Mobile Medical Review Team

Observation Services & the 2 Midnight Rule

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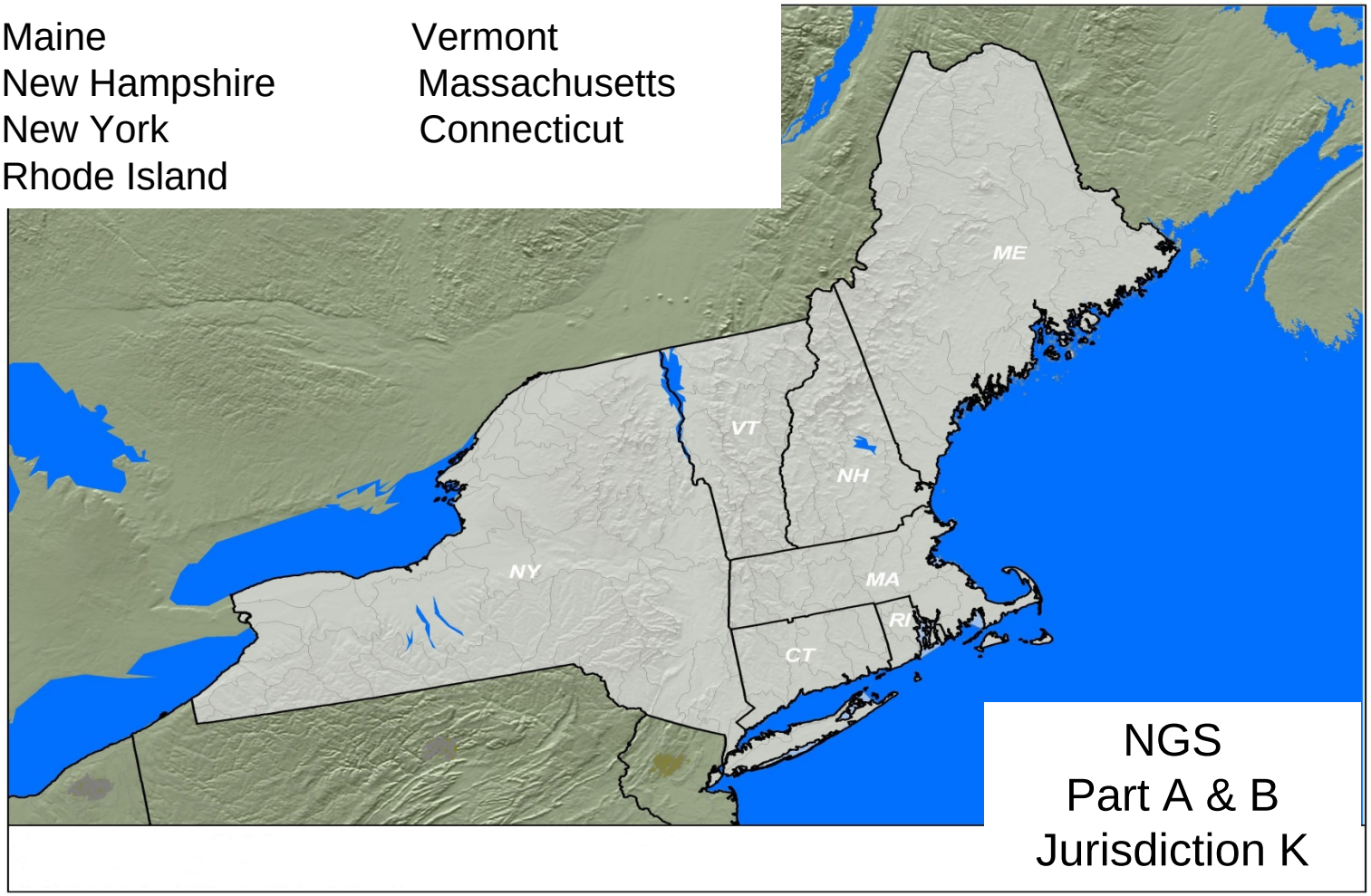

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Medicare Part A/B Differentiation

Part A

- Inpatient**
- Hospital
- Skilled Nursing Facilities

Part B

- Outpatient
- Hospitals
- Clinics
- Ambulatory Surgery Centers

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Mobile Medical Review Team
Jurisdiction K --Part A

Medical Directors:

- Laurence Clark, MD
- Stephen Boren, MD

J/K Operational Manager:

- Julia Meehan, MBA

Senior Medical Review Nurses:

- Cindy Mancill BSN, RN, CCM, CPHM
- Nancy Krupka BSN, MS
- Kay Osadchey RN, CCM, CPHM
- Jan Sawyer BSN
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- Mandy Zinger-Gutchess RN, CPHM

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Mobile Medical Review Team Onsite Visits

PRIOR to Onsite Visit

- MMR Notification Letter Sent to CFO

DURING Onsite Visit

- **Conference (Approx. 2 Hours)**
  - Introductions
  - PPT Presentation
  - Review of Findings (Including Facility BEST PRACTICES)
  - 1:1 Consulting Call with NGS Medical Director (when available)
  - Q&A
  - Surveys

AFTER Onsite Visit

- MMR Results Letter Sent via USPS

The Notification Letter includes10 original medical records that were originally DENIED by the Medical Review Staff for "Not Reasonable & Necessary Inpatient Services"

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Mobile Medical Review Team
Current Focus & Goals

Current Focus:

- Medical Necessity of Short-Stay Inpatient Admissions

Onsite Visit Goals:

- Provide an interactive educational opportunity for hospital clinicians.
- Identify and report facility best practices.
- Review & discussion of denied claims to assist in comprehension of the new “2 Midnight Rule” from CMS
- Provide resources to assist facility in addressing areas of concern.
- Provide a contact person for questions pertaining to proper utilization of Part A inpatient admissions.

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Observation

Definition: Set of specific, clinically appropriate services which include ongoing short term treatment, assessment and reassessment **before a decision can be made regarding whether patients will require further treatment as hospital inpatients** or if they are able to be discharged from the hospital.

Medicare Benefit Policy Manual 100-02 Chapter 20.6, B Coverage of Outpatient Observation Services

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Observation Services

Documentation for Observation Services and Inpatient Admissions must support medically reasonable and necessary care

- Medicare does **not** provide payment for custodial care
- Observations may span up to **2 Midnights**
- When the patient is stable and/or improving and the physician is excluding diagnosis/diagnoses- **consider observation services**
- When evaluating the patient and the treatment plan includes “monitor” and/or “observe”- **consider observation services**
- Medicare has no rule about designated “observation beds” - any bed may be assigned
- Transfer’s received should be evaluated upon arrival and a decision to admit as an inpatient or place in observation is based on the evaluation - not just the status of the patient from the transferring facility
- Apply screening criteria at the time the status decision is made - not necessarily upon presentation to the ED

The physician may convert from Observation to Inpatient Admission at any time during the hospital stay when the patient’s condition requires increasing services over a longer period of time

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Skilled Nursing Facility Stays

- The beneficiary must have a stay of 3 inpatient admission days before they qualify for the Skilled Nursing admission.
- Outpatient observation services do not count towards the three day qualifying hospital stay
- ***This rule has not changed in light of the new two midnight rule.***

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Outpatient Procedures

- Comorbid conditions have been successfully managed prior to scheduled outpatient procedure dates.
- Many of these patients have specialty clearance allowing for outpatient procedures.
- Outpatient surgery from the emergency room does not automatically mean the patient is admitted as an inpatient.

- ***Remember: Outpatient procedures that are billed as inpatient should have documentation to support the need for inpatient status.***

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General Rule for 0-1 Midnight Stays

- When a patient enters a hospital for a surgical procedure *(not specified by Medicare as inpatient only under 42 C.F.R 419.22(n), diagnostic test, or any other treatment)* and the physician expects to keep the patient in the hospital for 0-1 midnights, the services are generally inappropriate for inpatient admission and inpatient payment under Medicare part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed.

- CMS directs Contractors to deny these inappropriate admissions unless unforeseen circumstances shortened the stay or there are other rare or unusual circumstances that necessitate an inpatient admission.

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In Brief:

- Outpatient surgical procedures do not support inpatient admission, unless there is documented evidence of clinical complications

- The hour of the patient's arrival or the location in which the patient was treated do not play a role in supporting inpatient status.

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Appropriate Short Inpatient Hospital Stays

- If an unforeseen circumstance results in a shorter beneficiary stay than the physicians reasonable expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis and hospital inpatient payment may be made under Medicare Part A. Such circumstances must be documented in the medical record in order to be considered upon medical review.

- **Examples include:**
  - Death
  - Transfer to another hospital
  - Departure against medical advice
  - Clinical improvement where the patient stayed less than the expected 2 midnights

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In Brief:

- The physician's admitting note may correctly describe and support inpatient admission, even in circumstances that change and result in faster improvement and discharge than originally anticipated.

- The key factor here is an admission note that supports a reasonable and medically necessary plan of care, over an estimated timeframe of a period exceeding beyond 2 Midnights

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Inappropriate Short Inpatient Hospital Stays

Situations that do **not** represent instances in which an inpatient admission would be appropriate without an expectation of a 2 midnight hospital stay:

- CMS does not believe that the use of **telemetry**, by itself, is the type of rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. We note that telemetry is neither rare nor unusual, and that it is commonly used by hospitals on outpatients (ER and observation patients) and on patients fitting the historical definition of outpatient observation; that is, patients for whom a brief period of assessment or treatment may allow the patient to avoid a hospital stay.

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Inappropriate-- Short Inpatient Hospital Stays

Situations that do **not** represent instances in which an inpatient admission would be appropriate without an expectation of a 2 midnight hospital stay:

- Beneficiaries admitted to **Intensive Care Unit (ICU).** As CMS specified in the final rule, the use of an ICU, by itself, would not be the type of rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. An ICU label is applied to a wide variety of facilities providing a wide variety of services. Due to the wide variety of services, that can be provided in different areas of a hospital, CMS does not believe that a patient assignment to a specific hospital location, such as a certain unit or location, would justify an inpatient admission in the absence of a 2-midnight expectation.

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In Brief

- Use of telemetry services, or placing a patient in an ICU environment for care, do not, as isolated factors, support medical necessity for inpatient admission.

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CMS Directive to Contractors for Patient Status Reviews –

Documentation Requirements

- Do not review any Procedure on Inpatient-Only List
- Evaluate whether, at the time of the admission order, it was reasonable for the admitting practitioner to expect the beneficiary to require medically necessary services (incl. inpatient & outpatient services) over a period of time spanning at least 2 midnights.
- The beneficiary's medical necessity assessment is whether clinical presentation, prognosis, and expected treatment support the expectation of the need for hospital care spanning 2 or more midnights
- Severity of Illness and intensity of services are complex medical factors to consider when assessing whether the physician was reasonable in forming his or her expectation that a beneficiary required hospital services for 2 or more midnights.

- ***It is not necessary for a beneficiary to meet inpatient "level of care" as defined by a commercial screening tool, in order for Part A payment to be appropriate.***
- ***Just because a beneficiary meets inpatient level of care as defined by a commercial screening tool, this does not mean that a DRG Part A payment is appropriate.***

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CMS Directive to Contractors for Patient Status Reviews –

Documentation Requirements

- The **2 Midnight Benchmark** is based upon the physician's expectation of the required duration of medically necessary hospital services at the time the inpatient order is written and the formal admission begins.

- Consider all documented complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2 midnight benchmark, **including all of the following:**
  - Patient History/Co-morbidities
  - Severity of signs and symptoms
  - Current Medical Needs
  - Risk/Probability of an adverse event occurring during the time period for which hospitalization is considered

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CMS Directive to Contractors for Patient Status Reviews – 2 Midnight Benchmark

- Time the beneficiary spent receiving outpatient services within the hospital prior to inpatient admission, in addition to the post-admission duration of care. This pre-admission time may include services such as:
  - Observation services
  - Treatment in the emergency department
  - Procedures provided in the operating room or other treatment areas
  - If the beneficiary arrives through the emergency room the clock starts ticking when the beneficiary starts receiving care.
  - For other methods of arrival, the starting point is when the beneficiary starts receiving services following arrival to the hospital. Wait times prior to the initiation of care (ex: ED waiting room) and triaging activities will not be considered.

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In Brief

- MACs will **not** review claims for Inpatient-Only services
- Medical necessity drives these reviews: does the clinical picture correlate with the physician's estimate for care beyond 2 Midnights?

- ***We are awaiting final instructions from CMS on whether billable diagnostic services OR initiation of care by a physician or NPP starts the count toward 2 Midnights – CMS has already established that triage and subsequent time in the waiting room are not to be included in this time assessment***

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Claims for Admissions that Span 2 or More Midnights

2 Midnight Presumption

- Hospital stays spanning 2 or more midnights after beneficiary formally admitted as inpatient pursuant to physician order will be presumed to be reasonable & necessary for inpatient status as long as the stay at the hospital is medically necessary
- CMS has directed Contractors NOT to focus medical review efforts on stays spanning at least 2 midnights after admission absent evidence of systemic gaming, abuse, or delays in the provision of care, in an attempt to qualify for the 2 midnight presumption.

- ***Contractors may review these claims as part of routine monitoring activity or as part of other targeted reviews***

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Claims For Hospital Admissions That Span 0-1 Midnight

- Inpatient stays spanning 0-1 midnight after the beneficiary is formally admitted as an inpatient are not subject to the presumption and may be selected for review.

- If total time in the hospital receiving medically necessary care (*including pre-admission outpatient time from the time care is initiated in the hospital*) spans 2 or more midnights, the **2-midnight benchmark** for inpatient admission will be met and payment supported upon medical review.

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In Brief

- Inpatient stays of 2 Midnight duration after the decision for admission will carry a presumption of medical necessity
- Inpatient stays of 0-1 Midnight duration after the decision for admission will not carry a presumption of medical necessity and may be subject to review
- Hospitals need to avoid unusual delays in providing care, which may infer an abusive “gaming” pattern

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Status Decision Making

A "**TWO-STEP**" Process

- **Step One:** Is there medical necessity for facility services or can this patient be discharged home?

- **Step Two:** Beyond the ensuing "two-midnights", refer the patient to Inpatient Admission, based on a full assessment of care requirements and anticipated time frames.

Reminder: *Apply inpatient guidelines at the time of patient status decision, not at the point of arrival*

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Two Step Process

STEP ONE:

- Establish a probable or differential diagnosis and treatment plan

- The determination- Can the patient be discharged home?

  YES = Release Home

  NO= Proceed to Step Two

STEP TWO:

Definitive Diagnosis-Patient requires definitive multi day diagnostics &/or therapeutic treatments (longer than "two-midnights") = **INPATIENT**

- Patient remains unstable= **INPATIENT**

***Refer to Handout*

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Observation to Inpatient Admission Claims

All Time/Days Captured in DRG

January 1	January 2	January 3	January 4
ED OBS at 1800	OBS Ended At Noon / Inpt Admit	Inpatient	Inpatient Until D/C Home
6 hours/Units Observation	12 hours/Units Observation		

TOB= 111 (Inpatient Claim)
DOS = From 01/01 – To 01/04
Admission Date = 01/02
Revenue Code= (0762 Observation) 18 Units

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Condition Code 44

Changing an Inpatient Admission to an Outpatient Observation Status

- Must occur prior to patient discharge
- The beneficiary should be notified in writing of status change and fiscal responsibilities that correlate with Medicare Part B observation
- Admitting Physician & Utilization Review Physician must concur and both document appropriately the reason for the status change
- The beneficiary has appeal rights to the QIO

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Orders for Observation Status and Inpatient Admissions

✓ **"Place in Observation" or "Refer to Observation"**

- When **outpatient observation** services is the physician's intent.

✓ **"Admit to Inpatient"**

- When **inpatient admission** is the physician's intent.

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Practitioner Orders

A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner. **All of the following** will be considered in an effort to reinforce the policy that the physician should be involved in the determination of patient status and to improve clarity among hospitals, beneficiaries, and ordering practitioners regarding whether the beneficiary is being treated as a hospital inpatient or hospital outpatient:

- **CONTENT**
  - specify admission for inpatient services
- **QUALIFICATION OF THE ORDERING/ADMITTING PRACTITIONER**
  - Discussed in further detail on slide #32
  - Verbal/Telephone orders must be authenticated by the ordering practitioner (or another practitioner with the required admitting qualification in his/her own right) in the medical record prior to discharge unless the hospital or state requires an earlier time frame.
- **KNOWLEDGE OF THE PATIENT**
  - Discussed in further detail on slide #32
- **TIMING**
  - The order must be furnished at or before the time of the inpatient admission.
  - Medicare does not permit retroactive orders or the inference of orders. Authentication of the order is required prior to discharge and may be performed and documented as part of the physician certification.
- **SPECIFICITY OF THE ORDER**
  - Must be present in the medical record
  - Must specify the admitting practitioner's recommendation to admit to inpatient, or as an inpatient for inpatient services.

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Referring to Observation

- When a patient status decision determines that the patient will be placed in Observation Status the patient should be notified via signed consent about his/her status.

- This is **mandatory in NY** state & must occur within the first 24 hours of the time the order for observation is written.

- Beneficiary appeal rights do not apply

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Patient Status Appeals

- **Remember:**
  - *Observation is an outpatient status order that is billed on an outpatient Part B claim.*

- Currently the beneficiary has no avenue for appeal of an order written for outpatient observation services.

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Certification of Orders

- When conducting a patient status review, CMS instructs the contractor to assess the hospital's compliance with the admission order, the two midnight benchmark and the certification requirements.
- The physician certification, which includes the practitioner order, is considered along with other documentation in the medical record as evidence that hospital inpatient services were reasonable and medically necessary.
- "Medicare considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician:
  - The admitting physician of record ("attending") or a physician on call for him/her
  - A surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him/her
  - A dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure
  - And, in the specific case of a non-physician, non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above."

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Physician Certification Requirements

Content	Timing	Authorization to Sign the Certification	Format	Default Methodology for Initial Certification
• Authentication of the practitioner order • Reason for inpatient services • Estimated time the beneficiary requires hospitalization • Plans for post hospital care, if appropriate	• Certification begins with the order for inpatient admission • Certification must be completed, signed, dated and documented in the medical record prior to discharge • Outlier cases must be certified and recertified as provided in 42 CFR 424.13	• A Physician who is a doctor of Medicine or osteopathy, dentist in the circumstances specified in 42 CFR 424.12(d), and a doctor of podiatric medicine if his/or her certification is consistent with the functions her or she is authorized to perform under state law. • Must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospitals medical staff ***See previous slide for specific information regarding authorization***	• As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. • The provider may adopt any method that permits verification. • The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a separate form. • Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification.	In the absence of specific certification forms or certification statements, CMS and its contractors will look for the following medical record elements in order to meet the initial inpatient certification requirements: •The authentication requirement for the practitioner order will be met by the signature or countersignature of the inpatient admission order by the certifying physician. •The requirement to certify the reasons that hospital inpatient services are or were medically required will be met either by the diagnosis and plan documented in the inpatient assessment or by the inpatient admitting diagnosis and orders. •The estimated time requirement will be met by the inpatient admission order written in accordance with the 2 Midnight benchmark, supplemented by the physician notes and discharge planning instructions. •The post hospital care plan requirement will be met either by physician notes or by discharge planning instructions.

Plan of Care & Progress Notes

- **The expectation is that all documentation within a medical record will be legible, as sequential as possible; and that the detailed events (including dates, times, and data) will correspond accordingly.**

- **The Plan of Care & Progress Notes Should Include:**
  - Specifically whether services are Outpatient/Observation or Inpatient at the time of the documentation.
  - Date, time, diagnosis, plan, & legible signature.
  - The anticipated time-frame for completion of the defined treatment plan.
  - Any & all rationale or events that precipitated any change in patient status from Observation to Inpatient Services.

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Probe & Educate Program

Centers for Medicaid & Medicare Directive to Contractors

- Admissions on or after October 1, 2013 thru March 31, 2014
- Patient status reviews for claims submitted by acute care inpatient facilities, long term care hospitals, and inpatient psychiatric facilities
- Determine hospital compliance with CMS-1599-F which focuses on the appropriateness of an inpatient admission versus treatment on an outpatient basis **INCLUDING**:
  - **Admission Order Requirements** (http://ww.cms.gov/center/provider-type/hospital-center.html)
  - **Certification Requirements** (http;//www.cms.gov/center/provider-type/hospital-center.html)
  - **2 Midnight Benchmark**

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Initial Probe Reviews

- **Admissions on or after 10/1/13**
  - Contractor to select 10 claims for prepayment review (25 claims for large hospitals) & based on results of these
  - Deny claims found to be out of compliance with CMS 1599-F
  - Based on results Contractor to conduct educational outreach efforts during the next 3 months.

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Initial Probe Reviews – Educational Outreach Efforts

Providers with moderate/significant or major denial/non-compliance issues/concerns will be offered education from the Contractor via 1:1 telephone conferencing

Educational Call:

- Discuss reasons for denials
- Provide education
- Deliver reference materials
- Answer any questions

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Additional Probe Reviews

Those providers identified as having moderate/significant or major concerns will be placed on additional probe reviews on claims with dates of admission between January and March 2014

- 10 additional claims (25 for large facilities) for providers with moderate/significant concerns
- 100 additional claims (250 for large facilities) for providers with major concerns

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Of Claims In A Sample That Did NOT Comply With Policy (Dates of Admission 10/13 – 3/14)

	No or Minor Concerns	Moderate to Significant Concerns	Major Concerns
10 Claims Reviewed	0-1 Concerns	2-6 Concerns	7+ Concerns
25 Claims Reviewed	0-2 Concerns	3-13 Concerns	14+ Concerns
Action	**Contractor Direction from CMS:** •Deny Non Compliant Claims •Send Summary Letter Indicating Claims Denied & Reason for Denials •Explain that no more reviews will be conducted under the Probe & Educate process •Explain that the provider will be subjected to the normal data analysis and review process	**Contractor Direction from CMS:** •Deny Non Compliant Claims •Send detailed review results letters explaining each denial •Send summary letter offering 1:1 telephone call to discuss and indicate the contractor will repeat Probe & Educate process with 10 or 25 claims •Repeat Probe & Educate of 10 or 25 claims with dates of admission 1/14 – 3/14	**Contractor Direction from CMS:** •Deny Non Compliant Claims •Send detailed review results letters explaining each denial •Send summary letter offering 1:1 telephone call to discuss and indicate the contractor will repeat Probe & Educate process with 10 or 25 claims •Repeat Probe & Educate of 10 or 25 claims with dates of admission 1/14 – 3/14 •**IF PROBLEM CONTINUES REPEAT PROBE & EDUCATE WITH INCREASED CLAIM VOLUME OF 100-250 CLAIMS**

Gaming

- Contractors are instructed to monitor inpatient hospital claims spanning 2 or more midnights after admission for evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the 2 midnight presumption.

  - *Contractors must identify such trends through probe reviews and through its data sources, such as that provided by the CERT (Comprehensive Error Rate Testing) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and PEPPER reports (Program for Evaluating Payment Patterns Electronic Report).*

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CMS Monitoring

The Centers for Medicaid & Medicare will be monitoring provider billing trends for the purpose of avoiding Contractor prepayment probe audits during this initial probe & educate period. They will monitor for variances indicative of:

- Abuse
- Gaming
- Systemic delays in submission of claims

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Inpatient Provider Resources

www.NGSMedicare.com

- Tools & Materials (*upper right hand corner of web page*)
- Self-Help
- Inpatient Provider Resources

CMS Ruling 90-1 –

"Provide education regarding medical necessity of inpatient admission, role of physician documentation, and provider responsibility in providing economic & medically necessary care."

Thank You!

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