2015 Inpatient Prospective Payment Services (IPPS) and Insights on Best Practices

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Agenda

- 2014/2015 IPPS Final Rule
- 2015 proposed OPPS
- Transmittal 534/540/541
- Appeals Settlement offer
- Rebilling
- Understand best practices for operating under 2015 IPPS

Final IPPS 2015

AKA CMS 1607-F (Published in Federal Register on August 22, 2014)

1. **Calculation of payments.** The rule includes a 2.9 percent market basket update, offset by a negative 0.5 percent productivity adjustment and a negative 0.2 percent market basket cut as mandated by the Patient Protection and Affordable Care Act, and a negative 0.8 percent decrease in accordance with the American Taxpayer Relief Act of 2012.

2. **Hospital readmission reduction program.** CMS has increased the maximum penalty from 2 percent to 3 percent.

3. **Hospital-acquired condition reduction program.** Hospitals in the lowest quartile, will have their Medicare pay decreased by 1 percent.

4. **Price transparency.** Under the final rule, hospitals are required to make public a list of their standard charges or provide their policies for allowing the public to view a list of those charges in response to an inquiry.

5. **Hospital value-based purchasing program.** For 2015, CMS is increasing the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, to 1.5 percent of Medicare reimbursements, resulting in about $1.4 billion in value-based incentives.

6. **Medicare disproportionate share hospitals payments.** As part of the PPACA, Medicare DSH payments will be reduced 75 percent by 2019, or $49.9 billion. The final rule cuts overall Medicare DSH payments by 1.3 percent in fiscal year 2015, compared with fiscal year 2014.

Final IPPS 2015

Two Midnight rule remains intact

Little to no changes

Pages 50146 – 50148 pertain to the 2 midnight rule

Several comments regarding defining short or low cost inpatient hospital stays

No additional clinical exceptions added. However, still taking feedback: email to: SuggestedExceptions@cms.hhs.gov

Although the FY 2015 IPPS/LTCH PPS proposed rule did not include any proposed regulatory changes relating to the 2-midnight benchmark, we nonetheless received a number of public comments regarding the current regulation.

CAH: finalize a policy that a CAH is required to complete all physician certification requirements no later than 1 day before the date on which the claim for the inpatient service is submitted (pg. 50165)

2015 OPPS

CMS 1613-P

The 2015 Outpatient Prospective Payment System (OPPS) Final Rule was released on November 10, 2014

Comments found on www.regulations.gov

Highlights include:

- Refinements to Comprehensive APC Policy
- Significant Packaging of Ancillary Services
- ***Changes to Inpatient Certification Requirements***

The Final Rule and Elements of Certification

Documentation is Key:

- There is an expectation that the elements of certification (i.e. the reason for hospitalization, the estimated time the patient will need to remain in the hospital, and the plan of post-hospital care), generally can be satisfied by elements routinely found in a patient's medical record, such as progress notes (CMS-1613-P at 41057).

- "[I]n most cases, the admission order, medical record, and progress notes will contain sufficient information to support the medical necessity of an inpatient admission without a separate requirement of an additional, formal, physician certification" (CMS-1613-P at 41057).

- "[W]e believe that evidence of additional review and documentation by a treating physician beyond the admission order is necessary to substantiate the continued medical necessity of long or costly inpatient stays" (CMS-1613-P at 41057).

Changes to Physician Certification Requirements

- A separately signed Physician Certification statement would no longer be required to be submitted with each and every Inpatient Hospital claim.
  - Only required for long-stay (20 days or more) and outlier cases

- The Inpatient Admission Order will continue to be required as a condition of payment, but is no longer considered an element of certification.

Changes to Physician Certification Requirements

REMINDER, the 2015 OPPS Proposed Rules if finalized as written, would not take effect, **until the implementation date of January 1, 2015.**

Until that time, providers should continue to adhere to current guidelines and regulations pertaining to the Two-Midnight Rule and Physician Certification Requirements

“Doc Fix” – HR 4302 Extension of the Probe & Educate

CMS has extended the Inpatient Hospital Prepayment Review “Probe & Educate” review process through March 2015. This means that:

- Medicare Administrative Contractors (MACs) will continue to select claims for review and deny claims found not in compliance with CMS-1599-F (commonly known as the “2-Midnight Rule”).
- MACs will continue to hold educational sessions with hospitals as described below in “Selecting Hospitals for Review” through March, 2015.
- Generally, Recovery Auditors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after October 1, 2013 through March 2015.

Recovery Auditor Update (Medicare)

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Recovery Auditor Update

- CMS awarded the Region 5 Recovery Audit contract to Connolly, LLC. Connolly will be the nationwide auditor responsible for the identification and correction of improper payments for DMEPOS and home health/hospice claims.
- Procurement update: The new contracts for Recovery Auditor Regions 1, 2, and 4 remain under a pre-award protest and litigation which is expected to continue into late summer of 2015. Additionally, the procurement process continues for Region 3 (Florida, Tennessee, Alabama, Georgia, West Virginia, Virginia, North Carolina, and South Carolina).
- The Region 5 award to Connolly marks the beginning of the new Recovery Audit contracts and is the start date of the implementation of what CMS deems, “Recovery Audit Program Improvements.” The improvements are designed to reduce provider burden and increase transparency in the program.

Recovery Audit Program Improvements

- The following changes* will be effective with each new contract award beginning with the DME, Home Health and Hospice Recovery Audit contract awarded on December 30, 2014.
  - Establish ADR limits based on provider denial rates
  - Limit the Recovery Auditor look-back period to 6 months from the date of service for patient status reviews (so long as the hospital submits the claim within 3 months of the DOS)
  - Recovery Auditors will have 30 days to complete complex reviews and notify providers of their findings (previously 60 days)
  - Recovery Auditors must wait 30 days to allow for a discussion request prior to sending the claim to the MAC for adjustment and must confirm receipt of a provider's discussion request within 3 business days
  - Recovery Auditors will not receive a contingency fee until after the second level of appeal is exhausted
  - Recovery Auditors will be required to maintain an overturn rate of less than 10% at the first level of appeal and an accuracy rate of at least 95%

*This is not an exhaustive list. The full list of program changes can be found here: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf

Recovery Auditor Targets for 2015

- Patient status reviews
  - The moratorium on Recovery Auditors (RAs) performing patient status reviews ends on March 31, 2015.
  - Beginning on April 1, 2015, RAs can begin performing patient status reviews; however, these will be limited to current claims as the RAs are prohibited from reviewing claims with dates of service of October 1, 2013 through March 31, 2015.
  - RAs may pull zero and 1 day stays for claims from October 1, 2013 though March 31, 2015 but are not permitted to review for patient status. Medical necessity, NCD/LCD, documentation, and other approved issues all remain subject to audit scrutiny.
  - There exists potential for RA review of inpatient hospital claims with stays of 2+ days, especially if hospital data demonstrates an increase in 2-day or greater inpatient hospital stays since the implementation of the 2-midnight rule.

Medicare Administrative Contractor Update

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Probe & Educate Process

Number of claims in sample that did NOT comply with policy (Dates of admission October–March 2014)			
	No or minor concern	Moderate to significant concerns	Major concerns
10 Claim Sample	0–1	2–6	7 or more
25 Claim Sample	0–2	3–13	14 or more
Action	• Deny non-compliant claims • Send results letters explaining each denial • No more reviews will be conducted under Probe & Educate Process	• Deny non-compliant claims • Send results letters explaining each denial • Offer 1:1 Phone Call • REPEAT Probe & Educate process with 10 or 25 claims	• Deny non-compliant claims • Send results letters explaining each denial • Offer 1:1 Phone Call • Repeat Probe & Educate • If problems continue, repeat P&E with increased claim volume of 100–250.

Probe & Educate Status Update

As of February 7, 2014:

# of medical records requested	# of medical records received	# of medical records with MAC reviews completed
29,158	**18,110**	**6,012**

As of February 24, 2014:

- CMS is requesting that the Medicare Administrative Contractors (MACs) re-review all claim denials under the Probe & Educate process to ensure the claim decision and subsequent education is consistent with the most recent clarifications.

Number of denials: ?????

Published data – NGS 30–75% denied

Source: http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/UpdateOnProbeEducateProcessForPosting02242014.pdf

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Probe and Educate Results by Contractor

Not all MACs have posted their Probe and Educate results. The following information has been culled from various sources:

- **First Coast Service Options** – 33% Denial Rate
- **National Government Services** – 65% denial rate as of February 2014; however, their website indicates that 75% of reviewed claims have been denied.
- **Palmetto GBA** has posted denial rates by state:
  - North Carolina – 71%
  - South Carolina – 69%
  - Virginia – 59%
  - West Virginia – 55%
- **Novitas** has not published denial rates, but provider outreach and education handouts indicate that over 46% of their Probe and Educate claims were denied on the basis that the medical record documentation did not support a two-midnight expectation.

Examples

- Example 3 **- Short stays for medical conditions**: The beneficiary presented to the ED with recent onset of dizziness and denied any additional complaints. The beneficiary reported a recent adjustment to his blood pressure medication. The physician's notes stated that the beneficiary was stable and that his blood pressure medication was to be held and dosage adjusted. The notes also indicated that the physician intended to observe the beneficiary overnight. The beneficiary was discharged the next day. The hospital submitted a claim for a
  1-day inpatient stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a
  2-midnight stay.

Examples

- Example 4 - **Physician attestation statements without supporting medical record documentation**: The physician's order contained a checkbox with pre-printed text stating "The beneficiary is expected to require 2 or more midnights of hospital care." The physician's plan of care, however, stated that the beneficiary was to have diagnostics performed post-operatively, with a plan to discharge in the morning if stable. The beneficiary was discharged the following day as planned, after a 1-midnight stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a 2-midnight stay when the order was written.

- **CMS reminds providers that attestation statements indicating the beneficiary's hospital stay is "expected to span 2 or more midnights" are not required under the inpatient admissions policy, nor are they adequate by themselves to support the expectation of a 2-midnight stay. Rather, the expectation must be supported by the entirety of the medical record.**

Transmittal 541, CR 8802

- Earlier versions of Transmittal 541 have previously been introduced as Transmittals 505, 534 and 540; however those versions were rescinded.
- Issued on September 12, 2014, but Implemented and Effective on September 8, 2014 (date of service)
- Provided the MAC, Recovery Auditor, and ZPIC the discretion to deny other **related** claims submitted before or after the claim in question.
- The Recovery Auditors will be allowed to also auto deny if approved by the New Issues Review Board.
- **CHANGE FROM Transmittal 534** - Allowed as one approved example: now **only a surgeon's claim** could be automatically denied, but **NOT recoded** to an appropriate outpatient evaluation and management service following the denial of a hospital's inpatient admission.
- **CHANGE FROM Transmittal 540** – Paragraph in Policy section was changed to be consistent with paragraph in Manual, with respect to the surgeon's claim as outlined above.

Source: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R541PI.html

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Rebilling

- If a case has a physician inpatient order, yet fails “expectation 2 midnight stay” or medical necessity:
  - If patient is still in the hospital, hospital may use **Condition Code 44** to reclassify patient as in the past
  - If patient has been discharged, hospital may use **Self Audit/Rebilling** if within timely filing requirements

- Rebilling:
  - Submit provider-liable Part A claim
  - Summit an inpatient claim for payment under Part B and outpatient claim for Part B appropriate services
  - Status does not change – remains IP
  - Beneficiary responsible for Part B copayments

Rebilling Evolution

	Prior to new rulings	Interim 1455	CMS final rule
Self-auditing	Bill Part B Ancillaries only. Subject to limitations of CC 44	Allows providers to rebill only for claims denied by a Medicare contractor	Allows providers to rebill inpatient Part A claims denied as a result of a “self-audit”
Part B rebilling	Only allowed if Judge determined appropriate. No regulations	Rebilling of covered Part B charges when the Part A claim is denied as not medically reasonable and necessary	Part B rebilling to claims for services rendered to beneficiaries enrolled in Medicare Part B
Timeliness for rebilling	Only if within timely filing (one year) or Judge orders (no time limit)	Allows for rebilling 180 days from denial or lost appeal with date of service before Sept. 30, 2013	Standard timely filing requirements (1 year from the date of service) on rebilled claims with an admission date after October 1, 2013.
Impact to beneficiary	To be held harmless	Upon rebilling, requires hospital to adjust beneficiary billing	Upon rebilling, requires hospital to adjust beneficiary billing

Does Rebilling Make Cents?

- Where are you most likely to miss revenue in the UR process?
- Without ***concurrent*** reviews hospitals risk losing dollars *on observation/outpatient cases!*
- Consider:
- INPT DRG
  - > CC44 with 8 hours obs (APC)
    - > CC 44 with less than 8 hours of obs (No APC)
      - > Post discharge rebill 12x
        - » > Claimed denied after 1 year

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Best Practices to Comply With Current IPPS

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Conditions of Participations Have Not Changed

Conditions of Participations (CoPs) must be followed

- "We did not propose and are not finalizing a policy that would allow hospitals to bill Part B following an inpatient reasonable and necessary self-audit determination that does not conform to the requirements for utilization review under the CoPs."
  - *Page 50913, 2014 IPPS*

- 482.30 (c)(1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of:
  - Admissions to the institution
  - Duration of stays
  - Professional services furnished, including drugs and biologicals

Concurrent UM Still Matters

- "Use of **Condition Code 44 or** Part B inpatient billing pursuant to **hospital self-audit is not intended to serve as a substitute** for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols."

  – *Page 50914, 2014 IPPS*

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Components Required for an IP Claim

1. Expectation/completion of a 2-midnight stay
   - UR review must ensure expectation of 2 midnights is “reasonable”

2. Medical Necessity
   - UR review must establish hospital level of care is needed to care for the patient

3. Physician certification/documentation signed by the physician prior to DC
   - Order, reason for inpatient services, expectation and plan for post-hospital care

What is Medical Necessity?

- Is the physician's expectation of 2 midnights reasonable?
  - Achieved with criteria? PA evidence based determination? Other?
- Is hospital level of care needed to care for the patient?
  - Ensure no care for convenience, no delays in treatment/testing or custodial

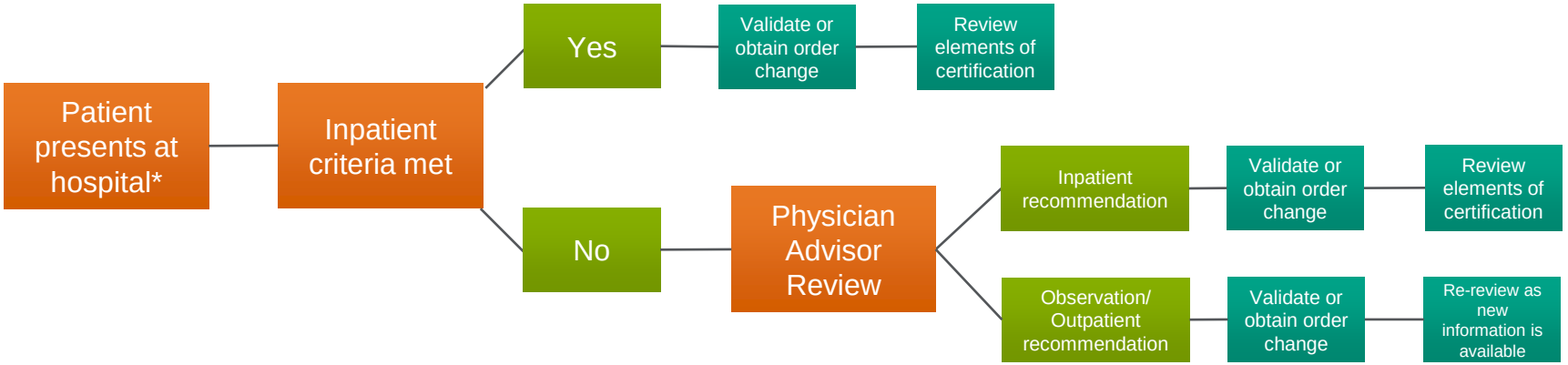
Admission Review – Key Considerations

Initial review for expectation of Length of Stay (LOS)

- Physician documentation of an expectation of 2-midnight stay generally falls into three categories:
  - **Supports expectation of 2-midnight stay**
    - "I expect this patient to remain in the hospital for longer than…"
    - Expected LOS > 2 midnights (in document signed by physician)
  - **No documentation/conflicting documentation**
  - **Clearly conflicts with or fails to support expectation of 2-midnight stay**
    - Order – "Discharge in am" (when care has not already crossed at least one midnight)
    - Progress note – "anticipate d/c in am" (when care has not already crossed at least one midnight)

Recommended Hospital Work Flow

Expected LOS greater than 2 midnights or unclear



Follow this process when:

- Physician documentation of expected discharge is greater than 2 midnights; or
- There is no documentation of expected discharge

* Patient hospitalized for condition other than Inpatient Only Procedure List

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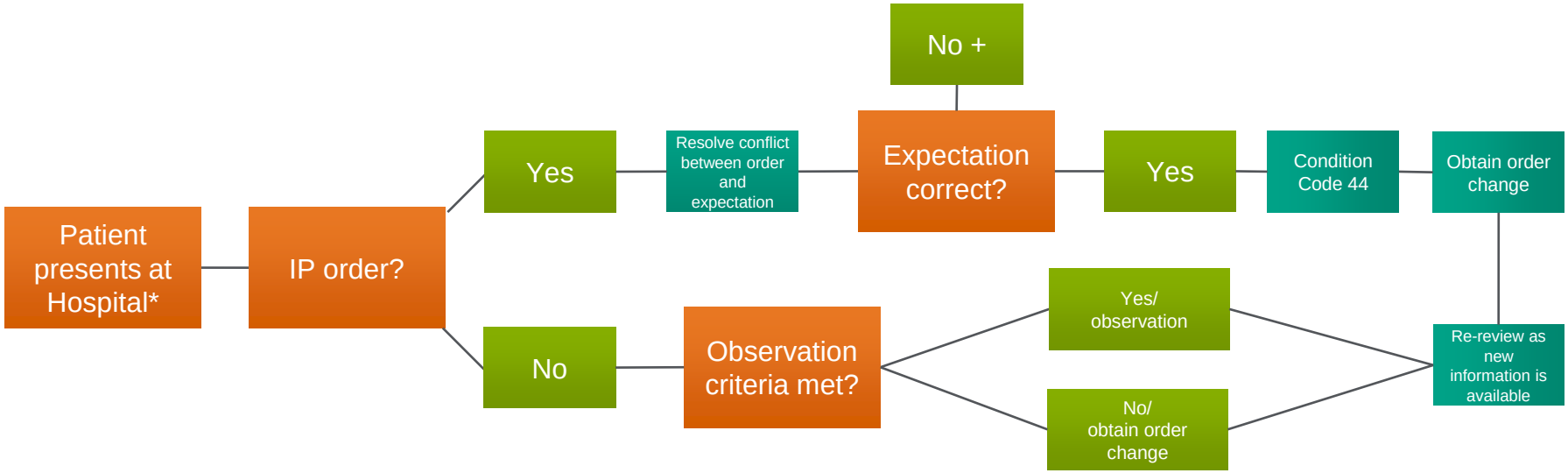
Recommended Hospital Work Flow

Expected LOS less than 2 midnights



Follow this process when:

- Physician documentation of expected discharge is less than 2 midnights

* Patient hospitalized for condition other than Inpatient Only Procedure List.
+If the expectation is not correct, follow the workflow for an expected length of stay of greater than two midnights.

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Considerations Regarding the Time of UR Review

- Review at admission:
  - IP
    - 2+ midnight expectation AND medical necessity established AND physician certification complete
  - Observation/Outpatient
    - Expectation of <2 midnight stay and medical necessity established
  - NOTA
    - Review for documentation of care for convenience, a delay in treatment/testing or custodial care
- Review after 1+ midnight:
  - IP
    - 2+ midnights completed or expected AND medical necessity established AND physician certification complete
  - Observation status should be rare after 2 midnights
  - NOTA
    - Review for documentation of care for convenience, a delay in treatment/testing or custodial care

Summary

- "Get It Right" while the patient is in the hospital and as early in the stay as possible
  - Implications for hospital, patient and physician

- Admission review – key considerations:
  - Order
  - Expectation
  - Medical Necessity
  - Documentation and Certification

- Rebill when appropriate

- While the time requirement has evolved, the science at the core of medical necessity remains the same

THANK YOU.

Questions?

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2 Midnight Example 1

Symptoms:	80 year old female admitted with chest pain, positive biomarkers and EKG changes in the emergency room, urgently taken to catheterization lab
Order	• Admit as inpatient
Expectation of LOS	• "I expect this patient to remain in the hospital for a time greater than 2 midnights"
Medical Necessity	• Documentation present to support inpatient admission
Certification	• All elements of certification present per document review

Follow up necessary	• Patient does not remain for 2 MN
	  • Was (presumption not met) due to: death, transfer, AMA, inpatient-only procedure or "recovery faster than anticipated"?
	  • Evaluate based on start of service to see if benchmark met

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2 Midnight Example 2

Symptoms:	**65 year old male, no previous cardiac history, presents with shoulder pain after exertion, physician suspects musculoskeletal, biomarkers below detection threshold, no EKG changes. Monitor overnight if telemetry, enzymes and EKG's remain negative, anticipate discharge in am. No planned stress test or further evaluation during hospitalization.**
Order	• Admit as inpatient
Expectation of LOS	• 23 hour monitoring
Medical Necessity	• Documentation does not support inpatient admission – observation
Certification	• Order and physician expectation of 2 midnights are in conflict • Order and medical necessity are in conflict
Follow up necessary	• Consider Condition Code 44 if requirements are met • If patient remains in hospital or new information available, re-review for medical necessity at inpatient level • If patient discharged – cannot do Condition Code 44, if within rebilling timeframe, consider for Part B rebilling

2 Midnight Example 3

Symptoms:	78 year old female admitted for atrial flutter, stabilized in Emergency Room. Although expected to be discharged after medication adjustments, patient developed heart block requiring additional adjustments and possible pacemaker
Order	• Place in observation
Expectation of LOS	• Anticipate short stay, 23 hour monitoring
Medical Necessity	• Delayed review suggests that inpatient may be appropriate
Certification	• All elements of certification would need to be completed prior to discharge
Follow up necessary	• EHR would recommend inpatient level of service • Call with physician to discuss medical necessity in light of order change requirement • Call with case manager to discuss order change and expectation documentation with regard to certification requirements • Inpatient order, documentation of expectation and all other elements of certification would need to be addressed prior to discharge

2 Midnight Example 4

Symptoms:	76 year old woman with UTI, treated with intravenous antibiotics. Fevers continue with tachycardia and hypotension requiring fluid support. Immunosuppressed due to post kidney transplant status.
Order	• Admit for inpatient services
Expectation of LOS	• Admission orders include order for “discharge in am”
Medical Necessity	• Would meet for inpatient by criteria, but documentation clearly violates 2 midnight expectation
Certification	• Depending on follow-up activity, if inpatient supported confirm all elements of certification prior to discharge
Follow up necessary	• Although historically inpatient medical necessity would be met, the documentation does not support 2 MN expectation • Resolve conflict between order/medical necessity and expectation • Update documentation if patient not discharged as planned • Consider Condition Code 44 if expectation of discharge remains

2 Midnight Example 5

Symptoms:	68 year old male, with a history of stroke, known carotid stenosis, and previous neck irradiation making carotid end-arterectomy high risk. Patient scheduled for carotid angiography and stent placement. .
Order	• Observation
Expectation of LOS	• Less than 2 midnights
Medical Necessity	• Procedure appropriate for inpatient based on inpatient-only status
Certification	• All elements of certification except the 2 MN expectation would be required to be documented prior to discharge to support inpatient claim
Follow up necessary	• Order should be corrected for procedure on CMS inpatient-only procedure list • For procedures on the inpatient-only list, order must be present on the medical record prior to the initiation of the procedure • Inpatient-only procedures are exempted from the 2 midnight expectation, but all other certification requirements remain

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