Welcome to the 2015 PA and UR Boot Camp

A couple quick highlights to set the tone – Getting it Right the First Time

All payers are auditing

In addition to Medicare RAC, where are you seeing increase in activity? 2 Year Trend

	Feb-13	Oct-13	Dec-13	Feb-14	Jan-15
MAC	57%	51%	45%	48%	34%
Medicaid RAC/MIC	22%	24%	28%	22%	20%
ZPIC	2%	3%	2%	2%	2%
Commercial Payor Audits/Denials	51%	64%	54%	51%	64%
Other	16%	9%	6%	16%	6%

Attacking Lost Inpts

- Quick questions at first point of contact:
- Can the pt/Medicare go home safely?
- If not, does the provider think they need 2 MN to resolve the condition?
- Regardless of what the clinical guidelines (IQ/Milliman) state
- If yes, admit to inpt with an excellent plan for WHY 2 MN?
- If the provider cannot admit with a 2 MN expectation, default to OBS.
- UR's daily/primary function – closely monitor all 'not discharge 1st MN outpt" – to see if a 2nd MN is going to be medically appropriate.
- If so, as the 2nd MN approaches, ask for the plan for the 2nd MN and convert to inpt.
- Regardless of what the clinical guidelines state.

OPPS 2016 proposed change to definition of an inpt (Budget neutral?)

- 2 MN rule is alive and well
- AND we are looking 'back to the future' with an enhanced definition of '**rare and unusual**.'
- Still use the physician's documentation of 'why an inpt' but if the provider cannot estimate 2 MN /Presumption –then declare an inpt with rationale for 'severity of the condition/intensity of the care' that will require in hospital care. HUGE AUDIT RISK!
- QIO/level 2 appeal group will perform all audits (more peer to peer)
- High volume of 'rare and unusual' flagged for audit = RAC
- RAC lookback to 6 months from date of service/30 days to review=more changes but only with new RACS
- No change to SNF
- No Short Stay DRG

CMS.gov:Fact Sheet: Two-Midnight Rules 7-1-15

Key elements for Payers- as ordered by providers

ALL PAYERS

- Admit to inpatient
- Diagnosis
- Reason for Admit/Plan for why an inpt for dx.
- All part of a pre-determined order set.(Ques in the EMR or paper)

- MEDICARE ONLY
- "Clarify" that the LOS is an estimated 2 MN/Presumption
- "Clarify' that after the 1st outpt MN, a 2nd 'in hospital' MN is required/Benchmark
- After 1-1-15, provider still outlines why the 2 MN, what is the plan that will take 2 MN. No longer 'certify' but still needs to clarify the order/signed prior to discharge and rationale for the 2 MN. (Do certify 20 day mark/outlier)
- Critical Access Hospital – must still certify initial 96 hrs and again, at the 96 hr mark.

Hot Spots for Documentation audits – inpt and obs

- Does the physician clearly state: Why an inpt? What is the plan that will take 2 MN/Medicare? For non- Medicare – why can't the pt be treated safely as an outpt. (Same issues as Medicare-just no 2 MN declaration)
- Medicare/only-If the pt needs a 2nd MN after 1 MN as an outpt – what is occurring with the pt's condition that will 'push the pt' to stay a 2nd MN? Convert to inpt and include: Why?
- **Mgd Care Medicare/PartC/Medicare Advantage – HIGH AT RISK.** What criteria are they using? Get it in the contract! NOT SUBJECT TO TRADITIONAL Medicare rules
- Commercial Mgd Care or Commercial- who knows? Makes their own rules for disallowed charges.

Key elements of new Medicare inpt regulations – 2 methods

- **2midnight presumption**
- "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.

- **Benchmark of 2 midnights**
- **The new Medicare Inpt**
- "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

CLEARLY – at the point of conversion to inpt – why does the pt need a 2nd medically appropriate MN? Tell the plan..

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 but still an inpt.**
- 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

STILL largest lost revenue – 2 MN benchmark – converting after 1st MN

- After the 1st MN as an outpt – anywhere – or the first MN in another facility and transferred in –

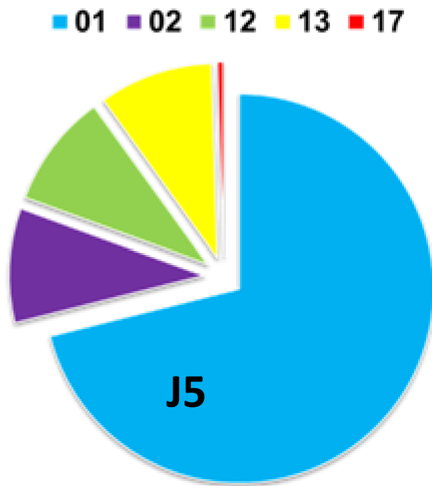
- "The decision to admit becomes easier as the time approaches the 2nd MN, and the beneficaries in *necessary hospitalization* should NOT pass a 2nd MN prior to the admission order being written.' (IPPS Final rule, pg 50946)

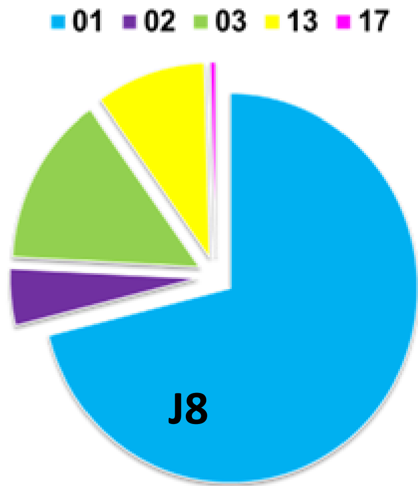
- Never, ever, ever, ever have a 2nd medically appropriate MN in outpt..convert, discharge or free…
- **Recent audits**: 16 spent 2nd MN in obs'; 13 should have been converted. 10 spent 2nd MN in obs; 6 should have been converted. UR – let go of the old language- doesn't meet Criteria! Means??

“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.**

Denials by Type – WPS 1st and 2nd Round P&E





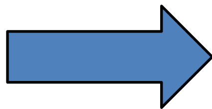
5PC01	**Documentation does not support services medically reasonable/necessary**
5PC02	**Insufficient documentation**
5PC12	**Order missing**
5PC13	**Order unsigned**
5PC15	**Certification not present**
5PC17	**No documentation of 2-midnight expectation**

Top Reasons for Denial – Second Round- Novitas/2nd round of P&E

Denial Reason	% Denials JH	% Denials JL
Documentation did not support two midnight expectation (did not support physician certification of inpatient order)	56%	53%
No Records Received	16%	17%
Documentation did not support unforeseen circumstances interrupting stay	4%	3%
No inpatient admission order	9%	15%
Admission order not validated/signed	11%	11%
Other	4%	1%

P&E findings: First Coast/MAC 244 hospitals: FL, PueRico, VirIsland

- 1st round:
  - 35% denial rate
- REASONS:
  - 55% failed to document need for 2 MN
  - 45% failed admission order requirements
    - 48% signed after discharge
    - 39% order missing from the record
    - 13 % order not signed



- 2nd round:
  - 36% denial rate
- REASONS:
  - 40% failed to document need for 2 MN
  - 60% failed admission order requirements
    - 35% order missing from record
    - 17% order not validated
    - 8% order not signed (as of 2-11-15)
  - MAC recommendations: Providers document their decision making process. Paint a clear, concise picture of the pt.

Tell a better, more complete patient story

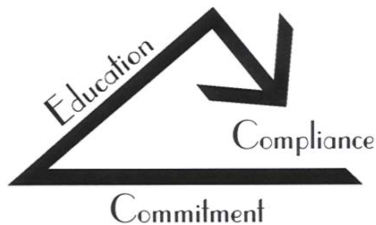
- Begin with the 1st point of contact – ER, direct or Surgery
- Why is the pt not safe to be discharged/ED?
- Why is the surgery an inpt if the CPT is not on the inpt only list? (Medicare only)
- What provider laid out a plan for why 2 MN for a direct admit to the floor? Did the hospitalist see the pt immediately? Did UR talk to the ordering provider?
- Who is validating status for transfers in? Who is asking both the sending and the receiving the 2 MN question? Count 1st in sending.

Let's listen to Dr Hirsch's wonderful training as it continues to simplify how to use the 2 MN rule… THANKS!!

Day Egusquiza, Pres

- Daylee1@mindspring.com
- 208-423-9036 Free Info Line
- www.arsystemsdayegusquiza.com

AR Systems, Inc.



"Finding HealthCare Solutions… together"
P.O. Box 2521
Twin Falls, ID 83303
(208) 423-9036
daylee1@mindspring.com