RAC Summit
Update on a Bunch of Things Separated by Slides with Just a Title so You Know to Reset your Brain

R1 Physician Advisory Services

My $0.02 on Total Knee Replacement

The Two Midnight Rule- Multiple Components

- Two Midnight Expectation from start of symptom-related care
- Inpatient Only Surgery
- Unexpected mechanical ventilation
- Case-by-case exception

Case-by-Case Exception

- Expectation of less than two midnights
  - But rarely under 24 hours so really “expectation of one midnight”
- Physician judgment inpatient care warranted in that particular case
  - The beneficiary history and comorbidities
  - The severity of signs and symptoms
  - Current medical needs
  - The risk of an adverse event
- NOT rare and unusual!!!!

Expect One Midnight but Warrant Inpatient

- Very sick patient who can be quickly cured- AMI, DKA, ESRD w/EKG changes, 3° heart block

- Higher risk patient having a surgery
  - This is where TKR fits
  - Are there any conditions that increase risk of surgery?
  - Poorly controlled disease ≠ uncontrolled disease

□ Admission as an inpatient is reasonable and necessary due to increased risk of surgery due to the factors indicated below or to the need for prolonged in-hospital or skilled post-acute care in order to improve this patient's functional ability.

But what will the QIOs and MACs and RACs do?

- Don’t let fear of an auditor misinterpreting the rule stop you from following the rule the way CMS intended it.
- Call them on their mistakes.
- Take notes, get names, contact the auditor and CMS.

What's the Big Deal about Status?

“We Treat all Patients the Same”

- Payer agnostic policies are as far from patient-centered as you can get.
  - Prescribe drug off formulary- not filled, can’t treat disease
  - Send to out of network physician- can’t pay for visit so cancels
  - Order imaging at out of network facility- test never done

- Status determinations are not treating the patient- it is purely about payment. Status does not determine which treatments are given and when the patient goes home.

Why Do You Want Inpatient Admission for Medicare?

- Access to Part A SNF benefit requires 3 inpatient days not counting day of discharge
- DRG usually pays more than APC
- Patient with recent admission has no deductible
- Patients think they are better as inpatient

but

- A patient cannot be “readmitted” after an Obs stay
- Unlikely an Obs stay will be audited or denied
- A lot less paperwork for nurses for Obs

But What about Commercial Payers?

- No 3 day SNF requirement, no 2 MN Rule

- Which status would you request from Payer A for TKR?
  - Inpatient– pays DRG of $20,000
  - Outpatient- pays 80% of charges- charge is $30,000

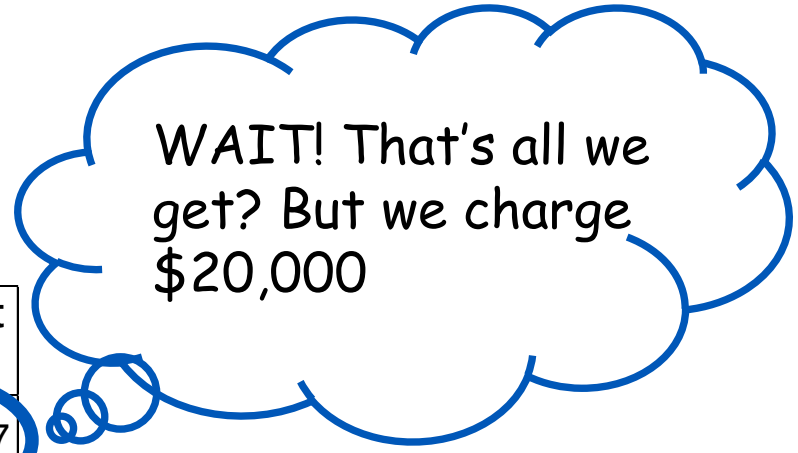
- What about 4 day stay for pneumonia from payer B?
  - DRG of $8,000
  - Observation per diem of $2,500

- Have you ever seen your contracts? Are you demanding to be paid less?

Short Lesson in Surgery Status and Payment

Inpatient Only List for Medicare Patients

- Addendum E of OPPS Rule
- Status Indicator= C on Addendum B



HCPCS Code	Short Descriptor	SI	APC	Payment Rate
47562	Laparoscopic cholecystectomy	J1	5361	$4,488.37
47563	Laparo cholecystectomy/graph	J1	5361	$4,488.37
47564	Laparo cholecystectomy/explr	J1	5361	$4,488.37
47570	Laparo cholecystoenterostomy	C		
47579	Laparoscope proc biliary	J1	5361	$4,488.37
47600	Removal of gallbladder	C		
47605	Removal of gallbladder	C		
47610	Removal of gallbladder	C		
47612	Removal of gallbladder	C		
47620	Removal of gallbladder	C		

How does this Work?

- Find out what procedure is planned
- Find CPT code for hospital billing (may be different than physician code)
- Look up on addendum B
- If SI=C, get admission order pre-op (or within 3 days)
- If SI≠C, determine if extenuating circumstances
  - Already an inpatient
  - Will need over 2 MN due to unique circumstances
  - Qualifies for case-by-case exception to be inpatient
    - But be careful! Outpatient may pay better
      - What does that mean? Let's see…

The Acute MI with an Expected 1 Day LOS

- What's the procedure code for cath with stent in AMI?
  - Physician coding- 92941- PCI during Ac MI- inpatient only
  - Facility code- C9606-PCI during Ac MI with DES- not inpatient only
    - Accounts for added cost of drug eluting stent c/w bare metal stent
- If use case-by-case exception, DRG for Ac MI- 247
- If don't use case-by-case, C-APC for Ac MI with PCI- 5194

Hospital	DRG 247	APC 5194
Community #1	$13,892	$15,750
Community #2	$12,254	$14,320
Teaching	$18,676	$14,917

- Can hospitals recommend physician pick status based on reimbursement if both are compliant? Remember- same doctor, same care, just different payment structure.

It’s PEPPER Time!

Program for Evaluating Payment Patterns Electronic Report

- Fee For Service Medicare only
  - If lots Medicare Advantage, your data may be insufficient for conclusions
- Released Quarterly ~ 5-6 months after quarter for acute care; yearly for others- SNF, Hospice, Psych, CAH, IRF, LTCH, PHP, HHA
- Fiscal Quarters- Q1- Oct-Dec, Q2- Jan-Mar, Q3-Apr-June, Q4- July-Sept
- Data is always at least 6 months old and your internal data will rarely match PEPPER data- need data analyst for performance improvement projects to reproduce data
- All contractors have access to same data through FATHOM- First-look Analysis Tool for Hospital Outlier Monitoring (which providers cannot get)

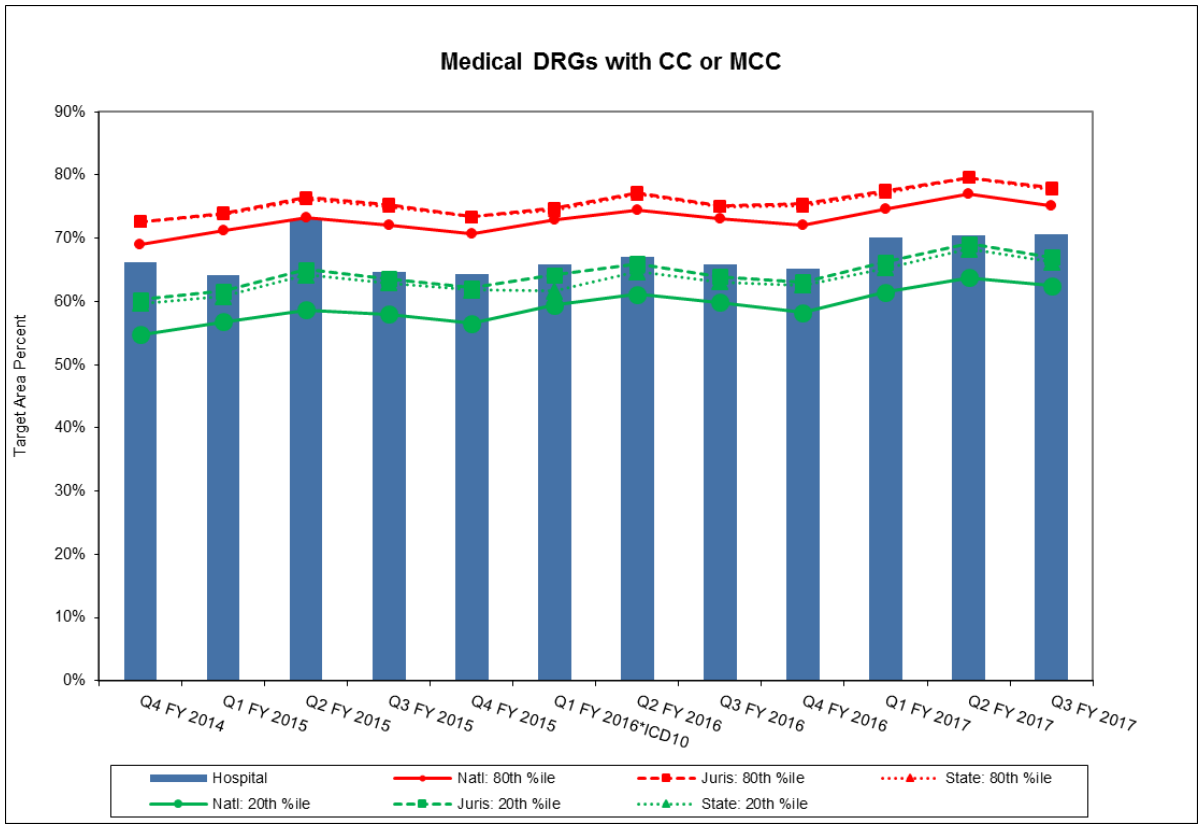
Strive for Accuracy not Mediocrity

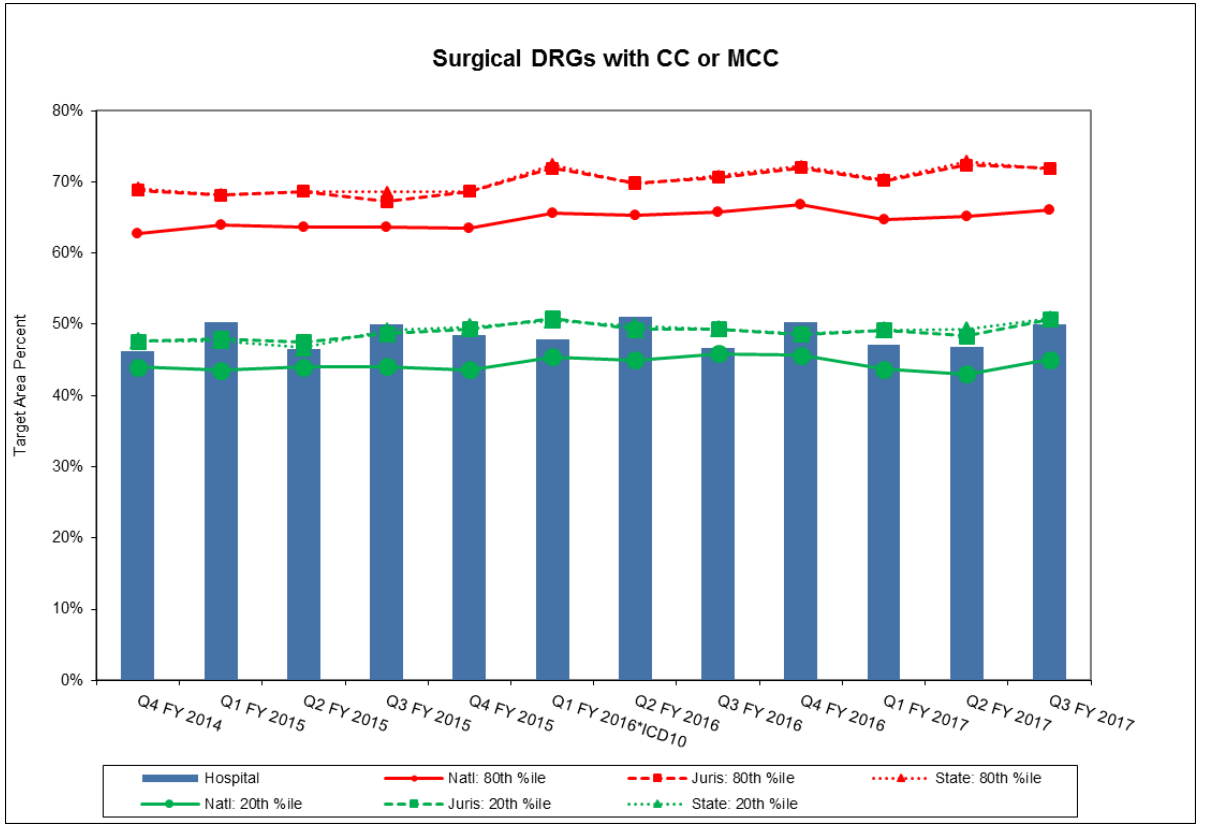
- PEPPER determines outliers based on preset control limits. The upper control limit for all target areas is the national 80th percentile. Areas at risk for undercoding also have a lower control limit, which is the national 20th percentile.

- If top 20% and bottom 20% are outliers, that leaves only 60% inliers.

- Being an outlier is not necessarily bad. If your patients really are sicker than everyone else's, you should be at or above 80th%ile.

CC and MCC Capture- Medical and Surgical





Q4 FY 2016	590	905	65.2%
Q1 FY 2017	629	898	70.0%
Q2 FY 2017	734	1,042	70.4%
Q3 FY 2017	665	941	70.7%

Q4 FY 2016	208	414	50.2%
Q1 FY 2017	196	416	47.1%
Q2 FY 2017	194	414	46.9%
Q3 FY 2017	191	382	50.0%

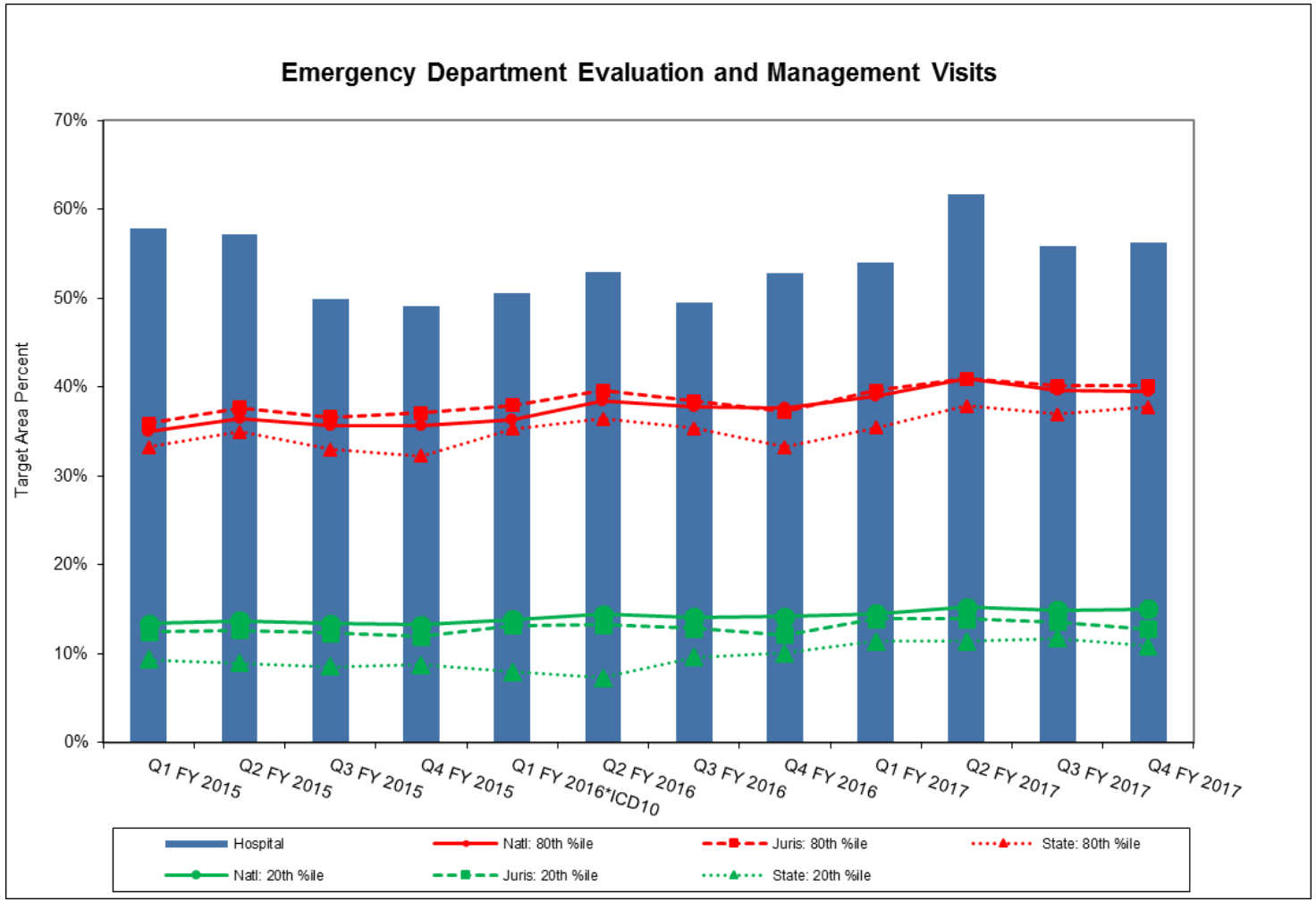
Show your CFO the Money to get the FTEs

		Community	Teaching
DRG 177 RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC		$12,548	$26,477
DRG 178 RESPIRATORY INFECTIONS & INFLAMMATIONS W CC		$9,199	$19,588
DRG 179 RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC		$6,997	$15,059
DRG 329 MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC		$31,010	$64,455
DRG 330 MAJOR SMALL & LARGE BOWEL PROCEDURES W CC		$16,274	$34,143
DRG 331 MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC		$11,493	$24,308

But do CDI to accurately capture the acuity of your patients

- O/E mortality, LOS, cost, PAC use, readmission rate
- Lots more data going public
- Which doc will the ACO choose when contracting?

New for Q4 2017- ED Facility Fee Billing 99285



99281
99282
99283
99284
99285
99291

Same codes as doctors but not same code assignment rules.

UHC automatically downgrading facility ED E&M codes per their algorithm.

Also New – Spending Per Beneficiary

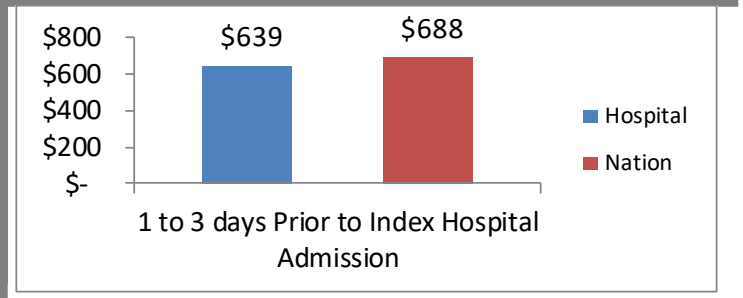
St Elsewhere Hospital Compared to the **Nation**

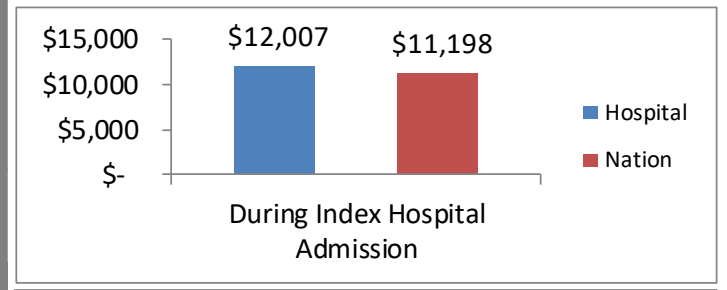
A quick look at where your hospital spent more or less than the national median hospital in CY 2016

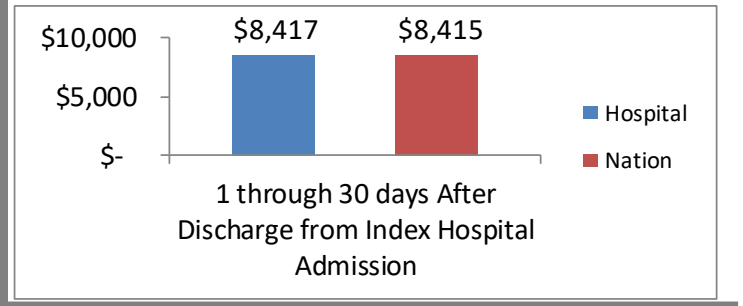
How did spending by Claim Type compare to the Nation?

	Avg Spending Per Episode Hospital	Greater or Less Than Nat'l Median Hospital
Inpatient	$ 12,201	-2%
Carrier (Physician / Supplier)	$ 3,304	7%
SNF	$ 3,772	25%
Outpatient	$ 780	-5%
HHA	$ 796	12%
Hospice	$ 125	2%
DME	$ 85	-24%

How did spending by Episode phase compare to the Nation?

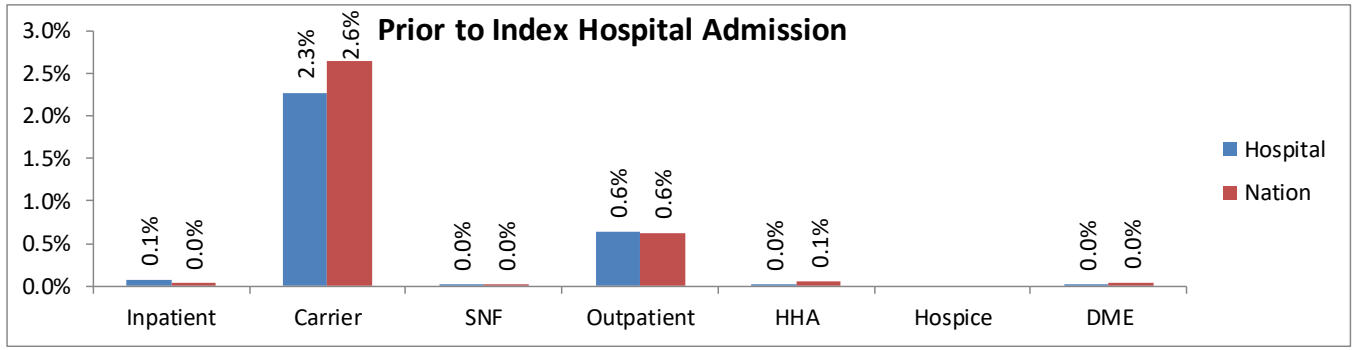


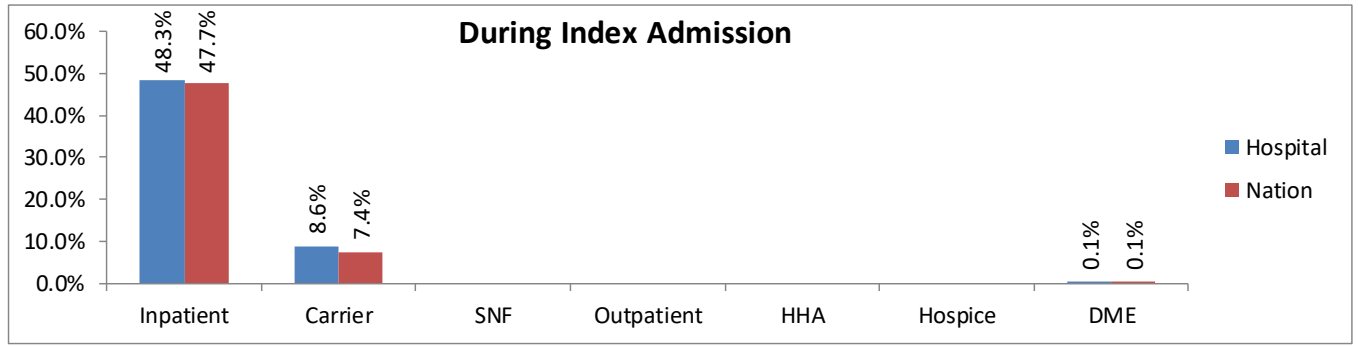


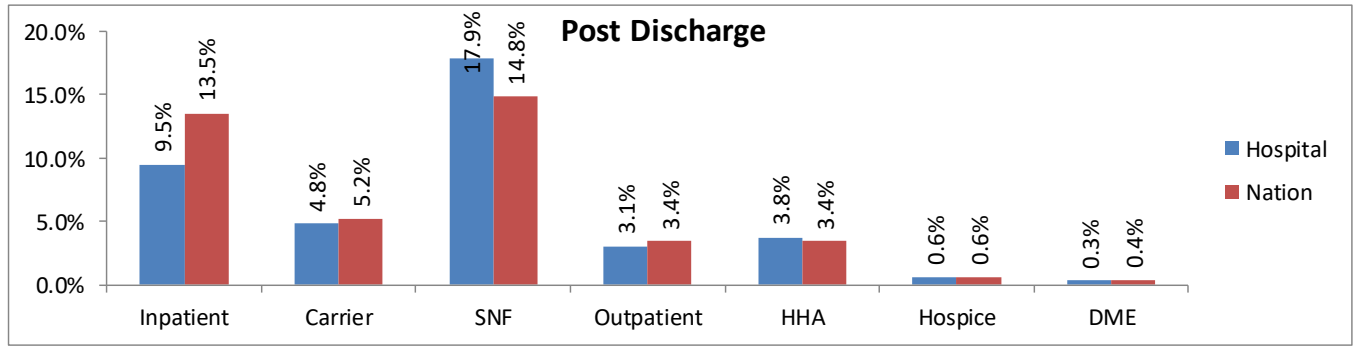


Broken Down by Pre-Admission, During, and Post-Discharge

Which cost centers were the major drivers of each phase of the episode?







Percentages may display as zero due to rounding

That Pesky Admission Order

History

- 2014 IPPS Final Rule established admission order authenticated prior to discharge as a condition of payment.

- Multiple denials by MACs and QIOs for lack of authentication.

2019 IPPS Proposed Rule

- CMS says “It was not our intent when we finalized the admission order documentation requirements that they should by themselves lead to the denial of payment for otherwise medically reasonable necessary inpatient stay, even if such denials occur infrequently.”

- (Maybe they should have told the MACs and QIOs that!!)

We'll Make it Up to You

- We are proposing to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment.

We'll Make it Up to You

- We are proposing to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment.

BUT…

- This proposal does not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission.

What does that Mean?

- Late signature?
- No signature?
- NPPs ordering admission?
- What about inpatient only surgery?
- What about the inpatient that should have been outpatient? Can we still “ignore” the order?
- Do we ever need an admission order?

What Does CMS Have in the 2019 OPPS Proposed Rule?

- No rule as of date Day made me turn in slides.
- What will be allowed at ASCs? Any clarification on total knees? What about hips?
- What surprises will be proposed?