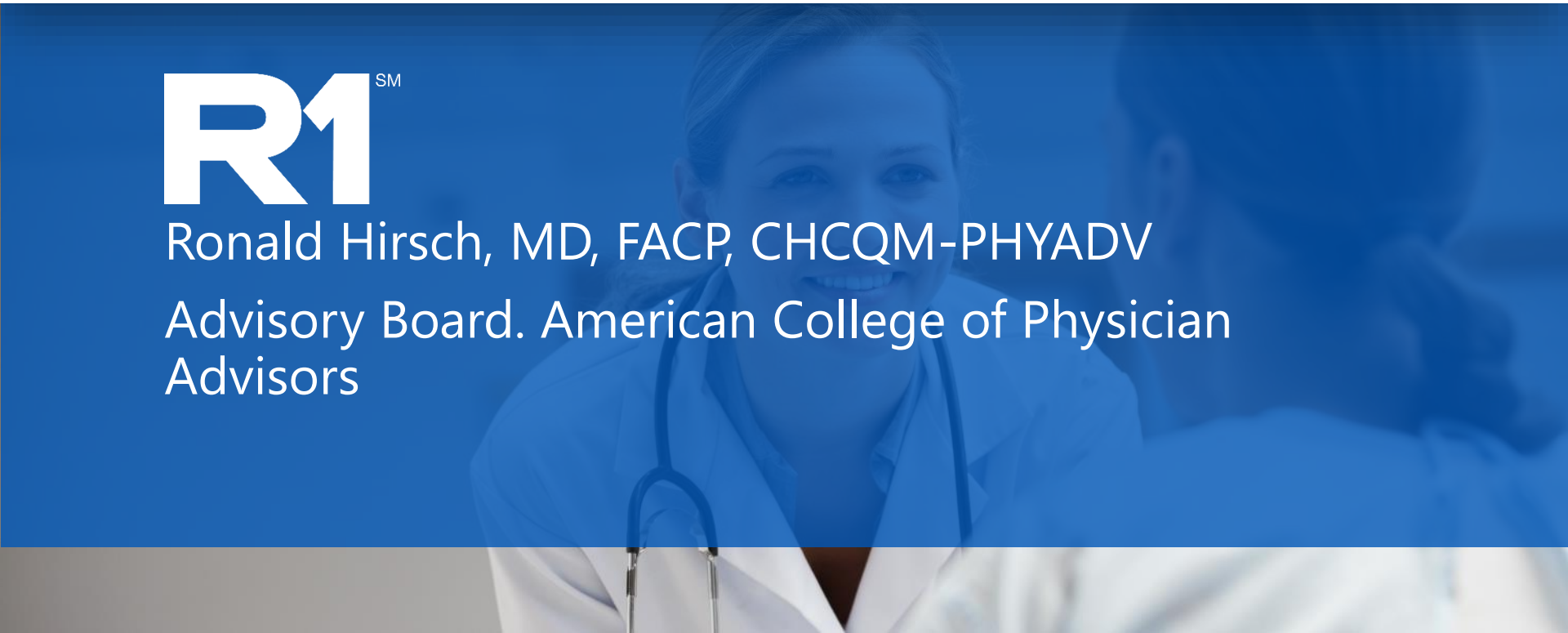
Regulatory Update
PA and UR Boot Camp



Ronald Hirsch, MD, FACP, CHCQM-PHYADV

Advisory Board. American College of Physician Advisors

Disclosures

I feel that laws and regulations have to be followed whether we like them or not.

I pay taxes every year which finance Medicare and Medicaid and pay for health insurance from Blue Cross. I want those entities to pay out my money to entities who deserve it and not to cheaters.

30 minutes is not enough for me so I am going to talk fast.

Everything I say is fee for service Medicare **ONLY**!

2018 OPPS Proposed Rule

- Total knee replacement coming off the inpatient only list (IOL)
- CMS soliciting comments on allowing total knees at Ambulatory Surgery Centers (ASC)- will happen 2019
- CMS soliciting comments on removing partial and total hip from inpatient only list and allowing them in ASCs- may happen 2019
- Removing laparoscopic prostatectomy from IOL
- Proposed cutting 340B reimbursement from Average sales price (ASP)+6% to ASP-22.5%
- One year delay to Appropriate Use Criteria mandate
- Delaying direct supervision for small hospitals by 2 yr

A Reminder- Two Midnight Rule

A hospital inpatient admission is considered reasonable and necessary if a physician or other qualified practitioner (collectively, “physician”) orders such admission based on the expectation that the beneficiary’s length of stay will exceed 2 midnights or if the beneficiary requires a procedure specified as inpatient-only under § 419.22 of the regulations.

How to Ruin a Rule- Add Exceptions to the Rule

We have accepted and considered suggestions from stakeholders regarding potential "rare and unusual" circumstances under which an inpatient admission that is expected to span less than 2 midnights would nonetheless be appropriate for Medicare Part A payment.

1- newly initiated mechanical ventilation (when medically necessary and excluding anticipated intubations related to minor surgical procedures or other treatment)

Two Midnight Rule Exception for Physician Judgment

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.

We are modifying 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.

What the Heck????

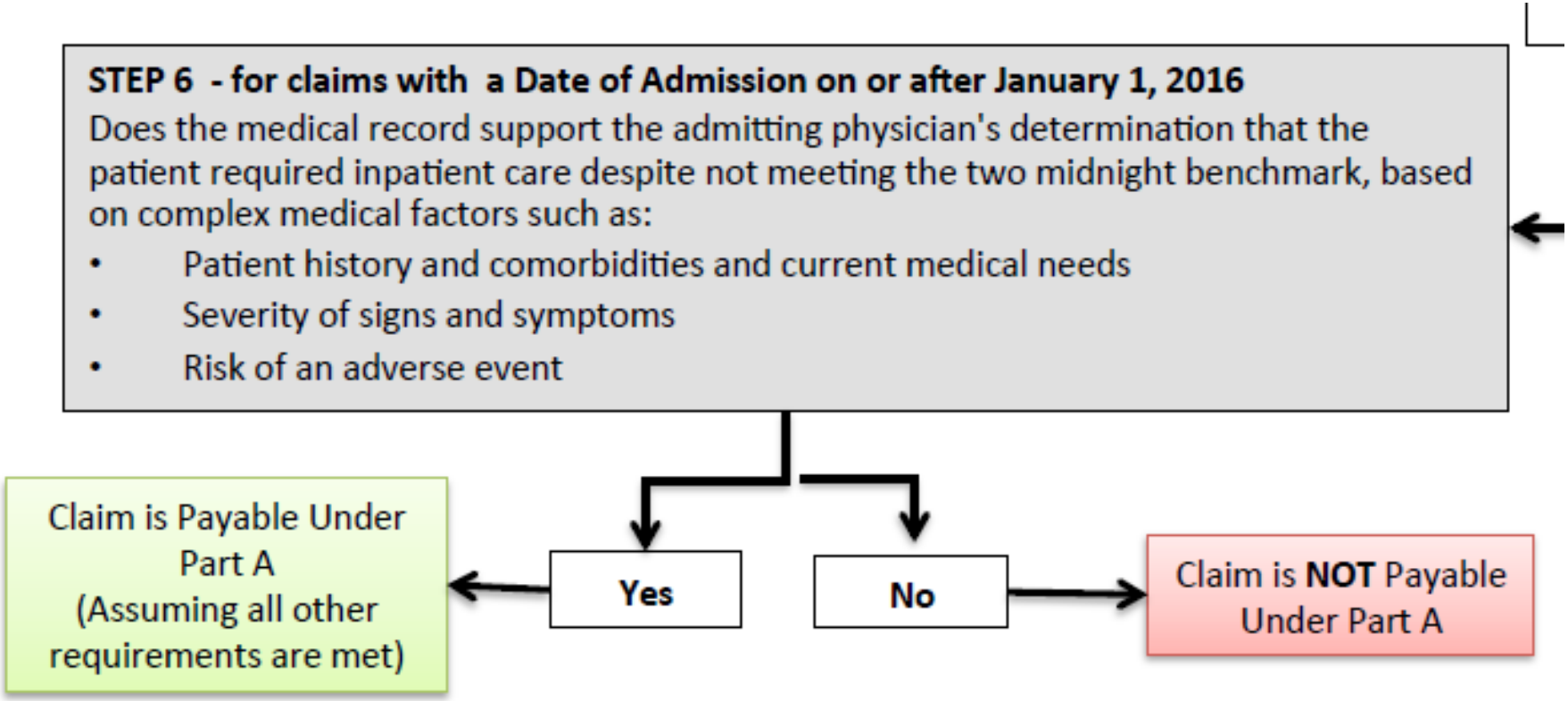
We would like to clarify that our proposed modification to the current exceptions process does not define inpatient hospital admissions with expected lengths of stay less than 2 midnights as rare and unusual. Rather, it modifies our current "rare and unusual" exceptions policy to allow Medicare Part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

Who Qualifies for this Exception?

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).

BFCC QIO 2 MIDNIGHT CLAIM REVIEW GUIDELINE



Thanks to Dr Laura ShawHughes from Kent Hospital in Rhode Island for sharing Livanta slides- "It takes a village!"

Livanta Presentation

If the physician documentation supports that the patient required inpatient care due to patient history, comorbidities, current medical needs, severity of signs and symptoms, and/or risk of an adverse event, Part A payment is approved. *The record should indicate the reason(s) that the above factors require inpatient care.*

- These determinations are made by the BFCC-QIO physician reviewers and cover the Case-by-Case exception

Example: Approved

Patients who did not have a 2 midnight stay but met the criteria for admission

- 75-year-old with CAD who presented with increasing chest pain. Hemodynamically stable, positive enzymes, no EKG changes. Admitted with NSTEMI, had cardiac catheterization with PCI on day of presentation. Patient was kept overnight, remained stable, and was discharged following a one midnight stay.

Note: this is a NSTEMI so obviously a STEMI would also qualify

Example: Approved

Patients who did not have a 2 midnight stay but met the criteria for admission

- Patient with known metastatic breast cancer who presented with hypercalcemia (CA 14) and altered mental status. Treated overnight with IV hydration, Lasix. After 1 midnight, her mental status cleared and Calcium returned to normal range (12). The patient was discharged after one midnight stay.

I think this patient has an expectation of 2 MN on admission.

Example: Approved

Unforeseen Circumstances – Improvement in Clinical Status

- Patient who missed dialysis presented with CHF, K of 6.9, and ST segment elevations. The patient was admitted for monitoring and urgent dialysis, and discharged with normal K and better fluid balance after an overnight stay.

I don’t see why this is unforeseen- it is what dialysis does! This is a high risk with one MN expectation.

Example: Approved

Unforeseen Circumstances – Improvement in Clinical Status

- Patient with DKA (pH 7.25, glucose 750) and altered mental status. The patient was admitted and given insulin drip. She improved over a one midnight stay and was discharged.

This could be unexpected rapid recovery or high risk patient exception.

Example: Approved

Concern over an adverse event

- 84-year-old with HTN and CAD who presented with “near syncope” and three episodes of rectal bleeding within 24 hours. No active rectal bleeding at the time of presentation in the ER but evidence of orthostatic changes in BP and Hgb of 8.7, with normal WBC, platelets, PTT, INR. The patient was admitted, hydrated, and transfused 2 units red blood cells with no further bleeding. Vital signs remained stable and she was discharged after an overnight stay.

This looks like an expected 2 MN stay patient with unexpected recovery

Are Livanta's Examples Precedential?

Good Afternoon Mr. Hu,

Yes… it would be reasonable to look to Livanta's education for examples. As some providers are (based on geographic location) may be interacting with both KEPRO and LIVANTA

And the QIOs are implementing the same Part A payment policy

Quality Improvement & Innovation Group

Centers for Medicare & Medicaid Services

But what about…

"the documentation in the medical record supports the admitting physician's determination that the patient requires inpatient hospital care"

Do we need the doctor to document "this patient warrants inpatient care"? I don't think so- Res ipsa loquitur.

How do I Think you can Interpret this Exception?

If life is in immediate jeopardy without near immediate intervention and treatment could result in “cure” in under 2 MN, then admit as inpatient. Factors should be self-evident and treatment should be ordered immediately per standard of care.

Subdural hematoma on dual anti-platelet was also approved- no treatment but life-threatening/high risk

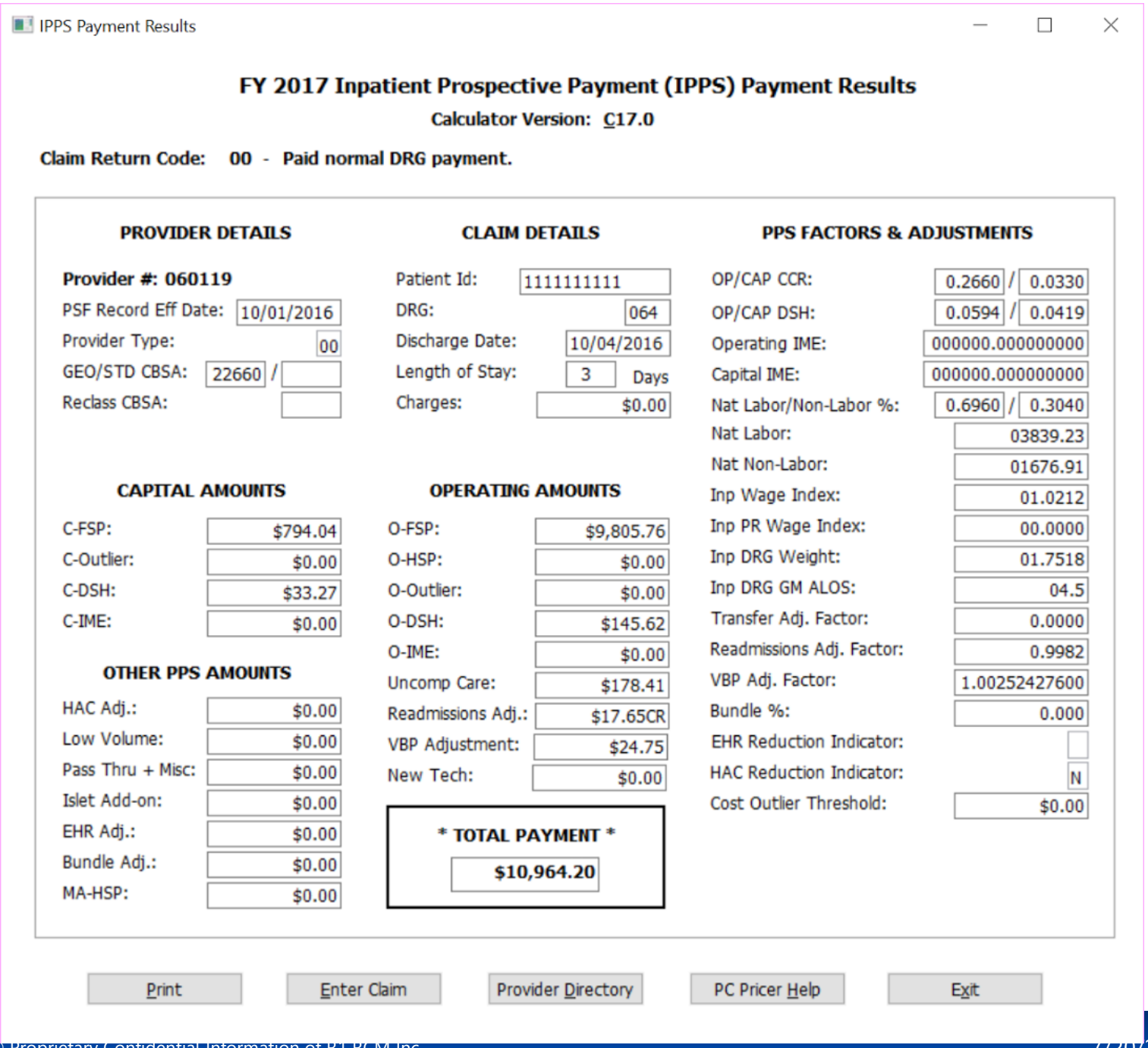
Stroke was approved- use at your own risk- good documentation mandatory

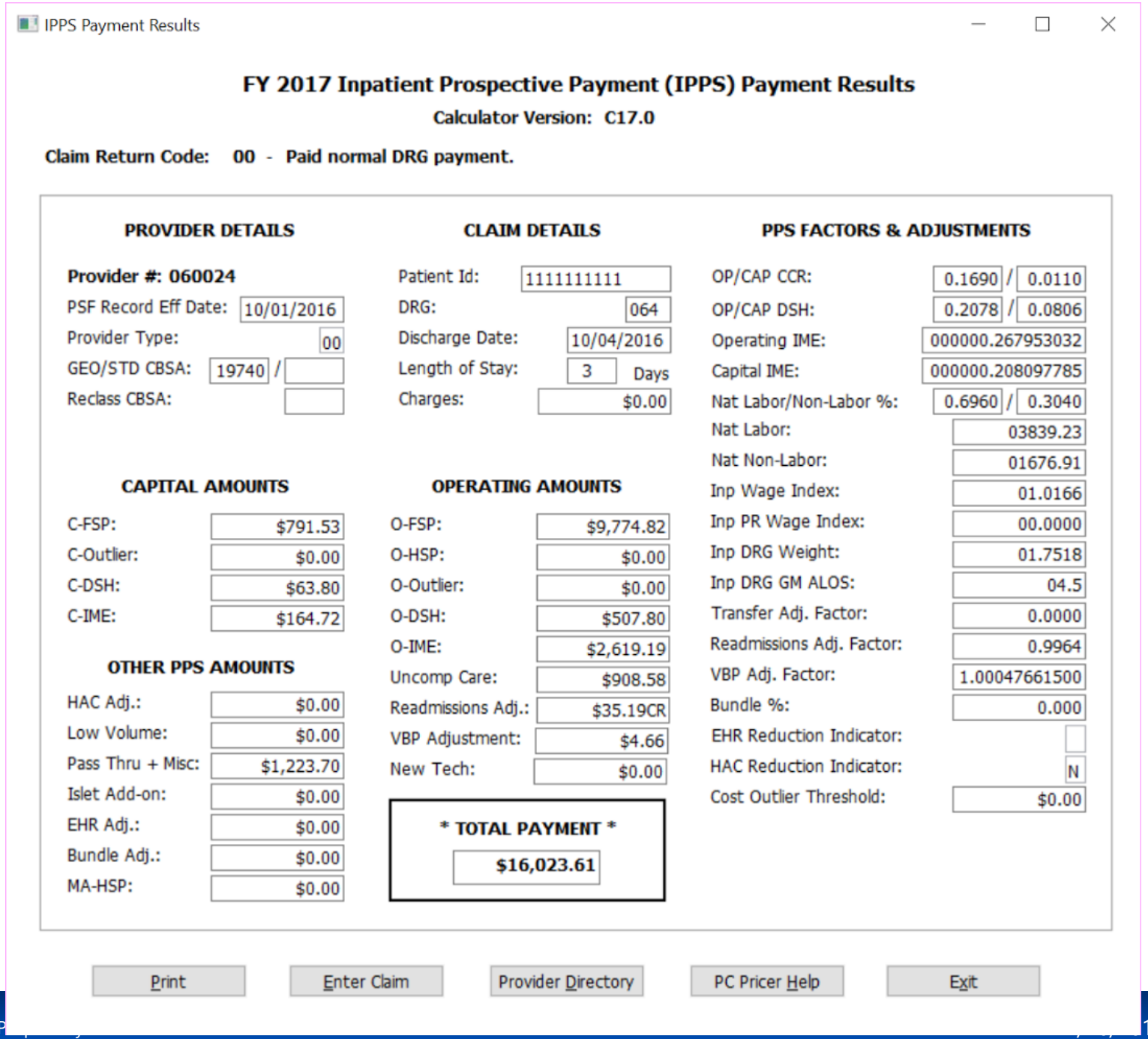
How Hospitals are Paid-- DRG Assignment

TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2017

MS-DRG	FY 2017 FINAL Post-Acute DRG	FY 2017 FINAL Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
064	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.7518	4.5	6.1
065	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0431	3.3	4.0
066	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.7464	2.3	2.7

Post-acute DRG- DRG payment/GMLOS=per diem. Per diem x2 for day 1, then per diem for add'l days, up to total DRG.
Special Final DRG- DRG payment/GMLOS=per diem Day 1= 50% total DRG plus 50% of per diem rate, Day 2 on= 50% of per diem, up to total DRG.


IPPS Payment Results
FY 2017 Inpatient Prospective Payment (IPPS) Payment Results
Calculator Version: C17.0
Claim Return Code: 00 - Paid normal DRG payment.
PROVIDER DETAILS
Provider #: 060119
PSF Record Eff Date: 10/01/2016
Provider Type: 00
GEO/STD CBSA: 22660 /
Reclass CBSA:
CLAIM DETAILS
Patient Id: 1111111111
DRG: 064
Discharge Date: 10/04/2016
Length of Stay: 3 Days
Charges: $0.00
PPS FACTORS & ADJUSTMENTS
OP/CAP CCR: 0.2660 / 0.0330
OP/CAP DSH: 0.0594 / 0.0419
Operating IME: 000000.000000000
Capital IME: 000000.000000000
Nat Labor/Non-Labor %: 0.6960 / 0.3040
Nat Labor: 03839.23
Nat Non-Labor: 01676.91
Inp Wage Index: 01.0212
Inp PR Wage Index: 00.0000
Inp DRG Weight: 01.7518
Inp DRG GM ALOS: 04.5
Transfer Adj. Factor: 0.0000
Readmissions Adj. Factor: 0.9982
VBP Adj. Factor: 1.00252427600
Bundle %: 0.000
EHR Reduction Indicator:
HAC Reduction Indicator: N
Cost Outlier Threshold: $0.00
CAPITAL AMOUNTS
C-FSP: $794.04
C-Outlier: $0.00
C-DSH: $33.27
C-IME: $0.00
OPERATING AMOUNTS
O-FSP: $9,805.76
O-HSP: $0.00
O-Outlier: $0.00
O-DSH: $145.62
O-IME: $0.00
Uncomp Care: $178.41
Readmissions Adj.: $17.65CR
VBP Adjustment: $24.75
New Tech: $0.00
OTHER PPS AMOUNTS
HAC Adj.: $0.00
Low Volume: $0.00
Pass Thru + Misc: $0.00
Islet Add-on: $0.00
EHR Adj.: $0.00
Bundle Adj.: $0.00
MA-HSP: $0.00
* TOTAL PAYMENT *
$10,964.20
Print
Enter Claim
Provider Directory
PC Pricer Help
Exit


IPPS Payment Results
FY 2017 Inpatient Prospective Payment (IPPS) Payment Results
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PSF Record Eff Date: 10/01/2016
Provider Type: 00
GEO/STD CBSA: 19740 /
Reclass CBSA:
CLAIM DETAILS
Patient Id: 1111111111
DRG: 064
Discharge Date: 10/04/2016
Length of Stay: 3 Days
Charges: $0.00
PPS FACTORS & ADJUSTMENTS
OP/CAP CCR: 0.1690 / 0.0110
OP/CAP DSH: 0.2078 / 0.0806
Operating IME: 000000.267953032
Capital IME: 000000.208097785
Nat Labor/Non-Labor %: 0.6960 / 0.3040
Nat Labor: 03839.23
Nat Non-Labor: 01676.91
Inp Wage Index: 01.0166
Inp PR Wage Index: 00.0000
Inp DRG Weight: 01.7518
Inp DRG GM ALOS: 04.5
Transfer Adj. Factor: 0.0000
Readmissions Adj. Factor: 0.9964
VBP Adj. Factor: 1.00047661500
Bundle %: 0.000
EHR Reduction Indicator:
HAC Reduction Indicator: N
Cost Outlier Threshold: $0.00
CAPITAL AMOUNTS
C-FSP: $791.53
C-Outlier: $0.00
C-DSH: $63.80
C-IME: $164.72
OPERATING AMOUNTS
O-FSP: $9,774.82
O-HSP: $0.00
O-Outlier: $0.00
O-DSH: $507.80
O-IME: $2,619.19
Uncomp Care: $908.58
Readmissions Adj.: $35.19CR
VBP Adjustment: $4.66
New Tech: $0.00
OTHER PPS AMOUNTS
HAC Adj.: $0.00
Low Volume: $0.00
Pass Thru + Misc: $1,223.70
Islet Add-on: $0.00
EHR Adj.: $0.00
Bundle Adj.: $0.00
MA-HSP: $0.00
* TOTAL PAYMENT *
$16,023.61
Print
Enter Claim
Provider Directory
PC Pricer Help
Exit

Payment For Various Stays

ED visit, 6 hrs Obs, discharge = ~$500

Outpatient Part B- 131 type of bill

< 8 hours Obs so no payment for Observation services

(Payment for the Observation “bundle” requires 8+ hours of Observation exclusive of carve outs)

Pay for ED visit as Ambulatory Payment Classification (APC), other payable tests

Payment For Various Stays

ED visit, 10 hrs Obs, discharge = $2,227

Outpatient Part B- 131 type of bill

Comprehensive-APC 8011- includes all services from ED arrival to discharge- “mini-DRG”

payable when 8+ hours Observation

Payment For Various Stays

ED visit, 42 hrs Obs discharge = $2,227

Outpatient Part B- 131 type of bill

Comprehensive-APC 8011- includes all services from ED arrival to discharge- “mini-DRG”

payable when 8+ hours Observation

NOTE: Same payment if 10 hours or 42 hours of Observation!

Payment For Various Stays

ED visit, 8+ hrs Obs, EGD, discharge = ~$1,250

Outpatient Part B- 131 type of bill

EGD is Status Indicator=T (on Addendum B) so C-APC for Observation cannot be paid

Pay for ED visit APC, EGD APC, other payable tests

All Obs hours provided for free!

Payment For Various Stays

ED visit, any Obs, lap chol'y, dc < 2MN =~$4,200

Outpatient part B- 131 type of bill

C-APC for surgery- all services from ED to discharge

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate
47562	Laparoscopic cholecystectomy	J1	5361	55.9877	$4,199.13

No pay for ED visit or any Observation hours

Payment For Various Stays

Scheduled Lap chol'y = ~$4,200

Outpatient part B- 131 type of bill

C-APC for surgery- from arrival to discharge

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate
47562	Laparoscopic cholecystectomy	J1	5361	55.9877	$4,199.13

Exactly same payment as the ED patient with higher costs!

Payment For Various Stays

ED visit, Obs over 1 MN, lap chol'y, stays after second midnight for standard recovery, dc > 2 MN

Inpatient part A- 111 type of bill

DRG for inpatient admission of ... $12,200

MS-DRG	FY 2017 FINAL Post-Acute DRG	FY 2017 FINAL Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
417	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.3944	5.5	6.9
418	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6499	3.9	4.7
419	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.2619	2.5	3.0

Payment For Various Stays

Outpt lap chol'y then 2 MN due to complication

Inpatient part A- 111 type of bill

DRG for inpatient admission for complication with surgery ~ $13,100

Thanks!

- No questions now

- Feel free to email me
  - rhirsch@R1rcm.com

  - Join American College of Physician Advisors
    - ACPAdvisors.org

  - Listen to Monitor Monday and Finally Friday