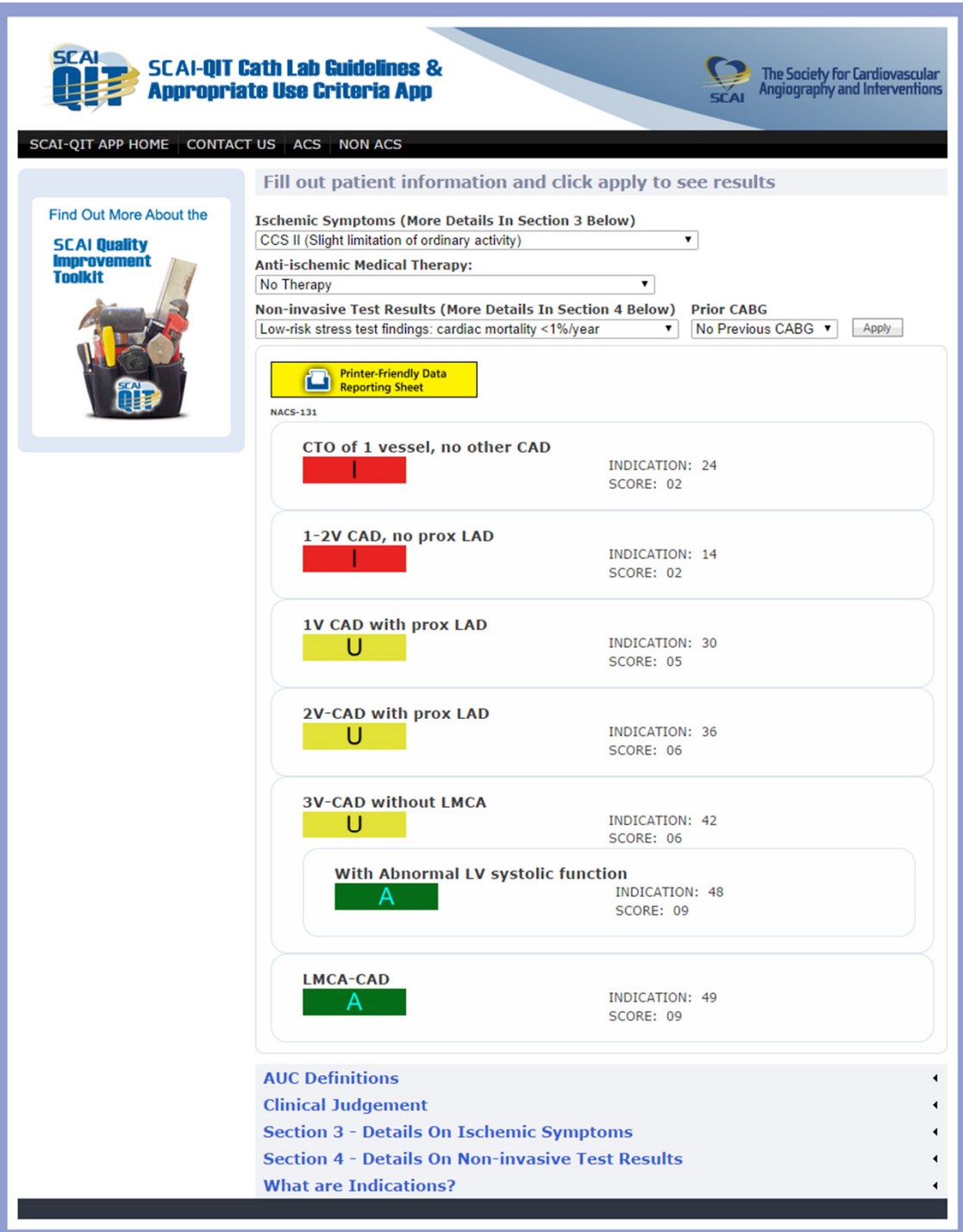
The auditors have a lot to learn!

9/24/14: REVIEW OF IPPS CLAIM UNDER CMS 1599-F FOR PROVIDER SPECIFIC REVIEW. BENE PRESENTS TO ED 8/3 AT 0521 VIA EMS FROM HOME WITH CHEST PAIN, AND GI DISTRESS. BENE FOUND TO BE HYPONATREMIC AT 113. BENE DX WITH HYPOVOMIA DUE TO VOMITTING AND DIARHEA IN THE SETTING OF HCTZ USE. BENE D/C'D HOME ON 8/4 WITH FOLLOW UP. DOCUMENTATION DOES NOT SUPPORT REASONABLE ANTICIPATION THAT HOSPITAL CARE WOULD BE REQUIRED FOR 2 MIDNIGHT STAY WITH BENE'S PRESENTATION. THEREFORE INPATIENT STATUS IS DENIED. DENY CLAIM. PROVIDER LIABLE. RC 55406. REF: CMS 1599-F, MBPM CH 1, MCPM CH 3, MPIM CH 6 SECTION 6.5. PT

SCAI's Quality Improvement Toolkit Cath Lab Guidelines & Appropriate Use Criteria

nacs.scai-qit.org




SCAI-QIT Cath Lab Guidelines & Appropriate Use Criteria App
The Society for Cardiovascular Angiography and Interventions
SCAI-QIT APP HOME | CONTACT US | ACS | NON ACS
Find Out More About the
SCAI Quality Improvement Toolkit
Fill out patient information and click apply to see results
Ischemic Symptoms (More Details In Section 3 Below)
CCS II (Slight limitation of ordinary activity)
Anti-ischemic Medical Therapy:
No Therapy
Non-invasive Test Results (More Details In Section 4 Below)
Low-risk stress test findings: cardiac mortality <1%/year
Prior CABG
No Previous CABG
Apply
Printer-Friendly Data Reporting Sheet
NACS-131
CTO of 1 vessel, no other CAD
I
INDICATION: 24
SCORE: 02
1-2V CAD, no prox LAD
I
INDICATION: 14
SCORE: 02
1V CAD with prox LAD
U
INDICATION: 30
SCORE: 05
2V-CAD with prox LAD
U
INDICATION: 36
SCORE: 06
3V-CAD without LMCA
U
INDICATION: 42
SCORE: 06
With Abnormal LV systolic function
A
INDICATION: 48
SCORE: 09
LMCA-CAD
A
INDICATION: 49
SCORE: 09
AUC Definitions
Clinical Judgement
Section 3 - Details On Ischemic Symptoms
Section 4 - Details On Non-invasive Test Results
What are Indications?

National Government Services Draft LCDs for Comment

The following draft LCDs are being presented for comment for the J6 and JK MACs. The formal comment period extends from 10/30/2014 through 12/13/2014. However, comments may be submitted from the time the drafts are viewable.

Comments can be submitted to the address listed at the end of each LCD.

J6

- Draft LCD for Left Atrial Appendage Closure or Occlusion
- Draft LCD for Noncovered Services

- National Government Services considers the UroLift a potentially promising treatment for symptomatic prostatic hyperplasia. However, the evidence is of short duration and insufficient to allow the device to be considered “reasonable and necessary.”
- Transtelephonic spirometry is considered to be of unproven benefit as there is inadequate evidence that its use will significantly affect the care of lung transplant recipients, asthmatics, and persons with other chronic pulmonary disorders/diseases (e.g., emphysema)
- Claims for VLDL and lipoprotein (a) will be denied as not medically necessary, since NCEP recommendations do not include monitoring of VLDL or apolipoprotein levels for treatment of elevated cholesterol as risk factors for coronary and vascular atherosclerosis.
- Given the lack of quality evidence that using CIMT to change risk stratification compared to traditional methods results in clinical meaningful improvements in relevant clinical outcomes and the general lack of support for the clinical value of CIMT in various published clinical guidelines, CIMT is not considered “reasonable and necessary” for Medicare beneficiaries.