AR Systems, Inc
Training Library Presents

Finding the Lost Inpatients with the 2 MN Rule, Plus Other Observation Confusion

Instructor:

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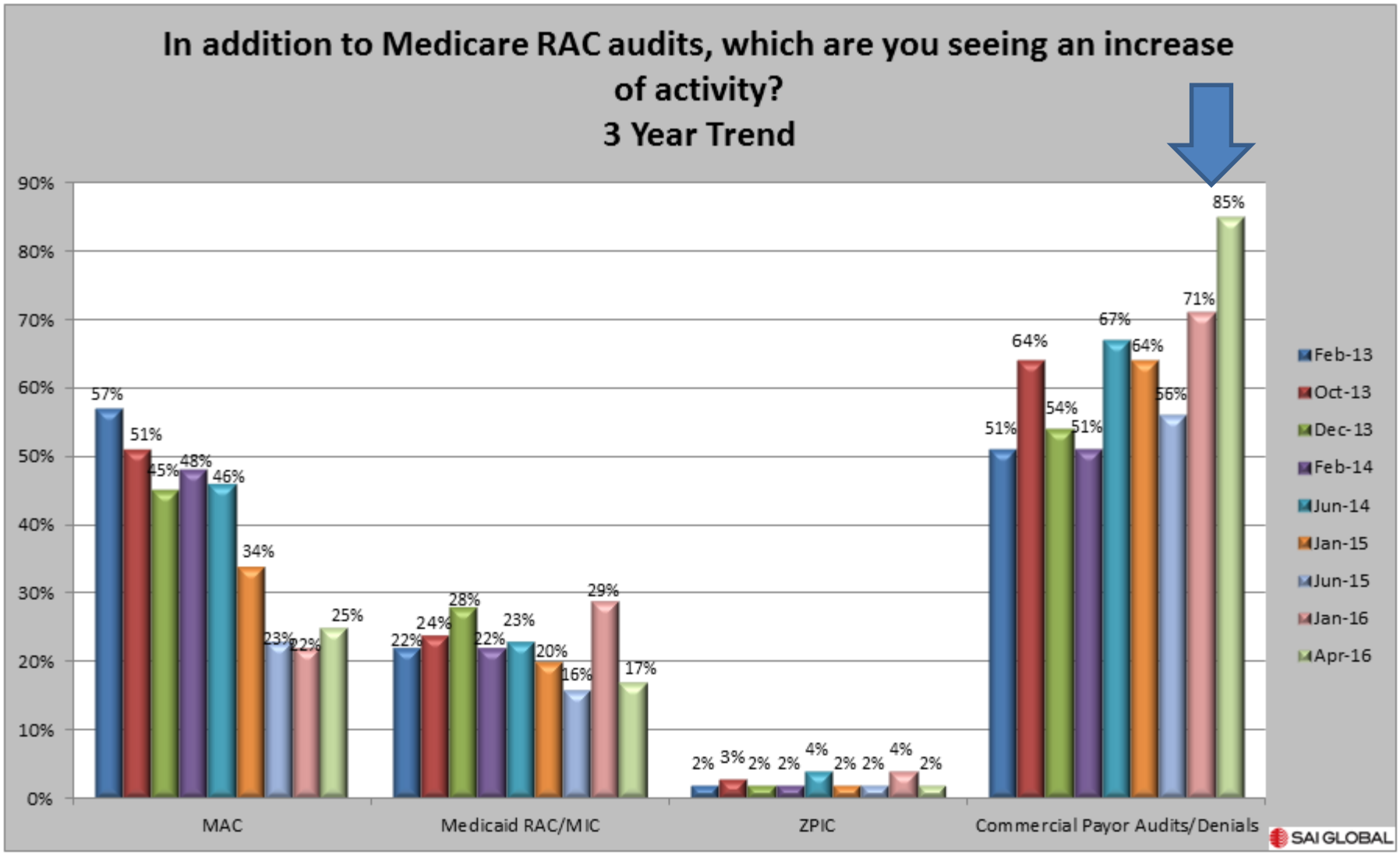
In addition to Medicare RAC audits, which are you seeing an increase of activity?
3 Year Trend
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
51%
45%
48%
46%
34%
23%
22%
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20%
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4%
2%
2%
4%
2%
51%
64%
54%
51%
67%
64%
56%
71%
85%
MAC
Medicaid RAC/MIC
ZPIC
Commercial Payor Audits/Denials
Feb-13
Oct-13
Dec-13
Feb-14
Jun-14
Jan-15
Jun-15
Jan-16
Apr-16
SAI GLOBAL

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….

What is a Medicare Inpt?

- Per WPS-MAC/Medicare claims processer/auditor (July 23, 2014)

- "If there is one place I would recommend beefing up the documentation, **it is the plan**. There are many patients who present in very acute , life threatening ways, who do not require 2 MNs of care. (think CHF) The plan, along with the diagnosis/clinical data on the claim are the 2 biggest supporters of the physician's reasonable expectation especially if that expectation isn't met. If all you have is '*monitor overnight and check in the morning'* – you are going to have a hard time supporting a part A/inpt payment, regardless of the symptomology. You could also add an unexpected recovery note at the end of the record, if they get well faster than the doctor thought at the time of the inpt order and expectation of 2 MN. But in this ex, you'll have to explain what you expected and what actually happened. It would be less charting if you actually just had a good plan up front."

Key elements of new 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.

Pg 50959

- **Benchmark of 2 midnights/NEW INPTS**
- "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. **HUGE LOST INPTS!**

Pg 50956

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

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 beneficiaries 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…

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.

- Impacts ER, Observation and Outpt Surgery.
- 1 MN out + 1 MN inpt expectations = 2 MN benchmark inpt.

- 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**.

2 MN with a plan and then an early discharge..

- **2 MN presumption**: ALWAYS ensure there is a clinical plan for why the pt needs 2 MN at the first point of contact. The plan is key!

  Ensure the ER provider and the Hospitalists or attending AGREE on the plan.. Handoffs need evaluated to ensure consistency. UR and PA involved.

  The care is then documented – with nursing and the provider – documenting the course of treatment/progression of care as it relates to the plan.

  SURPRISE: Clearly document the patient's unexpected recovery; unexpected transfer out; unexpected response to treatment. Then, a beautiful inpt.

- **2 MN benchmark**: ALWAYS ensure there is a clinical plan for why a 2nd MN was medically appropriate/in hospital care after an outpt 1st MN. The plan is the key !

  The hospitalists/attending and UR need to communicate closely as the 2nd MN approaches… DO NOT WAIT UNTIL the am of the 3rd day.

  CAREFUL not to convert early on the 2nd day and then discharge same day…no 2nd MN. What was the plan? Was it met early?

  Note: Order takes effect when written. EX) Day 3 am, doctor converted to inpt. 10 mins later, discharged. How was the plan met in 10 mins?

“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“**
- **<u>WAY TOO MANY SELF DENIALS or CC 44</u>… EX) UR says pt doesn’t meet criteria. (means??) Provider had written a (fairly) good order outlining the ‘why an inpt’ but clinical elements did not fit into the ‘inpt level of care criteria.’ UR said – need Condition code 44/an error has happened or if missed the timeline/prior to discharge – then self deny! Poor process as IMMEDIATELY ask: What is the plan that will take an estimated 2 MN? Or an additional MN after the 1st outpt MN?**

And more - Transfers

- 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.

- Q2.2: How should providers calculate the 2-midnight benchmark when the beneficiary has been transferred from another hospital?
  A2.2: The receiving hospital is allowed to take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, **the start clock for transfers begins when the care begins in the initial hospital.** Any excessive wait times or times spent in the hospital for non-medically necessary services shall be excluded from the physician's admission decision."

- 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

- Use Occurrence Code Span 72/field to identify the date of the 1st MN/sending hospital.
- Place the date on the Inpt UB that may only have 1 additional MN for the receiving hospital.
- 2 MN Benchmark is now present on the 1 MN UB from the receiving hospital.

- Reference: SE1117revised MLNMatters "Correct provider billing of admission date and statement covers period."

More Med Learn Updates

- National UB committee – **Occurrence code 72 MLN CR 8586, effective 12-13**

  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.*

MLM SE1117 REVISED: Correct provider billing of admission date and statement covers period.

DOS after 10-1-11, admission date (FL 12) is the date the pt was admitted as an inpt to the facility. It is reported on all inpt claims regardless of whether it is an initial, or interim or final bill.

The statement covers period (from and thru dates/FL 6) identifies the span of service dates included in a particular bill. The 'from' date is the earliest date of service on the bill.

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."

HINT: If being delayed 'to Mon'- ensure there is clear documentation of the clinical assessments/plan/other services BESIDES the delay for the test/service. Unfortunately, the record usually shows 'ready for discharge except waiting for Mon to do the final test." What is clinically appropriate about "MONDAY?"

HINT: Critical access hospital challenges..

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.)

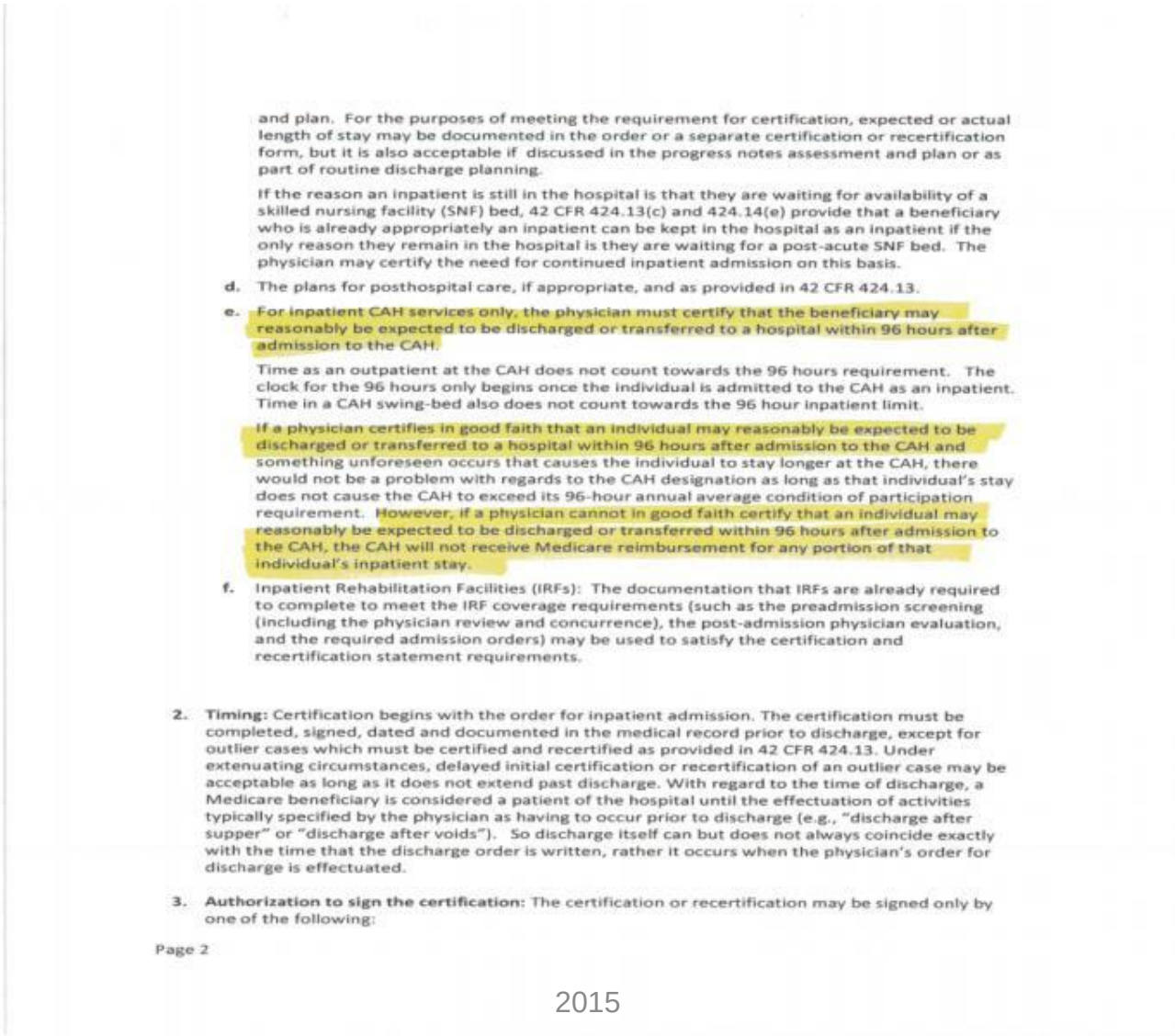
Ex) What if the surgery was delayed because the surgeon was only at the hospital 1 day a week? Is there another hospital where the surgery could occur without the delay?

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

96 hr CAH requirement/CMS Physician certification, Jan 31,2014 (still required/OPPS 1-15)



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:

Page 2

Let's get started-new language

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? 2 MN presumption
- 3rd question: If no, move to OBS/Default position and evaluate closely. If after the 1st MN, there is a reason to **receive care 'in hospital'** , convert to Inpt with a reason /plan why. 2 MN benchmark

Dedicated Outpt Ambulatory Beds = focus is outpt

- Change the focus of 'mini-inpt' to an outpt who is aggressively/rapidly being assessed/reassessed to determine to discharge safely or be admitted.
- Medicare – triggers in dedicated bed to 'actively involve the hospitalists/primary care provider' as each order is completed, move to an updated order: new order, d/c or admit. Watch closely as **the 2nd MN approaches**.
- Surgical cases – going home! Place routine recovery/after PACU rather than on the floor. Perception: not an inpt.
- Dedicated staff (Hospitalists, UR, Clinical) and focus on outpt and rapid discharge or timely conversion.
- Recovery beyond 'routine (usually 4-6 hrs) = extended recovery. Planned recovery beyond routine with a medical reason to be a bed. Ordered with an action plan – never just '**stay the night**." UG

Let's Get Updated on Numerous CMS audit activity + Probe and educate & Recommendations

Probe and Educate: Probe 1 Results (Shared at RAC/MAC Summit 9, Nov, 2014 & Probe 2 Results shared PA/UR Bootcamp, July 2015)
WPS /MAC

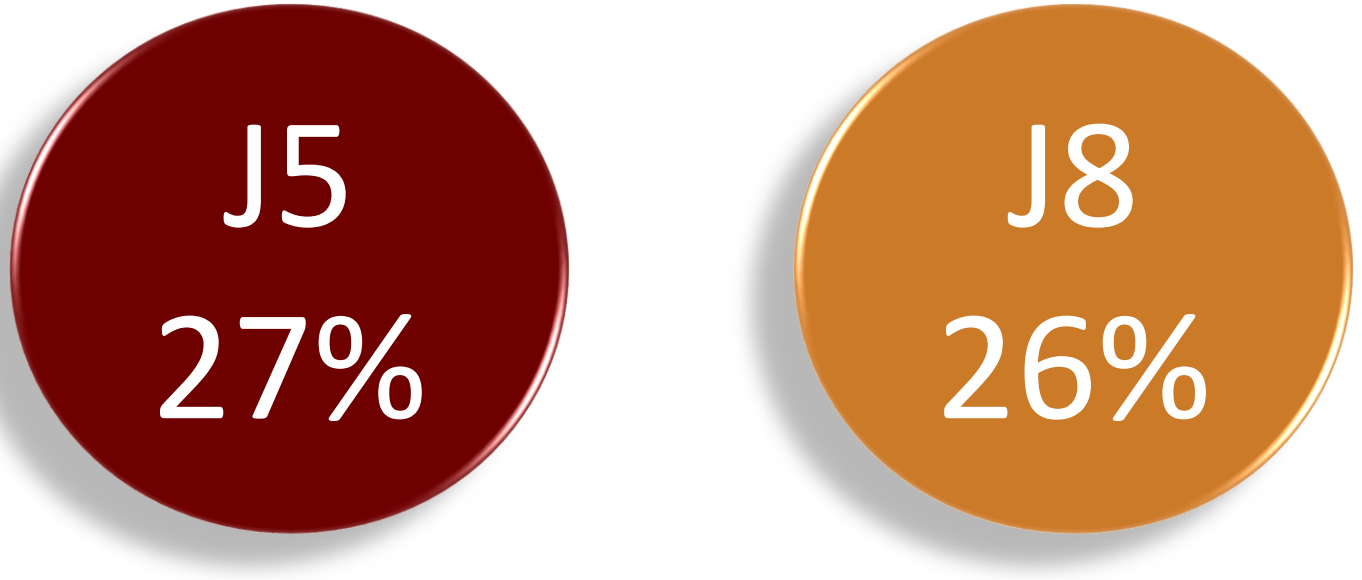
All 0 and 1 MN stays will be eligible to be audited by the QIO/2016 with 6 month look back. 2 QIOs for the country- KePro & Livanta. (On PAUSE/June 2016)

Probe 1- WPS data

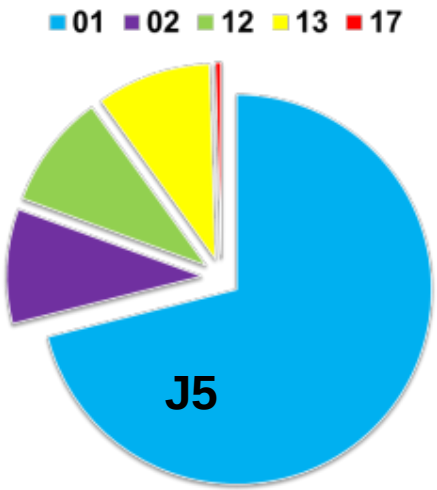
	J5	J8
Part A Hospital Provider Count	800*	300*
# of Providers Sampled	412	151
# of Claims Reviewed	3,625	1,328

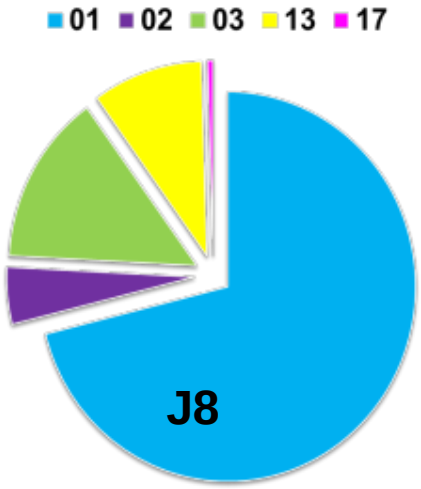
- Approximate number
- J5- NE, IA, KS, MO
- J8- MI, IN

Overall Denial Rate- WPS



Denials by Type - WPS





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**

Probe 2- WPS (Failed or not 10 in first sweep or had 1/0 now)

	J5	J8
Part A Hospital Provider Count	736	253
% of Claims Completed	32%	35%
Top Denial Code	5PC01	5PC01

New in Probe 2

- 5PC11 - Procedure not reasonable and necessary

Novitas -Probe and Educate Medical Reviews – First Round

JH: CO, NM, OK, TX, AR, LA, MS JL: PA, NJ, MD, DE, Dist of Co

PRESENTED TO THE RAC SUMMIT 11-14

	# Providers	# Claims Reviewed	# Claims Denied	% Claims Denied
JH	1004	3794	2206	58%
JL	586	2712	1720	63%

Probe and Educate Medical Reviews – Second Round*

	# Claims Reviewed	# Claims Denied	% Claims Denied
JH	3028	1666	55%
JL	1501	901	60%

* To date

Top Reasons for Denial – Novitas First Round

Denial Reason	% Denials JH	% Denials JL
Documentation did not support two midnight expectation (did not support physician certification of inpatient order)	50%	51%
No Records Received	29%	28%
Documentation did not support unforeseen circumstances interrupting stay	11%	11%
No inpatient admission order	3%	3%
Admission order not validated/signed	4%	3%
Other	3%	4%

Top Reasons for Denial – Second Round

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%

Problematic Clinical Situations- NOVITAS

- Inadequate historical detail to understand symptoms of unknown significance in patients with underlying diseases
- Unstated or unclear impressions and treatment plans
- Admissions for management based on clinical guidelines and algorithms then not following those guidelines
- Variations in descriptions of patient condition by different physicians without explanation or reason
- Disconnects (and disagreements) between admitting physician and attending physician and between attending physician and specialist physicians
- Unforeseen circumstance vs. incorrect admitting diagnosis and treatment plan

Examples- Novitas

- Transient Cerebral Ischemia
- Vague neurologic changes, altered mentation, uncomplicated syncope
- Gastrointestinal bleeding
- Cardiac arrhythmias (atrial fibrillation)
- Tube replacements
- Volume depletion
- Same day outpatient procedures
- Psychiatric problems, suicidal ideation, patient non-compliance, alcohol inebriation

What's Missing- Novitas?

- Solid documentation of the nature of an illness, the physician's impression (differential diagnoses), and a clear statement of diagnostic/therapeutic choices along with their stated or implied rationale

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.

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…

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

- Clarification of order 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…

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

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Thanks for joining us!

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