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Training Library Presents

Overview of the 2 MN Presumption & 2 MN Benchmark

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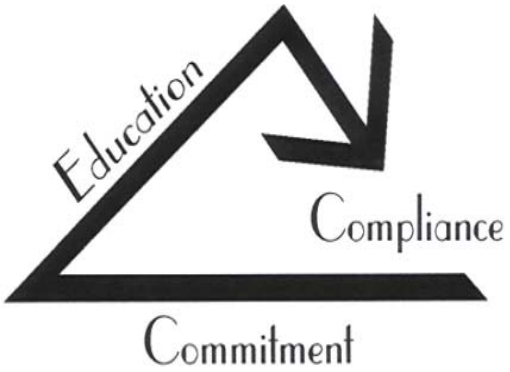

First and Foremost…

- 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.

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 $)

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.

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."

It never changed… Documentation to support the level of care…

- "No Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness of injury or to improve the functioning of a malformed body member."
  Title XVIII of the Social Security Act, Section 1862 (a) (1) (A)
- "Observation services must also be reasonable and necessary to be covered by Medicare." (Medicare claims processing manual, Chapter 4, 290.1) Obs did not change.
- "The factors that lead a physician to admit a particular patient based on the physician's clinical expectation are significant clinical considerations and must be clearly and completely documented in the medical record." (IPPS CMS 1559-F, p 50944)
- Only a physician can direct care …and…Patient Status….

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.

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- <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.

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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

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!!!*

"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.

Still struggling with Certification of 2 MN Presumption and old language.

- Case: ER doctor admits the pt on Sat am. Facility is not using a certification form/tool . The ER doc does not have admitting privileges, so bridge/transitional. Did not document conversation with the admitting or hospitalist.
- Mon am UR comes in.
- Determines the case does not meet clinical guidelines/Interqual.
- Asks Admitting to convert back to Obs.
- Pt was discharged home prior to having the UR provider agree.
- What is broken?

Still struggling with 2 MN Benchmark

- EX) Pt came to ER on Fri night/1900. ER provider, after discussing with the hospitalist, determines the pt is not safe to go home.
- They agree that the pt does not need 2 MN , at this time, and places in obs.
- No UR coverage in the ER or weekends.
- 1st MN/ER
- 2nd MN/Sat – does the pt need additional services/ care to resolve the condition?
- UR discusses with admitting provider and converts to INPT with the PLAN clearly outlined in the Reason for Admit for the 2 MN.
- NO dedicated Ambulatory Outpt Unit

Where do the patients come from? Two hot spots for referrals into "a bed"

- ER & Inpt surgery
- Attack these two places with a pro-pt status focus, not placing and chasing.
- Develop internal flows to attack:
  - ER - how much UR coverage ? 24/7? or utilize ER lead RNs or house supervisors. No pt is given a bed without pt status 'blessed.' Integrated CDI program will help with cross training.
  - Inpt surgery – all daily inpt surgery schedules are reviewed by UR to review outpt being scheduled as outpt.
  - Involve the internal UR leaders and PA for patterns.
  - Sr leadership will have to be prepared to push thru the regulation with any problematic providers.

Let's get started – Certification Process

It is the "why..because"

- Lots of 'chatter' but evaluate this process flow.
- 1st question: Can the pt go home safely from the ER? Assess the reasons the provider (ER doc consults with the provider directing care) and document same. (Risk factors, history of like condition with outcome, presenting factors, plan)
- 2nd question: Can the ER physician (after consulting with the admitting) attest/certify that the pt needs to 'be in the hospital' for an estimated 2 midnights to resolve the condition?
- 3rd question: If no, move to OBS and evaluate closely. If yes, move to inpt with other elements of the inpt certification.

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)"

- 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."

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…

HFMA's HFM article 2-14 issue-

"8 Critical Steps for 2 MN Compliance"

1) Embed questions from the optional certification form within the electronic orders or use the manual form.
2) Empower UR staff to assist with compliance
3) Know which procedures are riskiest, such as cath lab procedures and outpt surgeries that 'stay the night'.
4) Target physicians in the ED.
5) Hire internal physician advisors to assist with education.
6) Understand the implications for transfers
7) Use internal audits to identify problem areas
8) Learn from the probes and hammer the message home

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…

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