



Bootcamp Regulations Update

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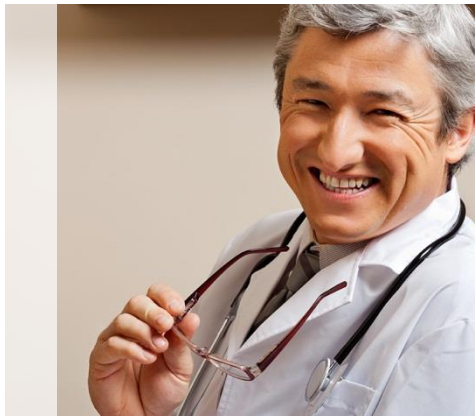
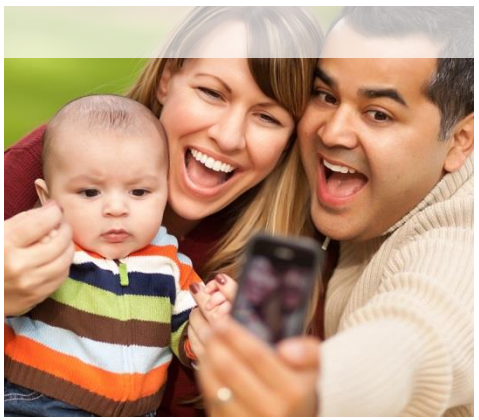
Accretive Health

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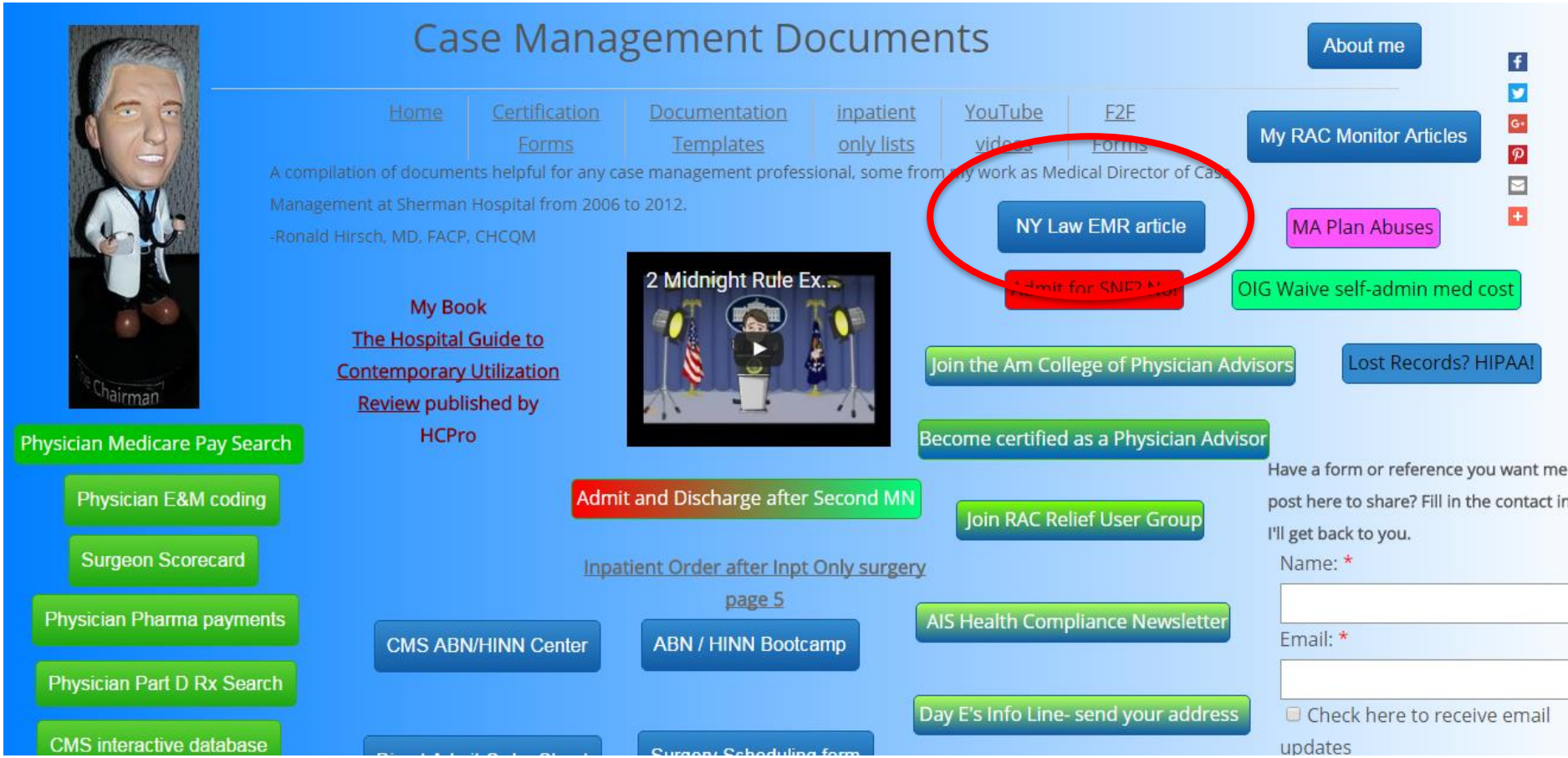


Novoseven and the dying patient

Don’t just do something, stand there.

Inpatient Only Surgery

Effective April 1, 2015, inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission, according to the policy for the payment window for outpatient services treated as inpatient services will be covered by CMS and are eligible to be bundled into the billing of the inpatient admission.

MLN Matters MM 9097

New Exception to 2 MN Rule

…we proposed to modify our existing “rare and unusual” exceptions policy to allow for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights.

CMS Double Speak

"…we would like to clarify that our proposed modification to the current exceptions process does not define inpatient hospital admissions with expected lengths of stay less than 2 midnights as rare and unusual. Rather, it modifies our current "rare and unusual" exceptions policy to allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark."

Requirements for using exception

1- Patient requires inpatient hospital care despite an expectation of less than 2 MN

“While we have been clear that the 2-midnight benchmark does not override the clinical judgment of the physician regarding the need to keep the beneficiary at the hospital, to order specific services, or to determine appropriate levels of nursing care or physical locations within the hospital, some stakeholders have argued that the 2-midnight benchmark removes physician judgment from the decision to admit a patient for inpatient hospital services. We disagree.

However, we believe the concerns raised by stakeholders merit continued consideration."

For payment purposes, the following factors, among others, would be relevant to determining whether an inpatient admission where the patient stay is expected to be less than 2 midnights is nonetheless appropriate for Part A payment:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient; and
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).

Where might this apply?

- InterQual or MCG says Inpatient
- High risk TIA- but “high” = 8.2%
- High risk chest pain- “high” can be 20-40% but is that high enough?
- Pacemaker/ICD in high risk patient- but if they need a device, aren’t they all high risk?
- Acute MI to cath lab and home next day if does well- Acute MI is life-threatening

Do these qualify for inpatient admission????

Next Requirement

if the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights.

What documentation is needed?

"I feel inpatient admission warranted"?

"My patient is at high risk"?

Will your doctors document anything????

And even if they document that…

The physician's "order and certification regarding medical necessity" are not entitled to any "presumptive weight" and are "evaluated in the context of the evidence in the medical record."

78 FR 50965

QIO Interpretations

- Older pt with syncope; had asystole in the ED, brief CPR, taken for pacemaker urgently and discharged the following day. Stay was 26 hours.

- The medical director told me for Case 3 that the event was serious enough to justify IP status.

- Older pt sent in with high BP (>200/100), found to have HR 40s but asymptomatic, received a few doses of IV hydralzine in ED, otherwise PO meds after admit. POC included PO BP meds, tele, serial cardiac enzymes (not sure why). D/Ced the next day (17 hours) with no rapid recovery statement.

- QIO thought the BP was high enough to justify IP status. Perhaps, but I (the hospital PA) may have self denied this case.

New APC for Observation 1-1-16

Previously APC 8009

-ED visit or direct admit plus 8 or more hrs Observation = $1,234

-Eligible part B services billed separately

-imaging, diagnostic and therapeutic procedures

New Comprehensive APC - 8011

-ED visit or direct admit plus 8 or more hrs observation = $2,275 (adjusted for wage index)

No other services will be paid

What's a Comprehensive APC?

- Status indicator – J1 (Addendum B of OPPS)
- Mini-DRG- all inclusive payment for outpatient procedure and any hospital care

- Lap Chol'y, Pacer, ICD, EP, stents, gyne surg, TURP, etc.

The new Quirk of Observation

If a patient is placed in observation and underwent a status T procedure at any point, the Observation APC is not paid. You bill for the T procedure and all other services provided, but get no payment for bed and nursing services.

T procedures-

cath without stent, colonoscopy, EGD, I&D abscess, nose packing

Find status indicators on Addendum B

What does this mean?

- Patient with abd pain, placed obs, labs and ultrasound done, goes home next day- $2,275

- Patient with abd pain, placed obs, labs ultrasound and EGD done, goes home next day- $1,200

Always do what is right for the patient, but realize the cost implications of what is being done.

Patient with abd pain in ED at 5 am, vomiting, blood noted, placed observation, has EGD with no ulcer, UTZ GB at 3 pm shows cholecystitis, goes for lap chol'y at 6 pm, going home next day. One MN stay- outpatient. Paid J1, APC 5362, $4,001- no pay for EGD, ultrasound, Obs hours.

Patient with abd pain in ED at 10 pm, vomiting, blood noted, placed observation, has EGD with no ulcer, UTZ GB at 10 am shows cholecystitis, goes for lap chol'y at 6 pm, will recover over 2nd MN. Admit as inpatient since passing 2 midnights.

Inpatient DRG- 413- wt=1.7996- $12,000

No Goldmine Here
Approved Charges Matter

Other services	
ED visit	$326-486
ECG	$56
CXR	$61
CT chest	$236
CT abd	$348
UTZ abd	$154
MRI Brain	$454
ECHO	$417
EGD	$745
Colon	$753

Labs (if no APC)	
CBC	$11
BNP	$46
CMP	$14
PT	$5
UA	$4
lipase	$9
trop	$13
blood draw	$3

Too Much Observation?
The Hirsch Rule of Observation

If every patient is reviewed by CM for proper admission status, and every patient is placed in the right status, and observation is only ordered on the proper patients, and every patient goes home as soon as their need for hospital care has finished and every patient who requires a second midnight is admitted as inpatient, then your observation rate is at your benchmark.

If you do this and your CFO wants fewer observation patients, you must commit fraud to get there.

Instead work on your Obs LOS!

Dx	80th %ile	20th%ile
TIA	34 hrs	20 hrs
CP	28 hrs	19 hrs
A Fib	31 hrs	19 hrs
HF	40 hrs	22 hrs

Advisory Group, 2016

Readmissions- CMS Policy

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals will adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Please be aware that services rendered by other institutional providers during a combined stay must be paid by the acute care PPS hospital as per common Medicare practice.

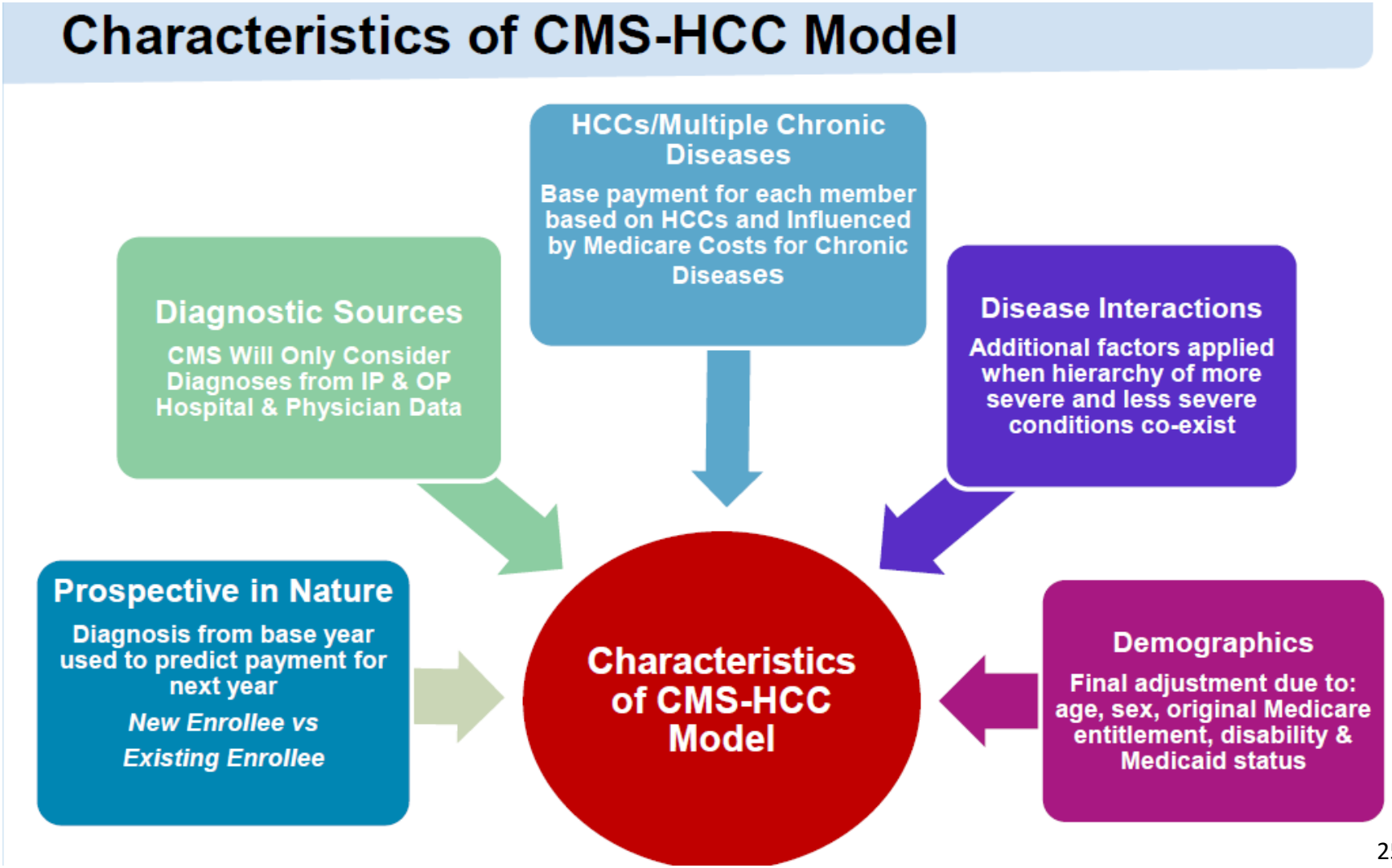
The $10,000 Question

If you prevent a readmission, you lose the second DRG.

Will the reduction in your readmission penalty by preventing that one readmission be more than the DRG payment?

What about the amount you are spending on your readmission reduction programs? Aren't you just spending money to reduce your overall reimbursement?

Hierarchal Condition Categories



Scenario 1 – Represents what would actually be coded and reported to the plan by many physicians					
Condition	**ICD 9 Code**	**CMS Risk Score**	**Demographic Score**	**Total RAF Score**	**Total Payment** *$800 (Illustrative Purposes) x RAF Score*
Diabetes Mellitus	250.00	0.162	0.44	0.602	$481.60
UTI	599.0	0.0			
Scenario 2 – Represents what can be coded and reported to the plan by the physician					
Diabetes Mellitus w/ Renal Manifestations	250.40	0.508	0.44	3.094	$2,475.20
UTI	599.0	0.0			
Diabetic Nephropathy	583.81	Trumped by CKD Stage 3			
CKD Stage 3	585.3	0.368			
Mild Degree Malnutrition	263.1	0.856			
Old MI	412	0.244			
BKA Status	V49.75	0.678			

Risk adjustment data validation

RADV

- The diagnoses that PacifiCare submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. For 55 of the 100 beneficiaries in our sample, the risk scores calculated using the diagnoses that PacifiCare submitted were valid. The risk scores for the remaining 45 beneficiaries were invalid because the diagnoses were not supported by the documentation that PacifiCare provided.
- As a result of these unsupported diagnoses, PacifiCare received $224,388 in overpayments from CMS. Based on our sample results, we estimated that PacifiCare was overpaid approximately $423,709,068 in CY 2007.

GAO Slams CMS on MA Audits

- GAO found that CMS's methodology does not result in the selection of contracts for audit that have the greatest potential for recovery of improper payments.
- CMS's goal of eventually conducting annual RADV audits is in jeopardy because its two RADV audits to date have experienced substantial delays in identifying and recovering improper payments.
- CMS has not expanded the recovery audit program to MA by the end of 2010, as it was required to do by the Patient Protection and Affordable Care Act.

GAO-16-76

Published: Apr 8, 2016

FOR IMMEDIATE RELEASE

Wednesday, July 6, 2016

Doctor Who Falsely Diagnosed Hundreds of Patients As Part of a Medicare Fraud Scheme Sentenced to Prison

Dr. Isaac Kojo Anakwah Thompson, M.D. 57, of Delray Beach, was sentenced today by United States District Judge William J. Zloch to 46 months' imprisonment, to be followed by two years of supervised release, after having previously pled guilty to health care fraud. Dr. Thompson was further ordered to pay restitution in the amount of $2,114,332.33.

Wifredo A. Ferrer, United States Attorney for the Southern District of Florida, Assistant Attorney General William J. Baer, Special Agent in Charge George L. Piro, Federal Bureau of Investigation (FBI), Miami Field Office and Special Agent in Charge Shimon R. Richmond, Department of Health and Human Services, Office of Inspector General (HHS-OIG), Florida region, made the announcement.

According to the court record, including facts admitted during the defendant's plea hearing and the parties' statements at sentencing, Dr. Thompson engaged in a scheme to defraud the Medicare Advantage program, a voluntary system which allows Medicare beneficiaries to enroll in health insurance plans sponsored by private insurance companies. For each beneficiary who chooses to enroll in a Medicare Advantage plan, Medicare pays the sponsoring insurance company a fixed, or capitated, monthly fee. Medicare does not adjust the fee based on the cost of providing medical care to the beneficiary. Instead, Medicare adjusts the fee based on the beneficiary's medical conditions. As a result, Medicare generally pays a larger capitated fee for a beneficiary with more serious medical conditions than it does for a healthier beneficiary. Medicare determines a beneficiary's medical conditions in part using diagnoses submitted by the beneficiary's Medicare Advantage plan physician.

(Re)Certification of Psych Admissions

- Certification
  - the physician is required to document that the inpatient psychiatric facility admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study

Recertification prior to August 15, 2015

IPF PPS requires facilities to provide a statement "that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.“

– No exact statement = denial

Recertification as of Aug 15, 2016 CR 9522, Transmittal 98

Contractors shall cease denials of IPF providers that do not use the statement “that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel” for recertification when, documentation is present that validates (not in any particular words) that the patient continues to need care.

So, Day, can you tell me what to do as we approach the second midnight?