Agenda

- 2014/2015 IPPS Final Rule
- 2015 proposed OPPS
- The Doc Fix Bill – HR 4302
- Transmittal 534
- Rebilling
- Lawsuit Update
- Conditions of Participation
- Understand best practices for operating under 2015 IPPS

Final IPPS 2015

AKA CMS 1607-F (Published in Federal Register on August 22, 2014)

1. Calculation of payments. The rule includes a 2.9 percent market basket update, offset by a negative 0.5 percent productivity adjustment and a negative 0.2 percent market basket cut as mandated by the Patient Protection and Affordable Care Act, and a negative 0.8 percent decrease in accordance with the American Taxpayer Relief Act of 2012.

2. Hospital readmission reduction program. CMS has increased the maximum penalty from 2 percent to 3 percent.

3. Hospital-acquired condition reduction program. Hospitals in the lowest quartile will have their Medicare pay decreased by 1 percent.

4. Price transparency. Under the final rule, hospitals are required to make public a list of their standard charges or provide their policies for allowing the public to view a list of those charges in response to an inquiry.

5. Hospital value-based purchasing program. For 2015, CMS is increasing the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, to 1.5 percent of Medicare reimbursements, resulting in about $1.4 billion in value-based incentives.

6. Medicare disproportionate share hospitals payments. As part of the PPACA, Medicare DSH payments will be reduced 75 percent by 2019, or $49.9 billion. The final rule cuts overall Medicare DSH payments by 1.3 percent in fiscal year 2015, compared with fiscal year 2014.
Final IPPS 2015

Two Midnight rule remains intact

- Little to no changes
- Pages 50146 – 50148 pertain to the 2 midnight rule
- Several comments regarding defining short or low cost inpatient hospital stays
- No additional clinical exceptions added. However, still taking feedback: email to: SuggestedExceptions@cms.hhs.gov
- Although the FY 2015 IPPS/LTCCH PPS proposed rule did not include any proposed regulatory changes relating to the 2 midnight benchmark, we nonetheless received a number of public comments regarding the current regulation.
- CAH: finalize a policy that a CAH is required to complete all physician certification requirements no later than 1 day before the date on which the claim for the inpatient service is submitted (pg 50165).

2015 Proposed OPPS

CMS 1613-P
The 2015 Outpatient Prospective Payment System (OPPS) Proposed Rule was released on July 13, 2014
Comments found on www.regulations.gov

Highlights include:
- Refinements to Comprehensive APC Policy
- Significant Packaging of Ancillary Services
- Changes to Inpatient Certification Requirements

The Proposed Rule and Elements of Certification

Documentation is Key:
- There is an expectation that the elements of certification (i.e., the reason for hospitalization, the estimated time the patient will need to remain in the hospital, and the plan of post-hospital care), generally can be satisfied by elements routinely found in a patient’s medical record, such as progress notes (CMS-1613-P at 41057).
- “[I]n most cases, the admission order, medical record, and progress notes will contain sufficient information to support the medical necessity of an inpatient admission without a separate requirement of an additional, formal, physician certification” (CMS-1613-P at 41057).
- “[W]e believe that evidence of additional review and documentation by a treating physician beyond the admission order is necessary to substantiate the continued medical necessity of long or costly inpatient stays” (CMS-1613-P at 41057).
Proposed Changes to Physician Certification Requirements

- A separately signed Physician Certification statement would no longer be required to be submitted with each and every Inpatient Hospital claim.
  - Only required for long-stay (20 days or more) and outlier cases
- The Inpatient Admission Order will continue to be required as a condition of payment, but is no longer considered an element of certification.

REMINDER: the 2015 OPPS Proposed Rules if finalized as written, would not take effect, until the implementation date of January 1, 2015.

Until that time, providers should continue to adhere to current guidelines and regulations pertaining to the Two-Midnight Rule and Physician Certification Requirements.

HR 4302 – “Doc Fix Bill”

HR 4302 – Protecting access to Medicare Act of 2014
- March 26, 2014: Introduced
- March 27, 2014: Passed the House
- March 27, 2014: Received by Senate
- March 31, 2014: Passed Congress/Enroll Bill
- April 1, 2014: Signed by the President

- Sec. 101: One year Sustainable Growth Rate payment formula fix
- Sec. 212: Delay in ICD-10 transition
  The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)) and section 162.1012 of title 45, Code of Federal Regulations.
HR 4302 – “Doc Fix Bill”

- Sec. 111: Extension of 2-midnight rule
  - Continuation of certain medical review activities
    - The Secretary of Health and Human Services may continue medical review activities described in the notice entitled Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013, posted on the Internet website of the Centers for Medicare & Medicaid Services, through the first 6 months of fiscal year 2015 for such additional hospital claims as the Secretary determines appropriate.
  - Limitation
    - Secretary of Health and Human Services shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contractors, under section ... for inpatient claims with dates of admission October 1, 2013, through March 31, 2015, unless there is evidence of systemic gaming, fraud, abuse, or delays in the provision of care by a provider of services ...
Probe & Educate Status Update

As of February 7, 2014:

<table>
<thead>
<tr>
<th># of medical records requested</th>
<th># of medical records received</th>
<th># of medical records with MAC reviews completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>29,158</td>
<td>18,110</td>
<td>6,012</td>
</tr>
</tbody>
</table>

As of February 24, 2014:
- CMS is requesting that the Medicare Administrative Contractors (MACs) re-review all claim denials under the Probe & Educate process to ensure the claim decision and subsequent education is consistent with the most recent clarifications.

Number of denials: ??????
Published data – NGS 30–75% denied

Examples

- Example 1 - Missing or flawed order for inpatient admission
- Example 2 - Short stay procedures: A beneficiary presented for a procedure in which treatment and discharge typically occur in less than 2 midnights. The procedure is not on the inpatient-only list. The physician wrote an order to admit to inpatient upon arrival at the hospital for pre-operative care. The medical record did not support the expectation of a 2-midnight stay for hospital care. The beneficiary underwent the procedure without any complications either during or after the procedure and was discharged within 16 hours after arrival to the hospital. The hospital submitted a claim for a 0-day inpatient stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a 2-midnight stay.

Examples

- Example 3 - Short stays for medical conditions: The beneficiary presented to the ED with recent onset of dizziness and denied any additional complaints. The beneficiary reported a recent adjustment to his blood pressure medication. The physician’s notes stated that the beneficiary was stable and that his blood pressure medication was to be held and dosage adjusted. The notes also indicated that the physician intended to observe the beneficiary overnight. The beneficiary was discharged the next day. The hospital submitted a claim for a 1-day inpatient stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a 2-midnight stay.
Examples

• Example 4 - Physician attestation statements without supporting medical record documentation. The physician’s order contained a checkbox with pre-printed text stating “The beneficiary is expected to require 2 or more midnights of hospital care.” The physician’s plan of care, however, stated that the beneficiary was to have diagnostics performed post-operatively, with a plan to discharge in the morning if stable. The beneficiary was discharged the following day as planned, after a 1-midnight stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a 2-midnight stay when the order was written.

• CMS reminds providers that attestation statements indicating the beneficiary’s hospital stay is “expected to span 2 or more midnights” are not required under the inpatient admissions policy, nor are they adequate by themselves to support the expectation of a 2-midnight stay. Rather, the expectation must be supported by the entirety of the medical record.

CMS Transmittal 534

• Effective: 09-08-14

• The Auditors have the discretion to deny other “related” claims submitted before or after the claim in question

• 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, post-payment recoupment will occur for the performing physician’s Part B service.

• The MAC, Recovery Auditor, and ZPIC are not required to request additional documentation for the “related” claims before issuing a denial for the “related” claims.

• Contactors shall process appeals of the “related” claim(s) separately.

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
  – Submit 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
Does Rebilling Make Cents?

- Where are you most likely to miss revenue in the UR process?
  - Without **concurrent** reviews, hospitals risk losing dollars on observation/outpatient cases!
- Consider:
  - INPT DRG
    - > CC44 with 8 hours obs (APC)
    - > CC 44 with less than 8 hours of obs (No APC)
      - > Post discharge rebill 12x
      - > Claimed denied after 1 year

Rebilling Demonstration Project

- On July 7 2014, OMHA introduced the Statistical Sampling Initiative
- Statistical Sampling Initiative draws a random sample from a universe of claims selected by the hospital (appellant) and extrapolates/projects the results of the sample on the entire universe of claims submitted
- An OMHA statistician will randomly select sample units for the ALJ to review and make a decision
- The decisions from the sample units are used to settle the larger universe of cases
Questions for Consideration

• Will clients be able to rebill claims from the sample unit that were denied? What about claims from the universe? How will effectuation work, and will the potential to rebill (if any) be factored into the amount of the extrapolated overpayment?
• If RAC cases are included in the sample/universe, will the RAC contingency fees be paid/reclaimed based on the extrapolated error rate?
• How is the error rate within the sample determined for purposes of extrapolation – based on the ratio of the number of denied claims to the total number of claims in the sample, based on the dollar value of the denied claims, or some other method?
• Will providers be entitled to interest on any previously recouped funds for any claim denials in the sample unit that are overturned? Will providers also be entitled to interest on previously recouped funds when the sample results are extrapolated to the universe?

Lawsuit Update

American Hospital Association (AHA) Files Multiple Lawsuits to Address Shortcomings of CMS 1599

The American Hospital Association, four delivery systems and four state hospital associations have filed three federal lawsuits against the Department of Health and Human Services in the United States District Court for the District of Columbia.

• The first lawsuit alleges concerns with the 2-midnight rule:
  – The two-midnight rule deprives “and will deprive” hospitals of Medicare reimbursement for the reasonable and medically necessary care they provide to patients;
  – It unwisely permits the government to supplant treating physicians’ judgment;
  – The lawsuit seeks to prevent CMS from applying an arbitrary one-year time limit on the ability for hospitals to obtain Part B payment when a CMS or one of its Contractors denies Part A payment;
  – The lawsuit alleges that CMS’s new regulations that require a written physician order as a condition of Medicare payment for every inpatient stay to be contrary to the Medicare statute.

• The AHA’s second lawsuit challenges the 0.2 percent across the board payment reductions for beneficiary discharges occurring on or after October 1, 2013 and alleges:
  – CMS claimed, “without setting forth its actuary’s reasoning or calculations,” that the two-midnight rule and related policy changes would result in an increase in the number of inpatient hospital admissions Medicare would cover under Part A;
  – That CMS calculated that the increase would cost the Medicare program $220 million in fiscal year 2014;
  – That CMS’s cost estimate was flawed, unexplained, and precluded meaningful participation in the notice-and-comment process that the Administrative Procedure Act (“APA”) requires.

• The AHA’s third lawsuit alleges that excessive inappropriate denials by Recovery Audit Contractors (RACs) are the direct cause of the current backlog at the ALJ level of appeal.
  – The lawsuit seeks to have the Court issue a declaratory judgment that HHS’s delay in adjudication on Medicare appeals violates federal law and seeks that the court direct HHS to handle appeals timely in accordance with the 90 day mandate
The Center for Medicare Advocacy, a Beneficiary Assistance Organization, Files Multiple Lawsuits to Address Shortcomings of CMS 1599

The Center for Medicare Advocacy (CMA) has filed a couple of lawsuits over the past year, on behalf of beneficiaries, addressing their concerns with CMS 1599 specifically as it relates to Medicare beneficiaries.

- The first case, Bagnall v. Sebelius, addresses whether the Secretary's policy of allowing hospitalized Medicare beneficiaries to be placed in "observation status," rather than formally admitting them, deprives them of their Part A coverage in violation of the Medicare statute, the Administrative Procedure Act, the Freedom of Information Act, and the Due Process Clause.
  - Bagnall is asking the court for declaratory and injunctive relief to end and correct the deprivation of Part A coverage for beneficiaries placed on observation status, and to provide notice and appeal rights for those placed on observation status.
  - Bagnall is currently in an appeal status and the issues have been briefed regarding the beneficiaries' right to receive effective notice and a review procedure for beneficiaries placed on observation status.

- CMA's filing on June 4, 2014, Hull v. Sebelius, asks the court to decide whether the Secretary of Health & Human Services' denial rate of about 98% at the lowest two levels of appeal in Medicare's system of administrative review (redetermination and reconsideration) violates the Medicare statute and the Due Process Clause.
  - Hull is asking the court for declaratory and injunctive relief for a Connecticut class of Medicare beneficiaries who have received or will receive adverse redetermination and reconsideration decisions on their claims for coverage of home health care services.

Conditions of Participations Have Not Changed

Conditions of Participations (CoPs) must be followed

- "We did not propose and are not finalizing a policy that would allow hospitals to bill Part B following an inpatient reasonable and necessary self-audit determination that does not conform to the requirements for utilization review under the CoPs."
  - Page 50913, 2014 IPPS

- 482.30 (c)(1) The UR plan must provide for review of Medicare and Medicaid patients with respect to the medical necessity of:
  - Admissions to the institution
  - Duration of stays
  - Professional services furnished, including drugs and biologicals
Conditions of Participation

“I’m still trying to sort out how the conditions of participation as it related to requiring some kind of review of appropriateness of admission ties into this. Are we still thinking that we need to have our case managers or utilization review specialist look at Medicare admissions and apply some type or criteria around medical necessity? Is that still even required at all?

This is Dan Duvall. We actually have not made any changes, there have been no changes in the conditions of participation on the hospital utilization review programs, therefore, don't have any changes in what applies to them.”

Best Practices to Comply with Current IPPS

Valid Admission: What Changed?

**OLD “Rules”**
- Expectation of 24-hour stay
- Physician order a best practice

**NEW “Rules”**
- Expectation of 2-midnight stay
- Physician order required

Medical Necessity Certification
Concurrent UM Still Matters

- "Use of Condition Code 44 or Part B inpatient billing pursuant to hospital self-audit is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols."

Components Required for an IP Claim

1. Expectation/completion of a 2-midnight stay
   - UR review must ensure expectation of 2 midnights is "reasonable"
2. Medical Necessity
   - UR review must establish hospital level of care is needed to care for the patient
3. Physician certification/documentation signed by the physician prior to DC
   - Order, reason for inpatient services, expectation and plan for post-hospital care

What is Medical Necessity?

- Is the physician's expectation of 2 midnights reasonable?
  - Achieved with criteria? PA evidence based determination? Other?
- Is hospital level of care needed to care for the patient?
  - Ensure no care for convenience, no delays in treatment/testing or custodial care
Admission Review – Key Considerations

Initial review for expectation of Length of Stay (LOS)

- 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
    - 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 one midnight)

Recommended Hospital Work Flow

Follow this process when:

- Physician documentation of expected discharge is greater than 2 midnights; or
- There is no documentation of expected discharge

Expected LOS greater than 2 midnights or unclear

Follow this process when:

- Physician documentation of expected discharge is less than 2 midnights

Expected LOS less than 2 midnights

Follow this process when:

- Physician documentation of expected discharge is less than 2 midnights
Considerations Regarding the Time of UR Review

• Review at admission:
  – IP
    • 2+ midnight expectation AND medical necessity established AND physician certification complete
  – Observation/Outpatient
    • Expectation of <2 midnight stay and medical necessity established
  – NOTA
    • Review for documentation of care for convenience, a delay in treatment/testing or custodial care

• Review after 1+ midnight:
  – IP
    • 2+ midnights completed or expected AND medical necessity established AND physician certification complete
  – Observation status should be rare after 2 midnights
  – NOTA
    • Review for documentation of care for convenience, a delay in treatment/testing or custodial care

Summary

• “Get it Right” while the patient is in the hospital and as early in the stay as possible
  – Implications for hospital, patient and physician
• Admission review – key considerations:
  – Order
  – Expectation
  – Medical Necessity
  – Documentation and Certification
• Rebill when appropriate
• While the time requirement has evolved, the science at the core of medical necessity remains the same

Thank you. Questions?

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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.

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 DRG Coding and Medical Necessity Denials and Appeals Management; Managed Care/Commercial Payer Admission Review and Denials Management; and Expert Advisory Services.

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.

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