



ABN, HINN, CC44

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ABNs and HINNs

Advance Beneficiary Notices and Hospital Issued Notices of Noncoverages are provided to Medicare patients when a service that Medicare in general covers is expected to denied for payment for this particular use in this particular patient.

ABN- outpatient service

HINN- inpatient admission, service or continued stay

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Advance Beneficiary Notice

Notice that service may not be covered by Medicare

Must be provided before service is rendered

Only traditional Medicare, no MA requirement- call the plan and ask what to do

Mandatory and voluntary issuance

Current form is Form CMS-R-131 (03/11)

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Mandatory v Voluntary

If a mandatory ABN is not issued pre-service, the beneficiary cannot be charged for the service, even if they agreed to pay.

A voluntary ABN protects the provider from the beneficiary claiming that they thought Medicare would pay for it but is not required and allows the claim to get processed and denied by Medicare so the supplemental will get it

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Mandatory uses

- Services that otherwise could be covered but which are not medically reasonable and necessary in the individual case at hand
- Custodial care which Medicare never covers,
- Home care given to a beneficiary who is neither homebound nor needs intermittent skilled services at home
- Hospice care given to someone not terminally ill
- Outpatient therapy services are in excess of therapy cap amounts **and** do not qualify for a therapy cap exception

- CMS CR6563, 2/19/2010

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Voluntary uses

Statutorily excluded services

- Personal comfort items
- Routine physicals, foot care, and eye care
- Dental care, hearing aids
- Cosmetic surgery
- War injury care
- Most routine immunizations

Fails to meet a technical benefit requirement

- Ambulance service provided that is beyond the nearest appropriate facility
- Self-administered drugs and biologicals

Medicare Webinar- Advanced Beneficiary Notice of Noncoverage (ABN) June 15, 2010

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Completing ABN's

Must complete all boxes

Good faith estimate of charges- within $100 or 25%

Signature not required (but proceed with caution here)

No routine ABN's, no after the service ABN's, no blank ABN's, no generic ABN's and ABN in the ED only after EMTALA examination

Do not use abbreviations for any words

Give patient adequate time to decide

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Patient can indicate in Box G that provider should bill Medicare so that a rejection can be recorded for secondary insurance or other reimbursement.

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Billing ABN's

Notify your billing department

Let them figure out the correct modifier and condition code

-GA- mandatory ABN issued
-GX- voluntary ABN issued
-GZ- no ABN issued but non-covered service provided

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Examples of mandatory use

Place Outpt in a bed for colonoscopy prep

PSA every 6 months

Elective defibrillator with EF 36%

Out of state patient wants transfer to home hospital or patient transfer to tertiary center when closer one exists (ambulance provider gets signature)

Outpatient off-label/compedium chemotherapy

Pain seeker insists on spending the night for Dilaudid

Routine labs ordered by MD without proper code (MD should obtain ABN but billing entity is responsible for completion)

Observation patient discharged but won't leave

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Hospital Issued Notice of Non Coverage- HINN

42 CFR 412.42 - Limitations on charges to beneficiaries

A hospital may charge a beneficiary for services excluded from coverage on the basis of § 411.15(g) of this chapter (custodial care) or § 411.15(k) of this chapter (medically unnecessary services) and furnished by the hospital after all of the following conditions have been met:

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The hospital (acting directly or through its utilization review committee) determines that the beneficiary no longer requires inpatient hospital care.

The attending physician agrees with the hospital's determination in writing (for example, by issuing a written discharge order). If the hospital believes that the beneficiary does not require inpatient hospital care but is unable to obtain the agreement of the physician, it may request an immediate review of the case by the QIO. Concurrence by the QIO in the hospital's determination will serve in lieu of the physician's agreement.

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The hospital (acting directly or through its utilization review committee) notifies the beneficiary (or his or her representative) of his or her discharge rights in writing and notifies the patient that in the hospital's opinion, and with the attending physician's concurrence or that of the QIO, the beneficiary no longer requires inpatient hospital care.

If the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or QIO subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital once again determines that the beneficiary no longer requires inpatient care, secures concurrence, and notifies the beneficiary.

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Pre-admission HINN

Physician orders Inpatient care

Hospital believes care will not be covered

Physician does not need to agree with hospital

QIO will review expeditiously

Examples:

- Admit for SNF placement
- Admit for Defibrillator with EF 36%
- Admit as Inpatient for outpatient surgery where Outpatient status more appropriate and physician won't change

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HINN 11

The item or service at issue must be a diagnostic or therapeutic service excluded from coverage as medically unnecessary, and

The beneficiary must require continued hospital inpatient care.

HINN 11 issued, patient may appeal to QIO

Example: Admit for acute MI, physician orders PET scan at patient request; admit for HF, EF 40%, ICD planned

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HINN 11 is not for…

While you are here tests that the patient needs

Colonoscopy for anemia

ultrasound for thyroid nodule on CT

screening mammogram

Caveat- if it is a purely screening test covered by Medicare, you can bill it as a part B charge during a part A admission, but you really don't want the test done at all

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HINN 10- Notice of Hospital Requested Review

Hospital requested review of Continued Stay when physician won't write order for discharge but care no longer medically necessary

No action needed by patient after getting notice

If QIO agrees with hospital, then give patient HINN 12

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How does this work?

Patient appears ready to be discharged

PA should review case

Ask for discharge order from attending, won't give it

Prepare HINN 10, contact QIO, give pt copy of HINN

Wait for QIO to rule

If QIO rules in your favor, prepare HINN 12

Give HINN 12 to patient, has right to appeal to QIO

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HINN 12- Continued Stay Review

Inpatient care no longer medically necessary but patient does not want to leave

Attending physician (or QIO) concurs

Patient may appeal to QIO

Responsible for costs at noon on next day

Days do not count towards SNF 3 day qualifying stay (or do they?)

There must be an available SNF bed (if required for care)

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Detailed Notice of Discharge

Give to patient when patient appeals to the QIO

You indicate reason you think it will be denied- Not medically necessary- and specifics of case

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Always reference CMS website for ABN/HINN forms

- They change all the time; miss a line, go back to Start

cms.gov/Medicare/Medicare-General-Information/BNI/HINNs.html

or Google-- CMS FFS HINN

Medicare Claims Processing Manual, Chapter 30 - Financial Liability Protections

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Condition Code 44- the Prequel

Federal Register 42 CFR§482.30

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy.

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Who is the UR Committee?

b(1) The UR committee must be one of the following:

- (i) A staff committee of the institution;
- (ii) A group outside the institution—
  - (A) Established by the local medical society and some or all of the hospitals in the locality; or
  - (B) Established in a manner approved by CMS.

(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.

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Standard:

Determination regarding admissions or continued stays.

- (1) The determination that an admission or continued stay is not medically necessary—
  - (i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of §482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
  - (ii) Must be made by at least two members of the UR committee in all other cases.

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- (2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c), and afford the practitioner or practitioners the opportunity to present their views.

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- (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient.

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Why Condition Code 44?

Prior to 2004, if an admission was deemed not medically necessary during the stay or after discharge, the hospital could only bill for ancillary services provided.

CC44 allows hospitals to fix their mistakes and get paid if caught prior to discharge.

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Conditions to use Condition Code 44 Condition #1

The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

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Still a patient?

a hospital inpatient is considered discharged from a hospital when—

(1) The patient is formally released from the hospital; or

(2) The patient dies in the hospital

- 42 CFR 412.4

Formally released- not defined, our interpretation is

- Order to discharge given
- And nurse has given discharge instructions/paperwork
- May still be in room waiting for ride

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Condition #2

The hospital has not submitted a claim to Medicare for the inpatient admission

- Not too hard to accomplish…

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Condition #3

A physician concurs with the utilization review committee's decision

Two UR docs cannot overrule an attending and change to outpatient.

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Condition #4

The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

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How often to can you use CC 44?

CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances.

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So what is the process?

Patient admitted thru ED or Direct Admit as Inpatient with no CM input- evening, weekend, sneaky ED doctor

CM reviews chart, does not meet criteria

CM refers case for secondary review by PA/PAS

Case does not pass secondary review

CM contacts UR Committee physician (can be PA)

UR Committee physician reviews case

UR committee physician contacts Attending physician

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Option 1-Attending agrees with change

Order written in chart

- Change to Outpatient- if near discharge
- Change to Observation- if more care to be provided

Indicate UR physician name and agreement

Indicate reason for change

"Change to Outpatient/Observation, case reviewed with Dr Smith, UR Committee, concur patient does not require Inpatient care" TORB from Dr Jones by S. Berg, RN.

- (not official wording- you may paraphrase)

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Option 2- Attending does not agree

Second UR Committee physician contacted

- Agrees with attending- Inpatient
  - Case stays Inpatient- medically necessary
- Agrees with first UR Committee physician
  - Contacts attending physician who agrees with change to Outpt/Obs, proceed as previous slide
  - Disagrees with change – patient stays Inpatient, hospital bills as not medically necessary, Submits an Inpatient (110) no pay claim and then rebills Inpatient and Outpatient part B
    - Refer case to full UR Committee for review

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Option 3- Attending fails to present views

Condition code 44 criteria not met

- Patient stays Inpatient, hospital bills as not medically necessary, Submits an Inpatient (110) no pay claim and then rebills Inpatient and Outpatient part B

Refer case to full UR Committee for review and action

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Notification requirements

CFR 482.30 - If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient.

Patient must be notified before discharge if Condition Code 44 is used. CMS MLN Matters SE0622

If CC 44 not used, (no concurrence, after discharge, etc.) still must notify hospital, patient and physicians within 2 days.

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How to Notify for CC 44

Hospital

- Write an note in order section “billing to invoke Condition code 44”
- Send an email to billing supervisor and copy into chart
- Any other way you want to interpret it

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Notification of patient

Requiring that the decision resulting in a change in patient status be made before the beneficiary is discharged is intended to ensure that the patient is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible. (apparently per CFR 482.13)

For example, if a patient has already met her Part A deductible, informing the beneficiary a month after discharge that she will now be responsible for additional coinsurance as an outpatient could impose a financial hardship.

CMS MLN Matters SE0622

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CMS gives no specified format or content requirements

No requirement for patient signature- should/must document that notification given to patient in case of audit.

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My format- use at your own risk

Medicare Observation – Information Sheet

Medicare requires your physician and hospital to determine the correct billing status for your hospital stay. This billing status is based upon the clinical guidelines regarding the severity of your illness and the intensity of the services that are provided to you.

Your Physician and the Hospital have determined that your correct billing status for this hospital stay is Outpatient, which means:

- You have an outpatient billing status, even though you are in a regular hospital bed and receive some of the same services as a patient with an inpatient billing status.
- Your outpatient/observation stay does not count toward the three-day inpatient stay requirement of admission to a skilled nursing facility.
- You may be liable for some charges on your bill if they are not covered under your Part B Medicare or if you do not have part B Medicare.
- You **will** be responsible for your yearly Part B deductible and any deductible co-insurance.

Please contact your Case Manager or the Case Management Department if you have additional questions or concerns.

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Physician Notification

Dear Dr.

Medicare requires the physician and hospital to determine the correct billing status for your hospital stay. This billing status is based upon the clinical guidelines regarding the severity of illness and the intensity of the services that are provided to your patient.

As discussed with you, it has been determined that your patient, _____, was incorrectly placed as Inpatient status and following Medicare guidelines has been changed to Outpatient or Observation status. As required, the patient has been notified of this change and this letter serves as official notification to you. Please adjust your billing codes accordingly.

If you have any questions about determining the proper status of a patient or about Condition Code 44, please feel free to contact one of the case managers.

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Physician Billing

Different codes for Inpatient and Outpatient

Different site of service for Inpatient and Outpatient

Previously no difference in fees, but that has changed, to the detriment of consultants

MAC's supposed to compare hospital and physician bills to be sure matching site of service and deny one or the other—who will they believe??????

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Common questions

Does the UR Committee physician need to examine the patient?

No, there is no requirement for an examination

Does the UR Committee physician need to review the medical record?

No, the UR Committee physician may discuss the case with the CM RN, attending physician or other party to get the required information to make the determination.

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Does the UR Committee physician need to document in the chart?

No, there is no requirement for a note from that physician.

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Is the UR Committee physician have any liability in participating in Condition Code 44 determinations?

There is no liability because the UR Committee physician is only determining the patient's status, not guiding or ordering or refusing treatment decisions in any way. The care is all determined by the attending.

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Can a physician order “Change to Observation as of initial presentation”?

No, Medicare does not recognize retroactive orders. Observation hour counting would begin at the time of the change from Inpatient to Observation.

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Is there any situation when a physician can unilaterally change a patient from Inpatient to Observation?

Yes, one. If the order for Inpatient has been written the order has not left the physician's hand. This only applies when the physician "changes their mind." If the UR Committee or CM was involved, then a CC44 should be done.

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But CMS did say…

If the physician or other practitioner responsible for countersigning an initial order or verbal order does not agree that inpatient admission was appropriate or valid (including an unauthorized verbal order), he or she should not countersign the order and the beneficiary is not considered to be an inpatient. The hospital stay may be billed to Part B as a hospital outpatient encounter.

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Does this mean…

That a patient admitted as inpatient but the order was not authenticated was never an inpatient?

What about the 10 day admission that needs a SNF?

Wasn't the patient told they are an inpatient?

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Patient admitted Inpatient, next day attending changes to Observation without UR Committee and discharges patient. Post-discharge, case sent to UR Committee and feels Inpatient was correct status. How do you bill this?

Inpatient is the correct status. The change to Observation was non-compliant and UR Committee review supported Inpatient.

– Correspondence Novitas Solutions, 11-20-2012

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The attending “just wants it changed.” What should we do?

CM talks to attending, gets views, calls UR physician and presents case. If UR physician agrees, CM writes telephone order for CC 44 from attending, as described previously.

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What about a physician that orders Observation after an Inpatient Only surgery that was properly admitted pre-op?

No, this order is not valid. Inpatient can only be changed to Outpatient with the UR Committee. I recommend you get a clarification order from the doctor to disregard order to avoid confusion in billing..

- -WPS Medicare 11-9-2009

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Can a patient appeal the change to Outpatient?

Not clear. There are no provisions in the COP or Policies to grant the patient appeal rights nor any requirement that patients be informed of appeal rights. But the patient is an Inpatient at the time of the determination so they have the right to contact the QIO. What the QIO determines, and whether it is binding, is anyone's guess.

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My UR Committee members do not want to be bothered by these. What do I do?

Get a new UR Committee. This is a requirement of the COP. It would be a compliance issue if a hospital billed a service that it knew to be not medically necessary.

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Does this apply to Medicare Advantage plans or other insurers?

No, Condition Code 44 only applies to patients covered by traditional Medicare. The procedure to change from Inpatient to Outpatient for a non-Medicare patient is a contractual issue between the hospital and the insurer.

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How about this scenario:

A patient is admitted Inpatient Friday evening for weakness, admit for placement. No weekend CM coverage. The CM reviews the case Monday morning and determines that the patient did not meet Inpatient criteria at the time of admission or now. The UR Committee physician concurs. The attending disagrees. The second UR Committee member agrees with the first. The attending disagrees. The patient remains Inpatient. On Monday afternoon, the attending writes for patient to be sent to SNF. What should the hospital do?

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There is no concurrence so conditions are not met to invoke Condition Code 44 therefore hospital should bill a Inpatient (110) no pay claim and rebill.

The hospital should inform the patient and the SNF that they have determined that the Inpatient stay was not medically necessary and that it has not met the requirement for the patient to receive their Part A SNF benefit. SNF can accept the patient under Presumption of Coverage and has until the 8th day to sort it out.

- Medicare Policy Benefit Manual Chapter 8 section 30.1

The case should be referred for full UR Committee review.

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In summary, Condition Code 44

Initiated by the UR Committee physician

Concurrence of attending physician

Prior to discharge

Everyone gets notified

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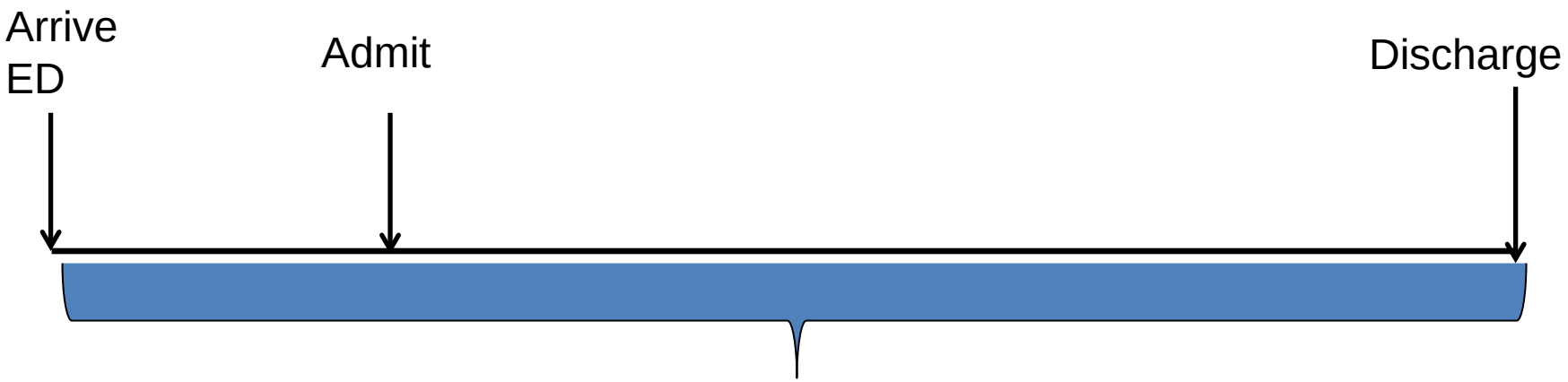
Normal Short Inpatient Stay



Inpatient Part A- DRG payment
$4,000 to $8,000

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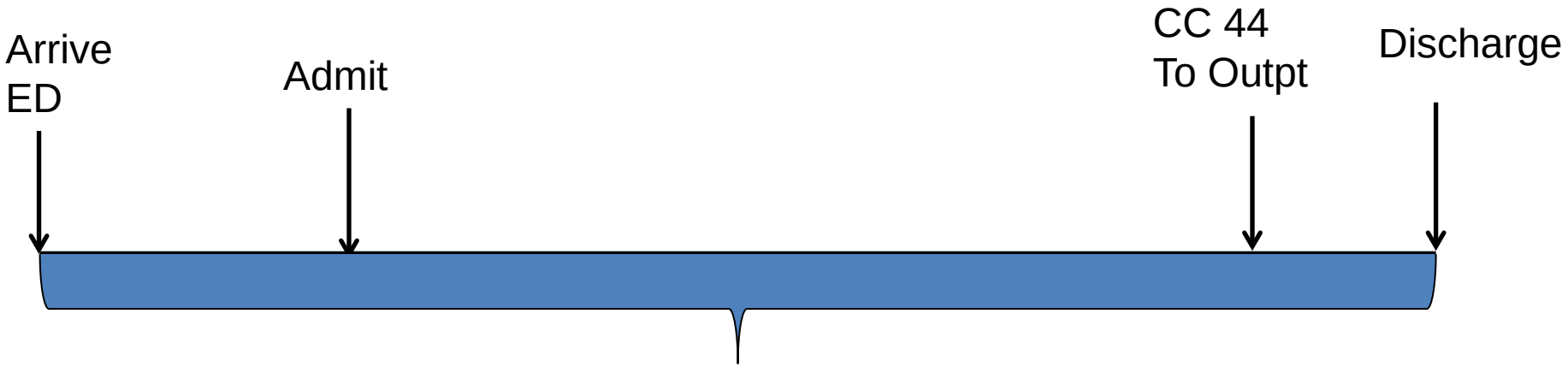
Condition Code 44 near discharge



Outpatient Part B payment 13x- ~$800
APC for ED visit $294-$456
Total= $1,100-$1,250

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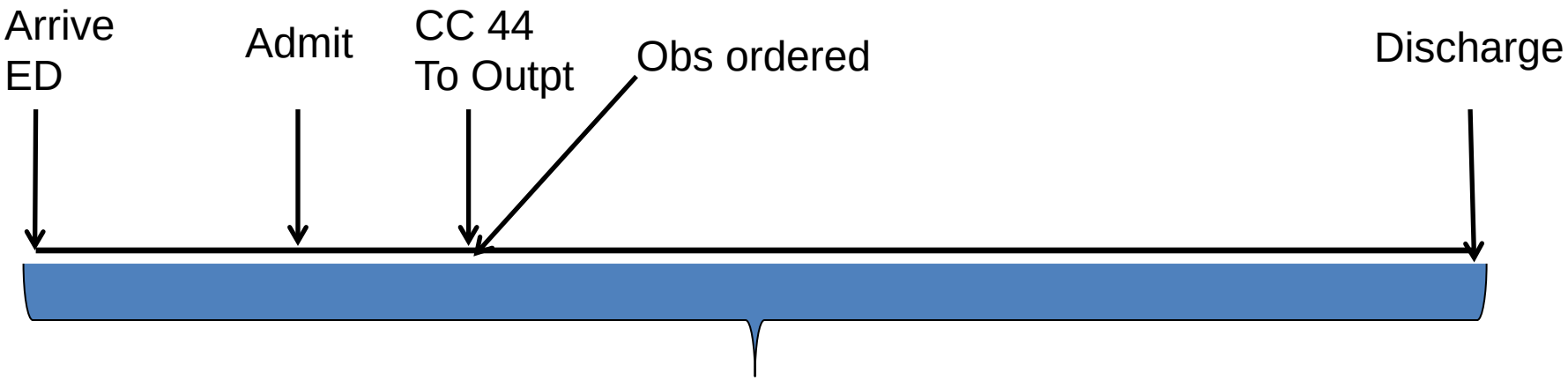
Condition Code 44 with > 8 hrs observation



Outpatient Part B payment 13x ~$800
APC for Observation (incl ED visit) $1,199
Total ~$2,000

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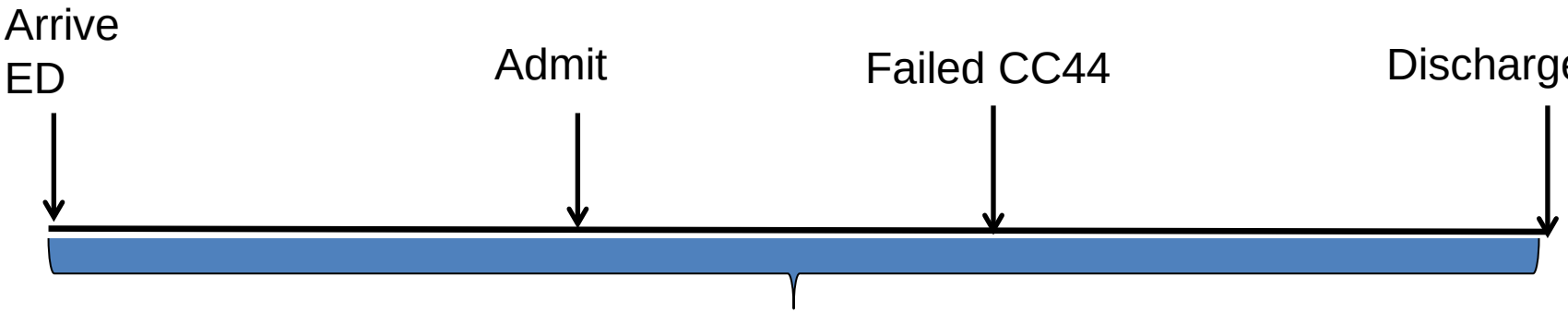
Attending does not concur- 3 claims



No pay inpatient 110 Claim

then

Outpatient Part B
13X ~$200, ED visit $294-$456

Inpatient Part B
12X ~$600

Total = $900-1,100

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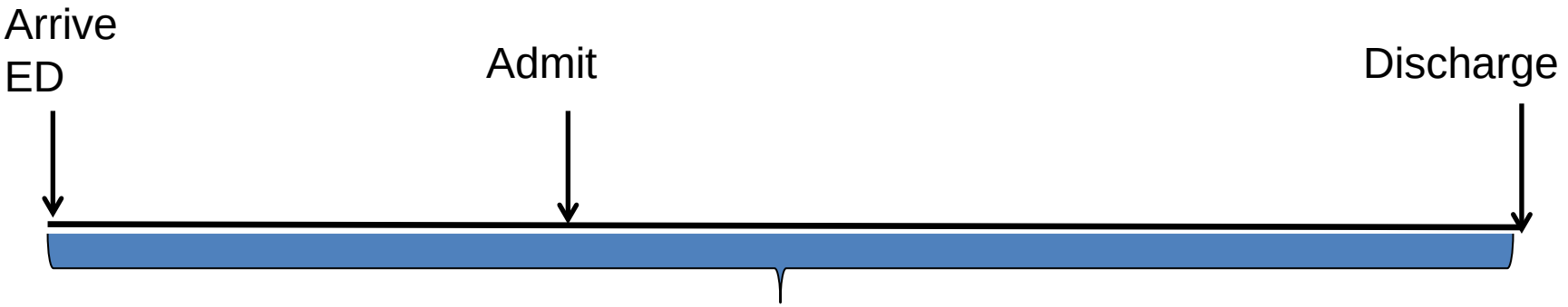
Rebilled Claim



UR Committee review with no pay inpatient 110 Claim or denied by auditor within a year of DOS

then

Outpatient Part B
13X ~$200, ED visit $294-$456

Inpatient Part B
12X ~$600
No bed or RN payment

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And just to confuse you…

If you review all short stays for rebill,

-inappropriately admitted as inpatient= eligible for full rebill, requires UR review

-appropriately admitted as inpatient but documentation poor= eligible for ancillary only rebill, does not require UR review

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