WPS Medicare
HEALTH INSURANCE
A CMS Medicare Contractor

LESSONS LEARNED FROM THE PROBE AND EDUCATE AUDIT

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AGENDA

- Basics and clarifications
- Probe and educate program
- Documentation
- Review Results
- Resources

BASICS

REVIEW AND NEW CLARIFICATIONS

GENERAL RULE

Surgical procedures, diagnostic tests and other treatments (in addition to services designated as inpatient-only), are generally appropriate for inpatient hospital admission and payment under Medicare Part A when (1) the physician expects the beneficiary to require a stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation

ADMISSION ORDER

- Completed by qualified physician/practitioner
- Furnished at or before the time of the inpatient admission
- Begins inpatient status and time for billing purposes
  - When combined with formal admission
- If missing or invalid
  - Intent may establish inpatient stay

    OR
  - Bill outpatient

AUTHORITY TO ADMIT

- Qualified physician or other practitioner
  - Licensed by the state to admit
  - Granted privileges by the hospital
  - Knowledgeable about the patient
- Includes non-physician practitioners
  - If allowed by their state

KNOWLEDGEABLE ABOUT THE PATIENT

- Admitting physician of record or attending
- Hospitalist
- Beneficiary's primary care practitioner
- Surgeon responsible for a major surgical procedure
- Emergency or clinic practitioner at beneficiary's point of inpatient admission
- Physician "on call" for one of the above
- Another provider actively treating patient at time of admission

IMPORTANT NOTE

Does **not** include utilization review committee physician unless actively treating patient at time of admission

BRIDGE ORDERS

CLARIFICATION

- Written by a practitioner that does not have admitting privileges
- Also called
  - Status orders
  - Placement orders
  - Holding order
- Not a valid admission order
  - Unless cosigned by a practitioner that meets requirements
    - Prior to discharge
- **If new order is written by admitting physician (instead of cosigning the bridge order) admission date/time corresponds with new order**

VERBAL/TELEPHONE ORDERS

- Written by a practitioner that does not have admitting or bridge order privileges
- Includes the identity the ordering physician or practitioner
- Authenticated by ordering physician or practitioner
  - Or another practitioner with admitting privileges
  - Prior to discharge or sooner if State requires

CONTENT OF CERTIFICATION

- Authentication of practitioner order
- Reason for inpatient services
- Estimated or actual length of stay
- Plans for post-hospital care (if applicable)
- CAH services only– 96 hour rule

(For Non- Psychiatric Inpatient Hospitals)

FORMAT OF CERTIFICATION

NO SPECIFIC WORDING OR FORMAT REQUIRED

- Providers may adopt any method that permits verification
- Generally met through good medical documentation in conjunction with a signed inpatient order for admission

TIMING

- Certification begins with the admission order
- Must be completed, signed, dated, and documented
  - Legibly
  - Prior to discharge
    - Meaning formal discharge from the hospital

DISCHARGE SUMMARY SIGNATURE

CLARIFICATION

- Are certification requirements met if the discharge summary is not signed prior to discharge?
- Yes, CMS would consider the requirement for a certification signature prior to discharge met if:
- Order for admission is properly authenticated
- All the elements of the certification are provided in the medical record

AUTHORITY TO CERTIFY

- Physician who is a doctor of medicine or osteopathy
- Dentist as specified at 42 CFR 424.13(d)
- Doctor of podiatric medicine (if authorized under state law)
- Must be responsible for the beneficiary or have sufficient knowledge of the case (and be authorized to certify)

KNOWLEDGEABLE ABOUT THE PATIENT

- Admitting physician of record ("attending") or a physician on call for him or her
- Surgeon responsible for a major surgical procedure beneficiary or a surgeon on call for him or her;
- Dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure;
- Member of hospital staff reviewed file (utilization review)
  - Non-physician/non-dentist admitting practitioner

2-MIDNIGHT BENCHMARK

STARTING THE CLOCK

2-MIDNIGHT BENCHMARK

- Clarification of prior 24 hour benchmark
- Intent is to provide consistent application of Part A benefits
  - Time, not clinical level of hospital services, used for benchmark

Important Note!

- Benchmark time is not the same as inpatient time
  - Outpatient services, though considered in the benchmark for medical necessity, remain outpatient time for billing purposes.

TIME INCLUDED IN BENCHMARK

- Included
  - Outpatient services
    - Observation
    - Emergency department
    - Operating room
- Excludes
  - Pre-hospital services (simple triage)
  - Ambulance
  - Delays in care

TRANSFERS
CLARIFICATION

- Initial hospital
  - Follow usual 2 midnight benchmark
    - Include only expected or actual time at initial facility
    - Do not include any anticipated length of stay after transfer
- Receiving hospital
  - Include all pre-transfer time and care provided in the initial hospital
  - **Beneficiaries who have already received two midnights of medically necessary hospital care in the initial hospital should be admitted by receiving hospital regardless of the expected length of stay in the receiving hospital**
    - **Request support documentation from initial provider**

EXCEPTIONS TO THE BENCHMARK
CLARIFICATION

- No expectation of 2 midnight stay required
  - Order and certification are required
- Inpatient-only procedures
- **Newly initiated mechanical ventilation**
  - Does not include routine intubation of outpatient surgical patients
  - **Limited to invasive mechanical ventilation only**
    - **Requiring an invasive artificial airway**
  - **Newly initiated BPAP or CPAP excluded**

SHORTER THAN EXPECTED STAYS

- 2 midnight expectation met
  - Order and certification completed
- Unforeseen circumstances
  - Death, transfer, against medical advice (AMA), unexpected recovery, canceled surgery
- Clearly document in medical record
- No penalty to provider

Do **not** convert
to an outpatient stay for billing purposes

PROBE AND EDUCATE

THE MEDICAL REVIEW PROCESS

PROGRAM OUTLINE

- Goals
  - Identify claims non-compliant with CMS-1599-F
  - **Issue denials for improper claims**
  - Educate providers about CMS-1599-F
- Facilities included
  - Acute care inpatient hospital facilities
  - Long Term Care Hospitals (LTCHs)
  - Inpatient Psychiatric Facilities (IPFs)

Critical Access Hospital (CAH) are subject to the rule, but excluded from the Probe and Educate audit

RECOVERY AUDITOR (RA) ROLE

- None
- Prohibited from conducting inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through March 31, 2015
- Recovery Auditors may continue to conduct CMS-approved claim reviews, unrelated to the appropriateness of the inpatient admission

PRESUMPTION

- Inpatient portion of the claim spans 2 midnights
  - Presumed to be medically necessary
- Not part of probe and educate
  - May edit for other hospital reviews

These claims are being monitored for systematic gaming or changes in provider billing practice

CLAIM SELECTION

- Dates of admission from October 1, 2013 – March 31, 2015
- Claims with inpatient dates that span 0-1 midnights
- 10 claim sample
  - 25 claim sample (large facilities as designated by CMS)
- Additional claim requests
  - Replace claims excluded during review process

ROUND 1 REVIEWS

- Prepay
- Reason code 58500
  - For WPS Medicare providers
- Ended in April 2014
- All final letters from WPS Medicare mailed as of May 28, 2014
  - To contact listed in PECOS

PROVIDER EDUCATION

- Optional – at provider's request
- Submit request via email to address on letter received
  - Two week timeframe to request education
- Nurse Analyst will contact to arrange provider specific educational teleconference

ROUND 2 REVIEWS

- Prepay
- Reason code 5CR85
  - For WPS Medicare providers
- Begins the later of:
  - 45 days from dated of final letter
  - 45 days after provider education teleconference
- Includes providers with
  - Moderate or high levels of concern

    OR
  - Providers with incomplete samples during round 1

REVIEW CRITERIA

- Last update 3/12/14
- MACs will assess compliance with
  - Admission order
  - Certification
  - 2 midnight benchmark

  - http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/ReviewingHospitalClaimsforAdmissionforPosting03122014.pdf

DOCUMENTATION

SUPPORTING MEDICAL NECESSITY – EASY AS 1-2-3

PROVIDE APPROPRIATE CARE

- Physicians and hospitals should continue to provide whatever care the beneficiary requires
  - Payment policy does not dictate clinical course
- Care resources
  - Evidenced based guidelines
  - Clinical pathways
  - National Coverage Determinations (NCDs)
  - Local Coverage Determinations (LCDs)
  - Professional organizations

Step 1

UNDERSTAND PAYMENT POLICY

- Part A
  - Appropriate hospital care expected to (or actually does) span 2 midnights
    - Write order and certification
- Part B
  - Appropriate hospital care not expected to span two midnights
  - Unsure if appropriate hospital care will span two midnights
  - Beneficiary has no Part A benefits available

Step 2

DOCUMENT

- Important questions to answer
  - What is wrong with this patient?
    - Diagnosis, comorbidities
  - What care does the patient require?
    - Hospital, outpatient follow-up, or unknown
  - What is my plan for this patient?
    - Interventions for the next day or two
  - Where are they going from here?
    - Discharge status

Step 3

REMEMBER

The expectation is that documentation rooted in good medical practice will meet certification requirements when paired with a valid order

ISN'T A STATEMENT ENOUGH?

Per the final rule

"… while the physician order and the physician certification are required for all inpatient hospital admissions in order for payment to be made under Part A, the physician order and the physician certification are not considered by CMS to be conclusive evidence that an inpatient hospital admission or service was medically necessary."

REVIEW RESULTS

WHAT MACS ARE CURRENTLY SEEING

MISSING OR FLAWED ORDER

- Error
  - Physician order states "observation" but facility billed as an inpatient
- Prevention
  - Use specific language for inpatient orders
  - Remember all care is outpatient care in the absence of an inpatient order
    - Or clear intent

SHORT STAY PROCEDURES

- Error
  - Patient presented for short stay procedure and discharged the next day
    - Not on inpatient-only list
- Prevention
  - Procedures with typical expected length of stay of less than 2 midnights are outpatient for payment purposes
    - Unless clinical course lengthens expected stay
  - Multiple short stay procedures performed together ≠ an inpatient procedure
    - In the absence of a 2 midnight expectation

UNCERTAIN COURSE

- Error
  - Patient with complaints of dizziness
  - Physician notes state intention to monitor overnight but patient admitted and inpatient claim billed
- Prevention
  - When clinical course is uncertain, utilize outpatient observation
  - Keep as an outpatient until it is clear the patient requires two midnights of care
  - Remember all clinical levels of care can be provided to a Medicare outpatient
    - Clinical level ≠ payment policy

ATTESTATION WITHOUT SUPPORT

- Error
  - Checkbox stating "The beneficiary is expected to require 2 or more midnights of hospital care"
  - Physician notes state plan to discharge in am if stable and patient discharged next day
- Prevention
  - Certification statements not required or adequate to support payment
  - Expectation must be supported by entire medical record

RESOURCES

HELP FOR PROVIDERS

CMS HANDOUTS

- Reviewing Hospital Claims for Admission 3/12/2014
- Selecting Hospital Claims for Patient Status Reviews 2/24/2014
- Questions and Answers Relating to Patient Status Reviews 3/12/2014
- Update on Probe & Educate Process 2/24/2014

- www.cms.gov > Research, Statistics, Data and Systems > Medicare Fee-for-Service Compliance Programs > Medical Review and Education > Inpatient Hospital Reviews

OTHER RESOURCES

- Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) Final Rule
  - www.cms.gov > Medicare > Acute Inpatient PPS > FY 2014 IPPS Final Rule Home Page
- Transcript of September 26, 2013 Special Open Door Forum
  - www.cms.gov > Research, Statistics, Data and Systems > Medicare Fee-for-Service Compliance Programs > Medical Review and Education > Inpatient Hospital Reviews