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AccretivePAS Client Update

We will be starting at approximately 3 minutes after the hour.

Audio: Call-in toll-free number: 1-866-203-0920
Conference Code: 621 078 1518

Please mute your phone and do not place your line on hold at any time.

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Discharge Planning CoP Proposal

All hospitals including CAHs

All inpatients, all observation patients, all outpatients who receive anesthesia or conscious sedation need formal discharge plan

Plan must be started within 24 hrs of presentation

Must establish a post-discharge follow-up process

Plan address patient goals and treatment preferences

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Medication reconciliation must include brand and generic names, risks and side effects for every medication

Strongly recommend query PDMP database on every discharge

Ensure patient knows which pharmacy will fill new Rx

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Send copy of discharge instructions and discharge summary within 48 hours

Send results from pending tests within 24 hours of their availability

21 items that must be included when patient transferred to another facility

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Data on quality measures and data on resource use furnished to patients on all post-discharge providers -HHA, SNF, IRF, LTCH- and document that data was provided

Present choice for HHA, SNF, IRF and LTCH and disclose financial interest

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Comment Period Closed

AHA, ACMA, ACPA all commented

AHA asked for 2 yr delay

We may hear by March 1…

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What are the three clocks?

Midnight clock to decide inpatient or outpatient- 2 MN Rule

- -begins with symptom-related care
- -two total necessary midnights = inpatient

Observation clock to count hours to get paid

- -begins with order for observation services
- -can bill any # of hrs: Medicare pays ≥8

Inpatient admission clock to count 3 days for SNF

- -begins with inpatient admission order, not retroactive

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The Two Steps of 2 MN Rule

1- Does the patient require care that can only be safely provided in the hospital?

"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."

Forget costs- does the patient need to be in the hospital, the most expensive place to receive care?

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2- How many midnights is the patient expected to require in the hospital until able to safely move to a lower level of care (regardless of who is going to pay for that care or what level it is – home with office follow up, home with HHA, home with live-in aide, SNF, assisted living, etc.)?

Clearly < 2- outpatient +/- Observation services

Clearly > 2- inpatient

Unsure?- Refer to PAS. Our doctors will review clinical data and help you decide.

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Remember…

The decision to hospitalize or not is a complex medical decision best made by a physician based on the severity of the signs and symptoms and the risk to the patient.

The decision on what level of care the patient will be placed in is purely an administrative decision. In either status, the patient should get all the care they need.

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Patients in Observation for 1 MN

"…The decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in *necessary hospitalizations* should not pass a second midnight prior to the admission order being written."

IPPS Final Rule p 50946

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Why do you want to admit them?

APC 8011- Observation- $2,275 all inclusive

DRG 293- HF no CC/MCC- $5,600+

Outpt Lap Chol'y- ~$4,000

DRG Lap Chol'y- ~$12,000

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What is "necessary hospitalization"?

Must the patient be kept at the hospital in order to continue to receive services or reduce risk, or can they be discharged because they may be safely treated through intermittent outpatient visits or some other care?

"If the patient came to your office should you hospitalize the patient or schedule an OP work up? Is there a short term risk requiring a hospitalization?"

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It Needs to be in Writing

"The factors that lead a physician to admit a particular beneficiary based on the physician's clinical expectation are significant clinical considerations and must be clearly and completely documented in the medical record…"

"The physician has ample opportunity to explain in detail why the expectation of the need for care spanning at least 2 midnights was appropriate in the context of that beneficiary's acute condition."

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What Should You Do?

Review every outpatient approaching second MN without discharge order

-if patient clearly ill, get inpatient order

-if patient going home, get discharge order

-if not clear if patient needs to stay, refer case to PAS for review

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What if there is no medical necessity but patient staying?

Find out why the doctor wants to keep them; many times they have a reason but did not document it.

Patient does not need to pass Inpatient "criteria" to be admitted as inpatient. They must require care in a hospital to reduce risk or receive services.

If no good reason, status stays outpatient

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Medically Unnecessary Observation

The patient is still in the room, the RN is giving meds and monitoring so they are "observed"

Inform billing office and patient that medically necessary observation and hospital care has ended- they need to know it does not count!

Separate necessary and unnecessary hours

Decide if charging patient for hours or writing off

-GZ if writing off

-GA if gave ABN and charging patient

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Example

75 yr old presents with chest pain. EKG and troponin negative. Doctor places observation to rule out MI and get stress test.

CM screens and passes observation.

Next day stress test negative and doctor orders GB ultrasound, GI consult for EGD the next day and inpatient admission.

Is admission correct?

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2016 OPPS Final Rule Change The New Exception

While we have been clear that the 2-midnight benchmark does not override the clinical judgment of the physician regarding the need to keep the beneficiary at the hospital, to order specific services, or to determine appropriate levels of nursing care or physical locations within the hospital, some stakeholders have argued that the 2-midnight benchmark removes physician judgment from the decision to admit a patient for inpatient hospital services. We disagree….but

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2016 OPPS Final Rule

but…we are modifying our existing "rare and unusual" exceptions policy to allow for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights.

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When can under "2 MN and inpatient ok" exception be used?

Inpatient only surgery (already allowed)

Physician states patient is high risk or has severe signs and symptoms and warrants inpatient admission

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But …

What is high risk?

What are severe signs and symptoms?

What documentation is needed to support "need for inpatient admission"?

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What is CMS really saying?

CMS says there is no difference between inpatient and outpatient care except when physician judgment says there is a difference. But even if the physician says it…

The physician's "order and certification regarding medical necessity" are not entitled to any "presumptive weight" and are "evaluated in the context of the evidence in the medical record."

42CFR 412.46

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CMS Sub-Regulatory Guidance 12-31

Under the revised exceptions policy pursuant to CMS-1633-F, for admissions not meeting the two midnight benchmark, Part A payment is appropriate on a case-by-case basis where the medical record supports the admitting physician's determination that the patient requires inpatient care, despite the lack of a 2 midnight expectation. The QIOs will consider complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event to determine whether the medical record supports the need for inpatient hospital care. These cases will be approved by the QIOs when the other requirements are met.

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"We have too much Observation!"- every CFO

ED or direct "admit" patients who are expected to stay in the hospital under two midnights

Post-procedure patients who need care past the normal recovery but under two midnights

Post-procedure patients who need recovery after the recovery room time

Late procedures who need recovery but recovery room closed

Post-procedure patients who need to spend a night in the hospital

Pre-procedure patients hospitalized the day prior for preparation or clearance

Patients who are staying because they can't get a ride home

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What do you call Observation?

ED or direct "admit" patients who are expected to stay in the hospital under two midnights

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The Hirsch Rule of Observation

If every patient is reviewed by CM for proper admission status, and every patient is placed in the right status, and observation is only ordered on the proper patients, and every patient goes home as soon as their need for hospital care has finished and every patient who requires a second midnight is admitted as inpatient, then your observation rate is at your benchmark.

If you do this and your CFO wants fewer observation patients, you must commit fraud to get there.

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New APC for Observation 1-1-16

Previously APC 8009

-ED visit or direct admit plus 8 or more hrs Observation = $1,234

-Eligible part B services billed separately

-imaging, diagnostic and therapeutic procedures

New Comprehensive APC - 8011

-ED visit or direct admit plus 8 or more hrs observation = $2,275

No other services can be billed

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The new Quirk of Observation

If a patient is placed in observation and underwent a status T procedure at any point, the Observation APC is not paid. You bill for the T procedure and all other services provided, but get no payment for bed and nursing services.

T procedures-

cath without stent, colonoscopy, EGD, I&D abscess, nose packing

Find status indicators on Addendum B

www.ronaldhirsch.com – Inpatient Only Lists

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Unexpectedly Rapid Recovery

The doctor correctly thought they'd need over 2 MN but they got better faster.

The 2 MN expectation at admission must be clinically sound.

Their unexpected recovery should be explained in the medical record.

This should happen infrequently.

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Post-Discharge Reviews

What cases need review?

Zero and one day inpatient admissions (except inpt only, death, hospice, AMA, transfer)

One day outpatient and one day inpatient if not reviewed concurrently

Two day "soft" inpatient admissions

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Things to Consider

Self-denial and rebilling available if wrong status was used

Must follow 42 CFR 482.30 and go thru UR Committee, notify doctor, patient of change

If you are self-denying because the medical necessity is present but the documentation is poor and you fear denial, then you can self-deny without following 42 CFR 482.30 but can only rebill for ancillaries.

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Audit Moratorium is Over

Probe and Educate by MACs is done

BFCC-QIOs taking over short stay reviews as of 10-1-15

Summary of Inpatient Status Reviews	
Date of Admission	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 conducting initial reviews. RACs conducting further reviews upon referral by QIOs.

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Then a New Year's Miracle!

Summary of Inpatient Status Reviews	
	Contractor Type(s)
Through September 30, 2015	MACs conducting probe and educate.
October 1, 2015 through December 31, 2015	QIOs **begin** conducting reviews. MACs completing some remaining provider education.
January 1, 2016 and beyond	QIOs **continue** conducting initial reviews. RACs conducting further reviews upon referral by QIOs.

On October 1, 2015, QIOs began applying CMS-1599-F when conducting patient status reviews for adjudicated claims that were submitted by acute care inpatient hospital facilities and Long Term Care Hospitals (LTCHs) for dates of admission within the previous 6 months. QIOs will not apply these instructions to admissions at Inpatient Rehabilitation Facilities (IRFs) and Critical Access Hospitals (CAHs). https://goo.gl/OYf06O

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No More Retrospectoscope

QIOs will continue to follow longstanding guidance to review the reasonableness of the inpatient admission for purposes of Part A payment based on the information known to the physician at the time of admission. The expectation for sufficient documentation is well rooted in good medical practice. Physicians need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

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It's not just the physician notes

The entire medical record may be reviewed to support or refute the reasonableness of the physician's expectation, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission.

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How Many Records?

Per QIOs, 10 from small, 25 from large, based on CMS determination of small or large, per 6 months.

CMS says: Twice a calendar year, the BFCC-QIOs will conduct patient status reviews using a provider sample from claims paid within the previous 6 months.

BFCC-QIOs will request a minimum of 10 records in a 30-45-day time period from hospitals. The maximum number of record requests per 30 days will be 30 records. https://goo.gl/5WoXZn

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Current State

QIO auditing began in December

Chart requests going back to May- "6 months from date paid" or "6 months from date of admission"

Inpatient Only surgery records being requested-
if you get one, put on cover sheet with CPT code and "**Inpatient Only Surgery**"

No education yet- call me if you are scheduled

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When will the RACs swoop in?

QIO Referral to the Review Auditors

At the direction of CMS, the BFCC-QIO will refer providers with inpatient status claims identified as having 'Major Concerns" to the Recovery Audit Contractor (RACs) to implement provider specific audits.

Major Concern = 7 or more of 10, 14 or more of 25

RACs can continue to do DRG, medical necessity, coding audits

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What about MA plans?

MA plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail.

Medicare Managed Care Manual, Ch 4

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What can we do?

Get a copy of your contract

Read the insurer's policies

See RACMonitor article at tinyurl.com/FightMA

Get a peer-to-peer review- PAS can help!

Complain to CMS

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Questions.CMS.gov

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Submit a Request

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Submit a Request

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What to tell them

Don't include PHI
Don't whine about "unfairness"

Provide details
Describe impact on beneficiary and/or you
- Costs not reimbursed
- Delays in care
- Lack of access to SNF, IRF, HHA
- Not following own policies

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Questions?

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