Looking at Patient Status and Part A to Part B Rebilling

Kathy Reep and Barbara Flynn

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Patient Status

Patient Status

We are specifying that for those hospital stays in which the physician expects the beneficiary to require care that crosses two midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. Conversely, we are specifying that hospital stays in which the physician expects the patient to require care less than two midnights, payment under Medicare Part A is generally inappropriate.

Patient Status

- Two midnight expectation or inpatient only procedure
- Physician order/rationale is the key
  - Requirement that the order specify "to inpatient," "as an inpatient," "for inpatient" or similar language
- CMS expects to issue additional guidance
- Results in IPPS payment offset
  - CMS finalized a 0.2 percentage point reduction to IPPS payments to offset estimated $220 million in expected additional expenditures

Patient Status

- Timeframe used in determining LOS expectation
  - Begins when patient starts receiving care in the hospital
  - Includes time in observation, emergency department, operating room or other treatment area
  - Cumulative time spent at the hospital beginning with the initial outpatient service
- Time spent before formal admission order may be used in making admission decision
- Time spent before formal admission does not count for SNF qualifying stay

Patient Status

… the decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in medically necessary hospitalizations should not pass a second midnight prior to the admission order being written.

Patient Status

- The key –
  - Documentation in the medical record must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance this also must be clearly documented in the medical record.

Patient Status

...the beneficiary's required "level of care" is not part of the guidance regarding inpatient admission decisions.

Patient Status

…we have stipulated that factors such as the procedures being performed and the beneficiary's condition and comorbidities apply when the physician formulates his or her expectation regarding the need for hospital care, while the decision of whether to admit a beneficiary as an inpatient or keep as an outpatient is based upon the physician's expectation of the beneficiary's required length if stay.

Patient Status

…a beneficiary who experiences an unexpected recovery during a medically necessary stay should not be converted to an outpatient but should remain an inpatient if the 2-midnight expectation was reasonable at the time the inpatient order was written, but unexpectedly the stay did not fully transpire.

Patient Status

- Two midnight presumption
  - Impact on contractor reviews in the absence of evidence of systematic gaming, abuse or delays in the provision of care
- Contractors will still review claims
  - To ensure that the services provided were medically necessary
  - To ensure that the stay was medically necessary
  - To validate the coding and documentation
  - As instructed by CMS

Part A to Part B Rebilling

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Part A to Part B Rebilling

- Contractor denial or self-denial
  - Defining self-audit
    - Physician involvement and concurrence
    - No pay/provider liable claim submitted first
- Timely filing for services after October 1, 2013
  - Administrative ruling applies to dates of service prior to October 1
  - Does not apply to Part A claim denials for which the timeframe to appeal has expired

Part A to Part B Rebilling

- Beneficiary liability
  - Must refund amounts associated with Part A services
  - Bill beneficiary for applicable Part B deductible and copayment

Part A to Part B Rebilling

- Final rule clarifies submission of Part B claim for services provided during the three-day window prior to admission
  - Diagnostic testing, procedures, observation, ED, etc.
- Allows rebilling for PT, OT, and speech-language pathology
  - Application of therapy caps and functional status reporting

Part A to Part B Rebilling

- Restricts the scope of administrative law judge review
  - Can only determine whether a claim is reasonable and necessary under Part A
  - Cannot order payment as outpatient

Questions??

kathyr@fha.org
barbaraf@fha.org