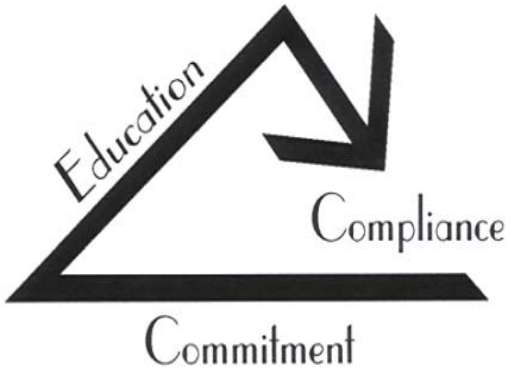
AR Systems, Inc
Training Library Presents

Current Audits and
Updates Impacting UR and PAs

Instructor:

Day Egusquiza, Pres
AR Systems, Inc



First and Foremost…

- The 2 MN rule is alive and well! In effect since Oct 2013. No 'grace period' for compliance. MACs are continuing to audit.
- HR 4302 "Protecting Access to Medicare Act of 2014" signed into law, effective 4-1-14.
- (b) Limitations- the Sec of HHS shall not conduct patient status reviews (as described in such notice) on a post-payment review basis through recovery audit contactors/RAC under section 1893 (h) of the Social Security Act for inpt claims with dates of admission Oct 1, 2013 – March 31, 2015, unless there is evidence of gaming, fraud, abuse of delays in the provision of care by a provider of services.
- Probe & ED / MAC audits thru March 2015. (RAC cannot audit until after 3-2015)

Maybe ‘enough is enough’

- AHA sued CMS on April 14th along with 4 hospital associations and 4 hospitals. Some key elements: "The hospitals take issue with the wholly arbitrary requirement that a physician must certify at the time of admission that a Medicare pt is expected to need care in the hospital for a period spanning two midnights to be considered an inpt.' and "The lawsuit also contents that the 0.2 percent cut in payment for 2014 the agency implemented to offset the increased costs to Medicare program the agency says are likely to result from the 2 MN rule is arbitrary and should be revoked. (2 lawsuits)

Reports & chatter in DC

- OIG reports to House Committee on Ways and Means. 3 areas of focus: a) 2 MN must be carefully evaluated, b) CMS should enhance oversight with the RAC program and c) Fundamental changes are needed in the Medicare appeals system.

http://oig.hhs.gov/testimony/docs/2014/nudelman_testimony_05202014.pdf

- Change obs and inpt = 1 flat rate for short stay hospitalization, regardless of obs or inpt historical status. Reduced for less than 2 MN= SSP.
- If change to DRG payment methodology, how will the critical access hospitals (1334ish) be paid as they are not paid by DRG but a per diem rate on weekly remittances?
- AHA's comment: 6-26-14, CAH/96 hr, SSP rate, obs fix & 2 MN rule (Short stay = less than 2 MN=transfer $, 2 MN = full $) Watch for Aug(ish)

If I was a skeptic –

- 2015 IPPS discussion: Reducing payment to a flat fee for 'short stays' = how much?
- Will it eliminate audits for 'being in a bed at all?"
- "If , based on the physician's evaluation of complex medical factors and applicable risk, the beneficiary may be safely and appropriately discharged, then the beneficiary should be discharged and hospital payment is not appropriate on either an inpt or outpt basis." CMS's FAQ 2 MN Inpt Admission Guidance & Pt Status Review for Admissions on or after Oct 1, 2013.

Proposed change to Certification

(included in OPPS 2015 7-14, Pgs 574-78, CMS-1613-P)

- "In CY 2014, IPPS Final Rule, CMS adopted revised certification requirements for all inpt admissions. Because all elements of the new certification had to be signed by the physician prior to discharge, this requirement has created a great deal of difficulty for hospitals and arguably required the most changes to computerized documentation systems of all changes in 2014. The proposal would modify the regulation on certification to ONLY require the certification for OUTLIER cases and long stays, defined as 20 days or longer. CMS is careful to note that the order requirements from the Final Rule are not proposed to change and an order complying with the new order requirements is still necessary to demonstrate the patient is considered an input during the stay." (Thanks, HcPro)
- We still need:
  - An order to admit to "inpt" (beginning of the pt story)
  - A reason for admit/WHY the pt needs 2 MN in a 'hospital' (middle)
  - A discharge note/plan (ending/wrap up)
  - The full medical record must support the REASON/plan demonstrated
  - Signed prior to discharge
  - Just no longer a statement: "I Certify."

Hot updates – March 2014

- Effective 3-6, Medicare contractors may automatically deny claims that are 'related' to other claims that have been denied as a results of a pre or post payment review.
- Contractors need not issue ADRS for the 'related' claims prior to issuing the denial.
- MAC, RAC, ZPIC have the discretion to deny – 'related' if documentation associated with one claim can be used to validate another.

RESCINDED Transmittal 505, effective March 17, 2014

- An inpt claim denied – the physician claim can be determined not to be reasonable and necessary.
- A dx test denied – the professional component denied.
- The change could impact coverage of payment for numerous services and products including, for instance episodic care, (eg SNF, home health and hospice) and rented DME.

Update Sub regulatory Guidance/FAQ 3-12-14

AHA ALERT 6-27-14

- CMS has agreed to postpone awarding the new round of Recovery Auditor Contractor contracts until at least Aug 15th because of pending litigation, according to court documents.
- CGI, one of the current RACs, has sued CMS in federal court to protest terms of CMS's proposed RAC contracts.
- CMS came to an agreement with the court to delay the awarding of new contracts while the court moves forward with proceedings in the case.
- AHA will continue to update members as more information regarding the new round of contracts is available.

More hot updates 3-14

www.cms.gov/research-statistics-data-and-systems/Monitoring-programs/Medicare-FFS-Compliance-programs/recovery-audit-program/recent_updates.html)

- PRG Schultz – out as a RAC subcontractor. Not enough money!! YEAHOO
- CMS announces RAC 'pause" (2-19-14)
- Feb 21- last day may issue an ADR
- Feb 28th – last day MAC may issue a prepayment ADR for the RAC demo project
- June 1st – the last day a RAC may send denied claims to the MAC to recoup payment.
- <u>5 changes to the RAC program announced:</u>
  - No longer discuss or appeal/30 days wait to allow time to discuss
  - RAC confirm receipt of discussion
  - RAC not paid until 2nd level appeal is upheld.
  - CMS will revise ADR limits that will take into account different claim types
  - CMS will require adjust ADR limits in accordance with the hospital's denial rate.

And more updates

- "Medicare calls for review of two midnight denials" Modern Healthcare, 2-26-14
- CMS told contractors to re-review all Medicare inpt denial payments since Oct 1, 2013.
- One of the reasons to extend the Probe and Ed: get the initial MAC audits consistent with the regs.
- CMS said its contractors had requested 29,000 MR as of Feb 7, and 6,000 of those were complete. No news on % denied.

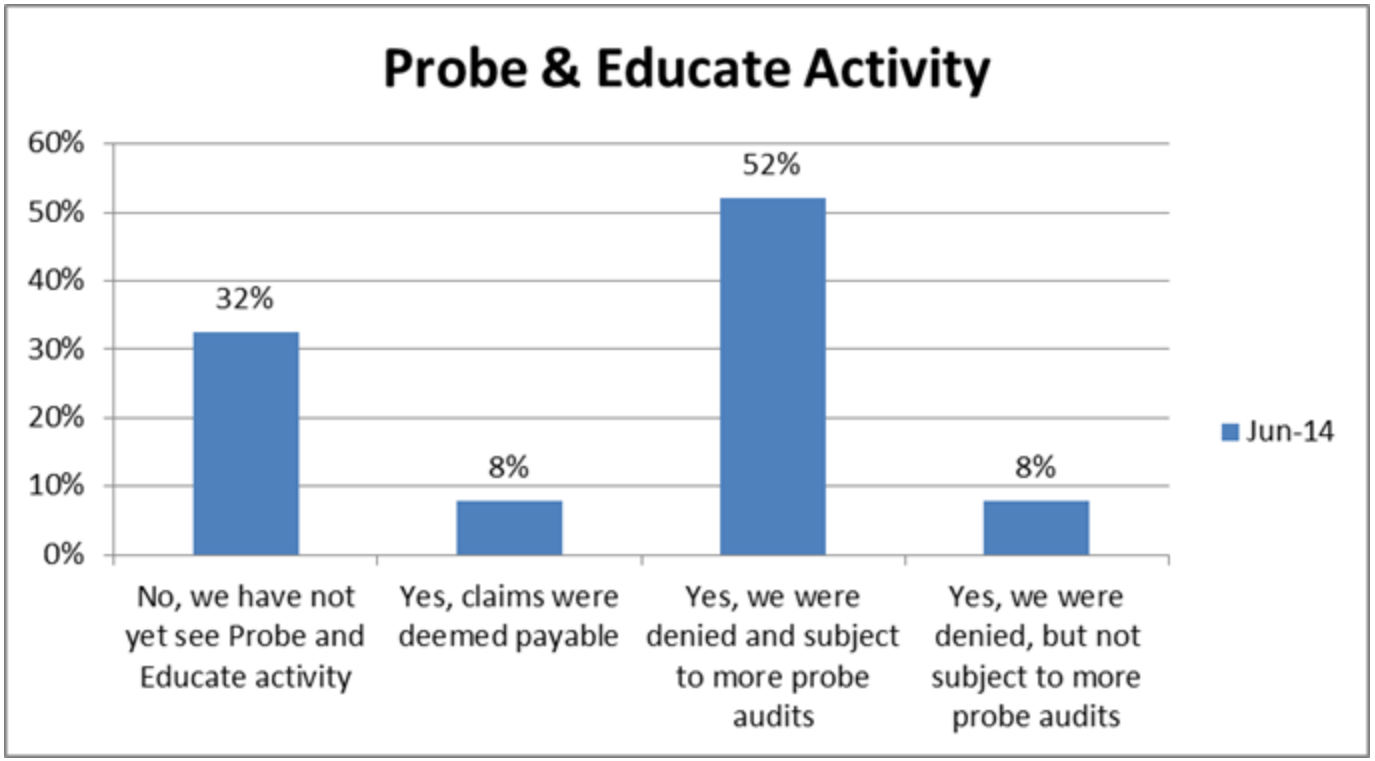
- Transfer update: During MedLearn call (2-26-14) CMS updated: receiving hospital CAN count time at a sending hospital toward their own 2 MN benchmark.
- Sending hospital – if there is knowledge that the pt is being transferred/next day, the pt is obs as only 1 MN is appropriate in the sending hospital.

More audit guidance – RAC

- "CMS will not permit RAC to conduct pt status reviews on inpt claims with dates of admission between Oct 1, 2013-March 31, 2015. These reviews will be disallowed PERMANENTLY, that is, the RAC will never be allowed to conduct pt status reviews for claims with DOS during that time period. "
- But they can audit all other areas – just not 2 MN.

- "In addition, CMS will not permit RAC to review inpt admissions of LESS than 2 MNs after formal inpt admission that occur between Oct 1-March 31, 2014. (now 3-15)"
- *www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medical-review/inpatienthospitalreviews.html*

Feedback from attendees at Compliance 360 Webinar (6-14)



Feedback on P&E

- Per Monitor Monday/7-14, listeners were asked with their replies.

Q: If you attended a MAC educational series either a 2 MN rule webcast or your hospital's probe and educate 1:1 session, what was your impression of the MAC's understanding of the rule?

A: 4% They did a great job explaining the rule and helping us comply.

13% They butchered the rule and we walked out more confused and frustrated than when we walked in

38% Their information was basic and provided us no new insight.

45% I have not attended a session yet.

Remember- site must request 'ed' call with MAC

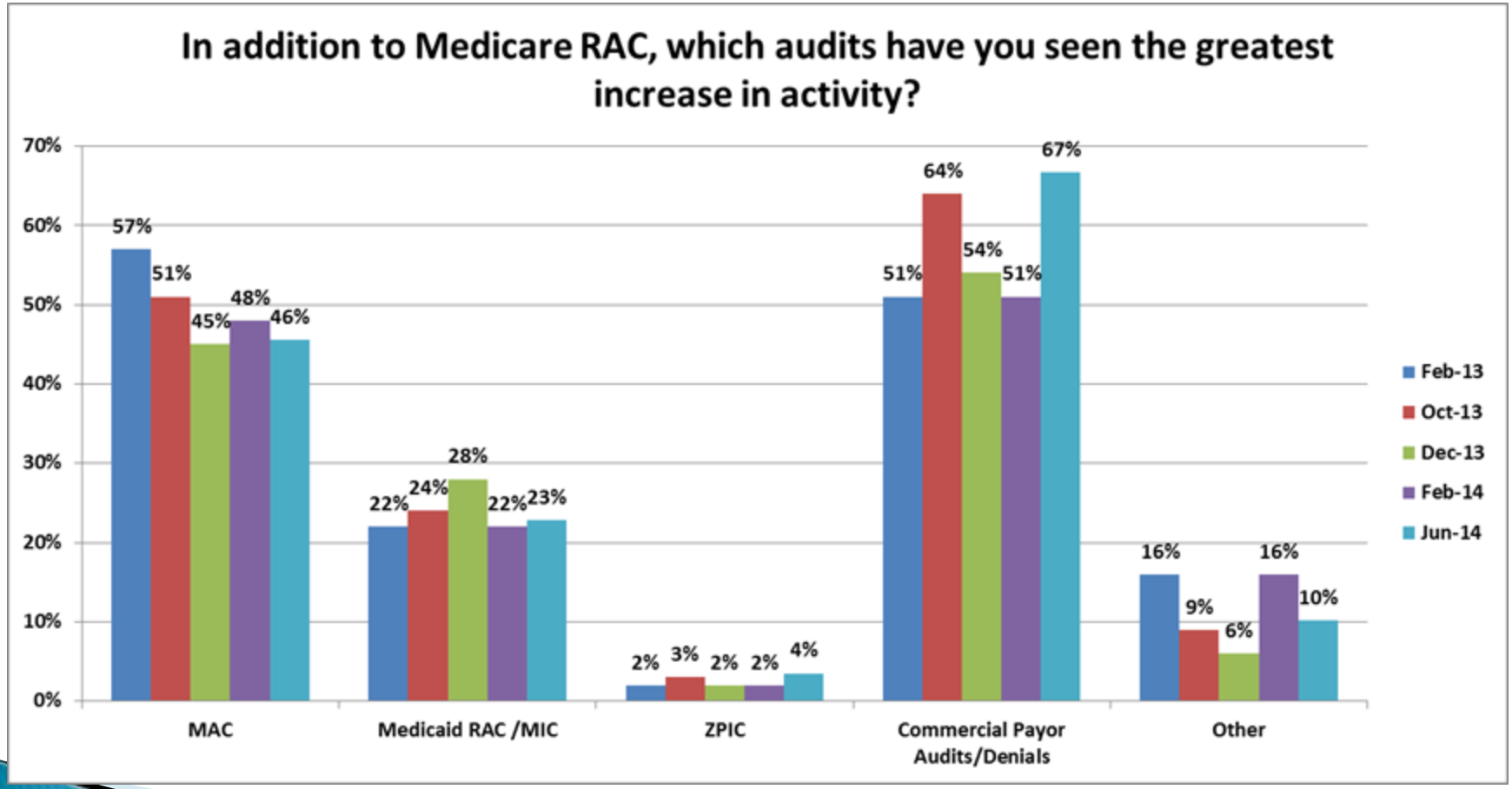
Summary of MAC training call/Palmetto 6-14

- Discussed learning curve for the MACs to audit
- Problem with identifying inpt only procedures.
- Re-Reviewed 3 claims and overturned during the call.
- Have 45 days to expect Round 2 (25 records requested)
- Next steps learned for the site:
  - Internal reviewers get checklist
  - Use of “rare and unusual’ circumstances with certification statement as to why , what happened, etc.
  - Orders should reflect the severity and intensity – what is the MD going to do about X, Y, Z.

Key weaknesses in P&E

- REASON FOR ADMIT /PLAN FOR CARE – why does the pt need an estimated 2 MN stay?
  If outlined as the plan, the treatment should address the same.
- IF THE PT IS DISCHARGED/TRANSFERRED/OTHER SHORT STAY when the provider estimated a 2 MN, be sure it is clear in the discharge note – all signed prior to discharge.
- Check off boxes with regulatory language that is done with each inpt does not support inpt.

Results from Feb 14 Compliance 360 Free Webinar – Attacking the 2 MN rule – All payers are auditing



More regulatory updates..

- CMS's Frequently Asked Questions/Nov 2014
- www.cms.gov/research-statistics-data-and-systems/monmitoring-programs/medical-review/downloads/reviewinghospitalsclaimsforadmissionFINAL.asp
- CMS's Instructions for Probe and Educate

  Each MAC is doing their own education on how it will roll out. CMS will do an update in Jan/posted Nov. One good example: Noridian www.noridianmedicare.com/cgi-bin/coranto/viewnews.cgi?id=EflykyEAyyOGlomhgg&tmpl=part_a_viewsnews&style (how receive request/30 days to reply)

Key elements of new inpt regulations – 2 methods

- <u>2midnight presumption</u>
- "Under the 2 midnight presumption, inpt hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care.

Pg 50959

- <u>Benchmark of 2 midnights</u>
- "the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpt service. In other words, if the physician makes the decision to admit after the pt arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the pt's total expected LOS.

Pg 50956

Understanding 2 MN Benchmark – 72 Occurrence Span MM8586 1-24-14

- EX) Pt is an outpt and is receiving observation services at 10pm on 12-1-13 and is still receiving obs services at 1 min past midnight on 12-2-13 and continues as an outpt until admission. Pt is admitted as an inpt on 12-2-13 at 3 am under the expectation the pt will require medically necessary hospital services for an additional midnight. Pt is discharged on 12-3 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.
- Ex) Pt is an outpt surgical encounter at 6 pm on 12-21-13 is still in the outpt encounter at 1 min past midnight on 12-22-13 and continues as a outpt until admission. Pt is admitted as an inpt on 12-22 at 1am under the expectation that the pt will required medically necessary hospital services for an additional midnight. Pt is discharged on 12-23-13 at 8am. Total time in the hospital meets the 2 MN benchmark..regardless of Interqual or Milliman criteria.

Effective 12-1-13:
new use of occurrence span code 72

- National UB committee – Occurrence code 72 First /last visit dates
- *The from/through dates of outpt services. For use on outpt bills where the entire billing record is not represented by the actual from/through services dates of Form Locator 06 (statement covers period) ……. AND*
- *On inpt bills to denote contiguous outpt hospital services that preceded the inpatient admission. (See NUBC minutes 11-20-13)*
- *Per George Argus, AHA, a redefining of the existing code will allow it to be used Dec 1, 2013. CMS info should be forthcoming.*
- *MM8586 ML Matters, Jan 24, 2014 CR 8586*
- *UPDATE: UG Some MACs are stating 'ignoring' the code!!!*

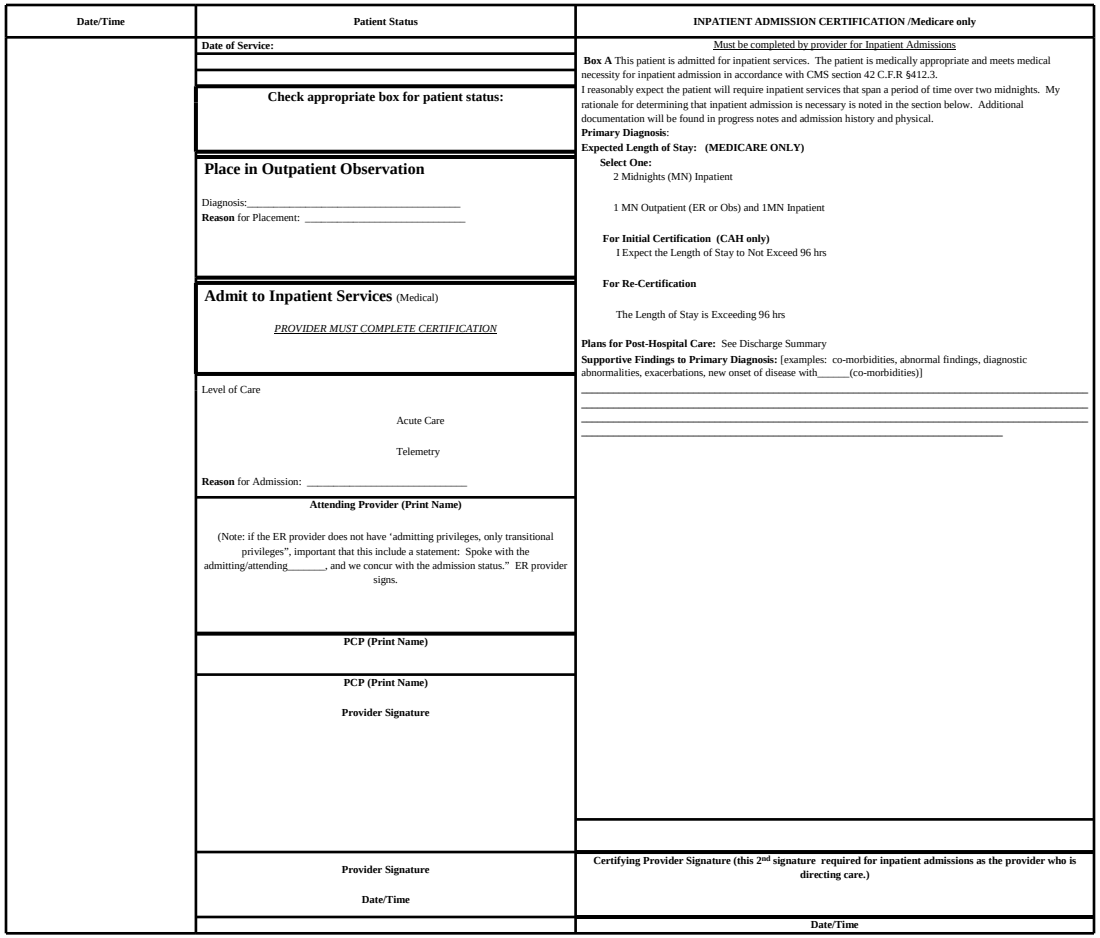
Complex Denials/Setting By Dollar 64% of denials =wrong setting

% of Complex Denials for Lack of Medical Necessity for Admission – thru 3rd Q 2013/4th Q 2011- by $$ Impacted	
Syncope and collapse (MS-DRG 312)	15/14/18/14/17/ 25/21%
Percutaneous Cardiovascular Procedure (PCI) w drug-eluting stent w/o MCC (MS-DRG 247)	19/17%/19/21/23 /24/14%
T.I.A. (MS-DRG 69)	4/0/0/0/0/6/8%
Chest pain (MS-DRG 313)	10/10/10/13/10/9 /8%
Esophagitis, gastroent & misc digest disorders w/o MSS (392)	11/13/16/13/10/3 /0%
Back & Neck Proc exc spinal fusion w/o CC/MCC (DRG 491)	0/5/5/5/5%//

AHA RACTrac

"Meeting Criteria" – means?

- It never has and never will mean – "meeting clinical guidelines" (Interqual or Milliman)
- It has always meant – the physician's documentation to support inpt level of care in the admit order or admit note.
- SO –if UR says: Pt does not meet Criteria – this means: Doctor cannot certify/attest to a medically appropriate 2 midnight stay – right?
- 11/1/2013 Section 3, E. Note: "It is not necessary for a beneficiary to meet an inpatient "level of care" by screening tool, in order for Part A payment to be appropriate"
- Hint: 1st test: Can attest/certify estimated LOS of 2 midnights? THEN check clinical guidelines to help clarify any medical qualifiers… but the physician's order with ROA – trumps criteria.



Date/Time	Patient Status	INPATIENT ADMISSION CERTIFICATION /Medicare only
	Date of Service: **Check appropriate box for patient status:** **Place in Outpatient Observation** Diagnosis:_____ **Reason** for Placement: _____ **Admit to Inpatient Services** (Medical) *PROVIDER MUST COMPLETE CERTIFICATION* Level of Care Acute Care Telemetry **Reason** for Admission: _____ **Attending Provider (Print Name)** (Note: if the ER provider does not have 'admitting privileges, only transitional privileges", important that this include a statement: Spoke with the admitting/attending_____, and we concur with the admission status." ER provider signs. **PCP (Print Name)** **PCP (Print Name)** **Provider Signature** **Provider Signature** **Date/Time**	Must be completed by provider for Inpatient Admissions **Box A** This patient is admitted for inpatient services. The patient is medically appropriate and meets medical necessity for inpatient admission in accordance with CMS section 42 C.F.R §412.3. I reasonably expect the patient will require inpatient services that span a period of time over two midnights. My rationale for determining that inpatient admission is necessary is noted in the section below. Additional documentation will be found in progress notes and admission history and physical. **Primary Diagnosis**: **Expected Length of Stay: (MEDICARE ONLY)** **Select One:** 2 Midnights (MN) Inpatient 1 MN Outpatient (ER or Obs) and 1MN Inpatient **For Initial Certification (CAH only)** I Expect the Length of Stay to Not Exceed 96 hrs **For Re-Certification** The Length of Stay is Exceeding 96 hrs **Plans for Post-Hospital Care:** See Discharge Summary **Supportive Findings to Primary Diagnosis:** [examples: co-morbidities, abnormal findings, diagnostic abnormalities, exacerbations, new onset of disease with_____(co-morbidities)] _____ _____ _____ _____ **Certifying Provider Signature (this 2nd signature required for inpatient admissions as the provider who is directing care.)** **Date/Time**

.SAMPLE CERTIFICATION FORM

Use for both OBS and Inpt – clarification of order and intent

And remember – it is not just a 'form' but the beginning of the pt story.

Key elements: **Reason for admit/what is the plan** for the estimated 2 MN stay or 1 additional MN after 1 outpt MN.

A form is just a form…

- If it doesn't tell the reason for admit, why the dx will take an estimated 2 MN/presumption or a 2nd MN /benchmark.
- If it doesn't outline the plan for treatment with the treatment done and wrapped up in the discharge note.
- Medically necessary? If it isn't addressed thru the Reason for Admit/Plan, action attached to the RFA, then clinical guidelines won't 'bail' out the inpt.
- SO….It is all about the story told by the provider- beginning, middle, end with a beautiful wrap up.

Key areas to support documentation for pt status

- Admitting physician 'starts the pt story' thru use of the certification process – including REASON FOR ADMIT.
- Internal Physician Advisor– trainer/champion, works closely with UR and all providers to ensure understanding/compliance.
- Nursing continues with the care/assessments/interventions relative to the reason for admit.
- UR works with the treating/admitting physician to expand/clarify the documentation at the beginning and conclusion of the patient's stay. Additionally UR closely monitors completion of the certification for ALL payers.
- Integrated CDI continually interacts with providers/nursing to ensure all elements are clear /complete . 1 voice of ongoing education…

More on decision making-Inpt

- If the beneficiary has already passed the 1 midnight as an outpt, the physician should consider the 2nd midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. (MN must be documented and done)
- Note: presumption = 2 midnights AFTER obs. 1 midnight after 1 midnight OBS = at risk for inpt **audit**
- Pg 50946

- **..**the judgment of the physician and the physician' s order for inpt admission should be based on the expectation of care surpassing the 2 midnights with **BOTH** the expectation of time and the underlying need for medical care supported by complex medical factors **such as history and comorbidities, the severity of signs and symptoms , current medical needs and the risk of an adverse event.** Pg 50944

And the 'what if's"

- 412.3 (e) (2) (see p. 50965 of Final Rule) – "If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and hospital inpatient payment may be made under Medicare Part A." (Thx, Accretive)"
- HINT: D/C note: Recovered sooner than anticipated.

- Can 1 day stay inpts still occur?
- YES –but as the regs clearly state, anticipate an audit as it should be a highly uncommon occurrence.
- 1 MN as outpt or OBS and 1 MN as inpt = inpt
- Just because a patient dies, is transferred for tertiary care, or leaves AMA, (paraphrased from LCD L27548) it does not change the *presentation of* clinical factors/criteria that went into the physician's complex medical decision to admit to an inpatient status. (Thx, Appeals Masters)

With unusual cases… Rare and unusual = ordered as a 1 day stay

- Lots of discussion on : "*My patient is very sick, at risk but I don't think they will need 2 midnights. I checked with Interqual/UR and it meets their definition of an inpt. I am admitting and highly anticipate they will only need 1 midnight." (nope, not an inpt/obs and monitor closely)*
- CMS has stated: Rare and unusual. 2 outlined definitions at this time: inpt only surgeries and initiation of mechanical ventilator with 1 midnight. They are still working on how to address transfers out & hospice referral. NOTE: transferring in hospital must still meet their own 2 MN threshold. The transferring out hospital's LOS does not count. (RAC Summit/12-13)

More examples of coverage

CAH: must use the 2 MN presumption/benchmark PLUS certification to reasonably expect the pt to transfer or discharge within 96 hrs. If longer, re-do but should be unusual cases. (Watch HR 3991/slim chance to pass.)

Ex) What if the surgery was delayed because the surgeon was only at the hospital 1 day a week? Is there another hospital where the surgery could occur without the delay?

EX) Is the stay beyond 96 hrs within the scope of the CAH?

Long obs: Pt in in Obs for 2 midnights. 1st Q: did the pt have 48+ hrs of billable obs or just hrs in a bed?
2nd Q: Was the regulation for OBS met? (OBS is: Active physician involvement/ongoing assessment.)

If MET- then the pt was eligible to convert to INP after the first midnight with the physician 'attesting' of the need for medically appropriate care -2nd MN

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-09-05-13.pdf

96 hr CAH requirement/CMS Physician certification, Jan 31,2014

and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, 42 CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

d. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.

e. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Time as an outpatient at the CAH does not count towards the 96 hours requirement. The clock for the 96 hours only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour inpatient limit.

If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH and something unforeseen occurs that causes the individual to stay longer at the CAH, there would not be a problem with regards to the CAH designation as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay.

f. Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

2. **Timing:** Certification begins with the order for inpatient admission. The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. With regard to the time of discharge, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the physician as having to occur prior to discharge (e.g., "discharge after supper" or "discharge after voids"). So discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the physician's order for discharge is effectuated.

3. **Authorization to sign the certification:** The certification or recertification may be signed only by one of the following:

Tough Limitation –document

Delays in the Provision of Care.: FAQ 12-23-13 CMS

- Q3.1: *If a Part A claim is selected for Medical review and it is determined that the beneficiary remained in the hospital for 2 or more MN but was expected to be discharged before 2 MN absent a delay in a provision of care, such as when a certain test or procedure is not available on the weekend, will this claim be considered appropriate for payment under Medicare Part A as an inpt under the 2 MN benchmark?*

A3.1: Section 1862 a 1 A of the SS Act statutory limits Medicare payment to the provision of services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body. As such CMS ' longstanding instruction has been and continues to be that hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment. Accordingly, CMS expects Medicare review contractors will exclude excessive delays in the provision of medically necessary services from the 2 MN benchmark. Medicare review contractors will only count the time in which the beneficiary received medically necessary hospital services."

WINS with the 2 midnight rule– Don't be afraid of your inpt…

- Certification form – always. Consistently start and clarify the pt story.
- UR in the ER – always involved prior to placement.
- Hospitalist – always see the pt rapidly/less than 2 hrs from referral to inpt.
- Integrated CDI program – one ongoing audit, one voice for ed
- Dedicated beds for OBS. OBS hasn't changed at all. UR assigned to closely monitor every OBS that exceeds the first midnight.
- Grow an internal physician advisor—NOW! Ongoing education, UR support/intervention = effective change
- Actively involve nursing as the eyes of the pt story 24/7.
- Actively involve surgery scheduling to 'spot' any common outpt surgeries being scheduled as inpt.
- Beef up the UR committee
- Beef up the UR 's role, separate from case mgt. Front end…

AR Systems' Contact Info

Day Egusquiza, President
AR Systems, Inc
Box 2521
Twin Falls, Id 83303
208 423 9036
daylee1@mindspring.com

Thanks for joining us!
Free info line available.
NEW WEBPAGE: http://arsystemsdayegusquiza.com

JOIN US FOR THE NINTH RAC (AND MAC) SUMMIT
November 13-14, 2014 – Washington, DC