The New Challenge of Patient Status

A Review of the Patient Status Provisions in the 2014 IPPS Final Rule
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Agenda

New Inpatient Admission Rules

Part B Inpatient Billing Final Rule
New Inpatient Admission Rules

- Two-midnight Benchmark
- Patient Status Order
- Condition Code 44
- Physician Certification
- Two-midnight Presumption
- Impact of Changes in Admissions
- Probe and Educate Program
Medicare Inpatient
Prior to October 1, 2013:

- **Physician Expectation**
  - Patient will need hospital care $\geq 24$ hours
  - Patient will remain in hospital at least overnight

- A formal inpatient admission order is written

- The Physician responsible for the care makes the status determination

Source: Medicare Benefit Policy Manual Chapter 1
Two-Midnight Benchmark
Guidance for Physicians
Why Change Now?

Major Concerns for the Centers for Medicare & Medicaid Services (CMS)

- Increase in Observation Length of Stays
- Increase in Comprehensive Error Rate Testing (CERT) error rate for short inpatient stays
- Increase in number of Inpatient Appeals
- Requests from Hospital Industry to clarify Inpatient Review Policy
"In the proposed rule, our reference to section 1861(e) of the Act was intended to specify that CAHs were included in the proposed policies, not that we were proposing that IPFs or other non-IPPS hospitals should be excluded. Having considered the public comments to the proposed rule, we believe that all hospitals, LTCHs, and CAHs, with the exception of IRFs, would appropriately be included in our final policies regarding the 2-midnight admission guidance and medical review criteria for determining the general appropriateness of inpatient admission and Part A payment."

Source: Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations 50949
The physician “should order admission if he or she expects that the beneficiary’s length of stay will exceed a 2-midnight benchmark or if the beneficiary requires a procedure specified as inpatient-only under §419.22.”
The Inpatient Order

Should be based on:

1. The **need for inpatient care** supported by “complex medical factors such as history and co-morbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event.”

2. The **expectation** that care will be needed beyond 2 midnights

Factors leading to an inpatient order are to be clearly and completely documented in the medical record.
When the Physician has the expectation that the patient will be in the hospital beyond two midnights and:

- Unforeseen circumstances such as death or transfer
- The patient rapidly improves and the reasonable expectation was clearly documented in the record
- Patient leaves Against Medical Advice (AMA)

Inpatient Appropriate for these exceptions
CMS has identified the following potential exception to the 2-midnight rule:

1. **Mechanical Ventilation Initiated During Present Visit:**
   CMS stated in its discussion of rare and unusual circumstance that treatment in an Intensive Care Unit, by itself, does not support an inpatient admission absent an expectation of medically necessary hospital care spanning 2 or more midnights. Stakeholders have notified CMS that they believe beneficiaries with newly initiated mechanical ventilation support an inpatient admission and Part A payment. CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than 2 midnights, and to embody the same characteristics as those procedures included in Medicare’s inpatient-only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, inpatient admission and Part A payment is nonetheless generally appropriate.

   **NOTE:** This exception is not intended to apply to anticipated intubations related to minor surgical procedures or other treatment.

CMS will continue to work with the hospital industry and with MACs to determine if there are any additional categories of patients that should be added to this list. Suggestions should be emailed to IPPSAdmissions@cms.hhs.gov with “Suggested Exceptions to the 2 Midnight Benchmark” in the subject line.
“While we have historically reference a 24-hour benchmark, we now specify that the 24 hours relevant to inpatient admission decisions are those encapsulated by 2 midnights. This distinction is consistent without application of Medicare utilization days, which are based on the number of midnights crossed.”
How CMS Arrived at 2-Midnight Benchmark

“The use of 2 midnights is an easy concept for beneficiaries to understand in assessing the appropriateness of their assigned status, associated coverage, and impacts.”
All of the time a beneficiary is in the Hospital and receiving services should be considered in the patient’s total length of stay.
2-Midnights: When the Time Begins

Examples of Services to be considered toward the 2-Midnight Benchmark

- Procedures performed in the operating room or other treatment areas
- Treatment in the Emergency Department
- Observation Services
What if the physician cannot make a reasonable time prediction?

“The physician should not admit the beneficiary but should place the beneficiary in observation as an outpatient. As new information becomes available, the physician must then reassess the beneficiary to determine if discharge is possible or if it is evident that an inpatient stay is required.”
“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.”
Example:

- Beneficiary has spent 1 midnight as an outpatient receiving observation services.
- The physician assesses the patient the following morning and the patient is still in need of medical services.
- At this point, the physician should consider the 2 Midnight Benchmark will be met if the expectation is that the beneficiary will require another midnight in the hospital.
What about 3 Day Qualifying Stay for SNF?

- Outpatient time
  - **Can not** be counted towards 3 Day Inpatient Qualifying Stay
  - **Can** be counted for 2-midnight benchmark
Condition Code 44

When not to use:

- A patient should remain in inpatient status when he/she has a shorter than expected recovery and the record supports that the expectation of a 2-midnight stay was reasonable when the inpatient order was written.

When to use:

- When UR determines inpatient is not appropriate patient status and the Attending agrees that stay should be converted to outpatient before the patient is discharged.
Patient Status

Outpatient with Observation Services vs. Admit to Inpatient
Not new: The Conditions of Participation (CoPs) requirement that there is a physician order for hospital inpatient admissions.

New: The “physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.”
Inpatient Order Do’s and Don’ts

- Must be written at or before the time of the admission.
- If written in advance (i.e. elective surgeries) the inpatient admission doesn’t occur until the formal admission at the hospital for inpatient services.
- Medicare DOES NOT permit retroactive orders or the inference of orders.
Verbal Orders are acceptable.

- “Admit to inpatient v.o. (or t.o.) Dr. Jones”
- “Admit to inpatient per Dr. Jones”

However, the order must be authenticated (signed, dated and timed) prior to discharge, or earlier if required by the hospital or state.
The specificity requirements in the Final Rule are most clearly met by using the word “inpatient” in the admission order.

However...

When the order does not specify beyond “Admit,” this will be considered to specify an inpatient status provided that this interpretation is consistent with what is found in the medical record.
Prior to October 1, 2013:
The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.

Source: Medicare Benefit Policy Manual Chapter 1
On or after October 1, 2013:

“The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient’s hospital course, medical plan of care and current condition.”
Who is Knowledgeable?

- Admitting Physician of record (“Attending”)
- Physician on call for the Attending
- Primary or covering Hospitalist
- Beneficiary’s Primary Care Physician (PCP)
- Physician on call for the PCP
- Surgeon responsible for a major surgical procedure or the on-call surgeon
- Emergency or Clinic Practitioners caring for the patient at the point of inpatient admission
- Other qualified practitioners qualified to admit inpatients and actively treating the patient at the point of inpatient admission decision
When the Attending Physician writes the inpatient order
- Must be licensed by the State to admit
- Has been granted admitting privileges by the hospital
- Knowledgeable about the patient’s course, medical plan of care, and condition at the time of admission
Ordering/Admitting Practitioner

When the “Ordering Practitioner” who is NOT the Attending writes the inpatient order:

- Licensed by the State to admit
- Has been granted privileges by the hospital
- Knowledgeable about patient’s hospital course, medical plan of care, and condition at the time of admission
- Makes determination of medical necessity for inpatient care and makes the decision to admit to inpatient
- If allowed by State Law and Hospital Privileging this may be a Non-Physician Practitioner (i.e. Nurse Practitioner)
When, after discussion with and at the direction of the Ordering Practitioner, a Practitioner without the Authority to admit writes the inpatient order:

- The order, including verbal orders, may be written by practitioners who do not have admitting privileges (i.e. Physician Assistant, Resident, RN).
- In this instance the Ordering Practitioner does not need to write a separate admit order.
- However, it must be authenticated by the ordering practitioner or another practitioner with admitting qualifications prior to discharge.
Inpatient Admission Physician Certification
September 5th, 2013 CMS Guidance
Physician Certification

CMS is “requiring under new §424.13(b) that, for inpatient services other than inpatient psychiatric services: For all hospital admissions, the certification must be completed, signed, and documented in the medical record prior to discharge.”

Certification requirements can be found in the Code of Federal Register (CFR) at §424.10, §424.11 and §424.13
Physician Certification

“We are adding parallel provisions in 42 CFR 424.1(b) and 424.15(a) to include the content of the physician certification for payment for inpatient psychiatric services and inpatient CAH services, respectively, that the services were provided in accordance with § 412.3.”

Certification Content

- **Authentication of the Practitioner Order:** Certifies that inpatient services are reasonable and necessary

- **Reason for inpatient services:** Either reason for inpatient medical treatment or medically required diagnostic study OR special/unusual services for cost outlier cases

- **Estimation of the inpatient time required**

- **Post hospital plans, if appropriate**
Certification Timing

- Certification....

  - Begins with inpatient admission order
  - Must be completed signed, dated and in medical record prior to discharge
Who is Authorized to Sign the Certification?

- A Doctor of Medicine or Osteopathy
- A Dentist in circumstances specified in 42 CFR 424.13(d)
- A Doctor of Podiatric medicine if his/her certification is consistent with functions he/she is authorized to perform under State Law
Who Can Sign the Certification?

- The Attending or Physician on call for the Attending
- Surgeon responsible for a major surgical procedure or the on-call surgeon
- Dentist functioning as the Admitting Physician or as the Surgeon responsible for a major dental procedure
Who Can Sign the Certification?

- In the specific case of a non-physician non-dentist admitting practitioner that is:
  - Licensed by the State and
  - Has been granted admitting privileges by the facility,

- Then a physician member of the hospital staff (such as a UR Committee physician) can complete the Certification if he/she has:
  - Reviewed the case and
  - Enters into the record a complete certification containing all Certification elements.
Who can...

**Write a Patient Status Order**
- Attending or Physician on call for Attending
- Primary or covering Hospitalist
- Beneficiary’s Primary Care Physician (PCP)
- Physician on Call for PCP
- Surgeon responsible for major O.R. procedure or the on-call Surgeon
- ED or Clinic Practitioners caring for patient at point of inpatient admission
- Other qualified practitioners qualified to admit & actively treating the patient at point of admission

**Sign the Physician Certification**
- Attending or Physician on call for Attending
- Surgeon responsible for major O.R. procedure or the on-call Surgeon
- Dentist functioning as the Admitting Physician or as the Surgeon responsible for a major dental procedure
- In specific case of non-physician non-dentist admitting practitioner then a Physician Member of Hospital staff (i.e. UR Committee Physician) who has reviewed the case & enters certification elements in the record can sign
No specific procedures or forms are required for certification and recertification.

Can adopt any method that can be verified.

Certification and recertification statements can be on forms, notes or records that the Physician signs or a special separate form.
Elements to Meet Initial Inpatient Certification:
In the Absence of Specific Certification Form or Certification Statement
Authentication Requirement

How met:

By the signature or countersignature of the inpatient admission order by the certifying physician prior to discharge
How Met:

- Either the diagnoses and plan documented in the inpatient admission assessment or, by the inpatient admitting diagnosis and orders
Estimated Time Requirement

How Met:

By the inpatient admission order written in accordance with the 2-midnight benchmark, supplemented by physician notes and discharge planning instructions.
Post Hospital Care Plan Requirement:

How Met: Either by the Physician Notes
Or, by Discharge Planning Instructions
One Hospital’s Experience at Complying with the Final Rule Guidance:

- Worked with Clinical Decision Support to build a report of all patients with a 3 Midnight or Less Admission
- Concurrently, for “0” and “1” Midnight Stays that are discharged prior to being seen by Case Management — conduct a review to determine if documentation supports the inpatient admissions
  - If Yes — bill as Inpatient
  - If No — Follow Part A to Part B re-billing process
October 2013: Record review for ALL “0” and “1” Midnight Inpatient Stays

Patient classifications identified:

- Admits for Medicare Inpatient Only Procedures
- Patient met InterQual® screening criterion for Inpatient AND MD documentation supported the admission
- Patient did not meet InterQual® but Physician Documentation clearly supported an anticipated 2-Midnight Inpatient Stay
- Transfers / AMA / Expired
- Couple of Surgical Cases that will need to be re-billed not identified prior to coding
- Case referred to Physician Advisor and approved as Inpatient
Two-Midnight Presumption
Guidance for Review Contractors
This presumption “directs medical reviewers to select claims for review under a presumption that the occurrence of 2 midnights after admission appropriately signifies an inpatient status for a medically necessary claim.”
CMS directs contractors to:

Review inpatient stays spanning less than 2 midnights after admission

Why? These claims would not be subject to the presumption that services were medically appropriate for inpatient
What Contractors will be looking for:

**Physician Certification Elements**

“The physician order and the physician certification are not considered by CMS to be conclusive evidence that an inpatient hospital admission or service was medically necessary. Rather, the physician order and physician certification are considered along with other documentation in the medical record.”
What Contractors will be looking for:

- Medical documentation supporting that the decision to admit as an inpatient was reasonable and necessary.

- They will “consider complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2-midnight benchmark.”
Caution: While stays greater than 2 midnights will no longer be the focus of reviews they will monitor for “evidence of systematic gaming, acute delays in the provision of care in an attempt to qualify for the 2-midnight presumption.”
2-Midnight Benchmark & Presumption

Financial Impact to CMS
Background

- FY 2009 — FY 2011 Medicare claims data examined
  - Specifically Extended Outpatient and Short Inpatient Stays CMS
- Why Focus on these specific types of Stays?
  - CERT Contractor in 2012 Improper Payment Rates
    - 1-Day or Less: 36.1%
    - 2 Day: 13.2%
    - 3 Day: 13.1%
  - RAAs have recovered > $1.6 Billion in improper payments due to inappropriate patient status
Claims Data Review Findings

Net Shift of 40,000 stays = 1.2% Increase in number of Short Inpatient Hospital Stays

- Shift from Outpatient to Inpatient: Approximately 400,000 stays
- Shift from Inpatient to Outpatient: Approximately 360,000 stays

Financial Impact for CMS:
- Increase IPPS expenditures approximately $220 million
Financial Impact to IPPS Hospitals

“We are finalizing a reduction to the standardized amount, the hospital specific rates, and the Puerto Rico-specific standardized amount of -0.2 percent to offset the additional $220 million in expenditures.”

Source: Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations 50954
New Probe & Educate Program
October 1, 2013 – March 31, 2014
Who will perform Probe Reviews:
- Medicare Administrative Contractors (MACs)

Claims Subject to Review:
- Admissions on or after October 1st, 2013 with a “0” or “1” day Inpatient length of stay

Volume of Records:
- Initial Review of 10-25 records per hospital

Type of Review: Pre-payment probes
Hospitals Subject to Probe Reviews

- Acute Inpatient Hospitals
- Long Term Hospitals (LTCHs)
- Inpatient Psychiatric Facilities (IPFs)

Note: Critical Access Hospitals (CAHs) are not subject to Probe Reviews but are still subject to the Final Rule
MACs instructed to assess Hospital Compliance with Final Rule CMS-1599-F based on:

- Admission Order Requirements
- Physician Certification Requirements
- 2-Midnight Benchmark Guidance
### MAC Actions Following Patient Status Probe Reviews

<table>
<thead>
<tr>
<th>Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October – March 2014)</th>
<th>No or Minor Concerns</th>
<th>Moderate to Significant Concerns</th>
<th>Major Concerns</th>
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</thead>
<tbody>
<tr>
<td>10 claim sample</td>
<td>0-1*</td>
<td>2-6*</td>
<td>7 or more*</td>
</tr>
<tr>
<td>25 claim sample</td>
<td>0-2*</td>
<td>3-13*</td>
<td>14 or more*</td>
</tr>
</tbody>
</table>

**Action**

- For each provider with no or minor concerns, CMS will direct the MAC to:
  1. Deny non-compliant claims
  2. Send summary letter to providers indicating:
     - What claims were denied and the reason for the denial.
     - That no more reviews will be conducted under the Probe & Educate process.
     - That the provider will be subjected to the normal data analysis and review process.
  3. Await further instruction from CMS

- For each provider with moderate to significant concerns, CMS will direct the MAC to:
  1. Deny non-compliant claims
  2. Send detailed review results letters explaining each denial.
  3. Send summary letter that:
     - Offers the provider a 1:1 phone call to discuss.
     - Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims.
  4. Repeat Probe & Educate of 10 or 25 claims with dates of admission January – March 2014
  5. If problem continues, Repeat Probe & Educate with increased claim volume of 100 – 250 claims.

*Note: If the provider claim submissions do not fulfill the requested sample, the error rate shall be calculated based on percentage of claims with findings.

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Source: November 1, 2013 CMS Download Titled: Selecting Hospital Claims for Patient Status Reviews
Not to Review:

- Claims spanning >2 midnights after admit for appropriateness of patient status
- Inpatient admissions on or after October 1, 2013 through December 31st with a “1” Midnight or less length of stay
- Pre-payment Demonstration suspended during this 90 day period (States in demonstration: FL, CA, MI, TX, NY, LA, IL, PA, OH, NC and MO)

Will continue to Review:

- Pre-Payment Reviews for Therapy Caps
Physicians should base inpatient admission decisions in accordance with the 2 Midnight Guidance.

In this 90 days Contractor reviews for medical necessity of a surgery (i.e. total knee replacement) and coding validation reviews can continue.

Other Contractors are not limited by this 90 days and can continue to pick any claims for review. (i.e. CERT, ZPIC, OIG, DOJ)
Benefit of Pre-Payment Reviews

Hospitals could re-bill any denied pre-payment probe reviews in accordance with the Part A to Part B rebilling in the 2014 Final Rule.
Surgical DRGs: DRG Group 246 & 247 was the 5th highest Surgical admit with an Inpatient Admission Spanning 0-1 Midnights.

Did you know? DRG 247 is one of the DRGs that Cahaba reviews as part of a CERT Special Project Targeted Review. In a November 2013 Cahaba website post, in Alabama there was a 68% Error Rate for DRG 247.

<table>
<thead>
<tr>
<th>DRG Group</th>
<th>DRG Description</th>
<th>GMLOS Range</th>
<th>Patient Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>308, 309, 310</td>
<td>Cardiac Arrhythmia and Conduction Disorders with MCC, with CC or without CC/MCC</td>
<td>1.9 - 3.8</td>
<td>538</td>
</tr>
<tr>
<td>640 &amp; 641</td>
<td>Miscellaneous Disorders of Nutrition, Metabolism, and Fluids and Electrolytes with MCC and without MCC</td>
<td>2.8 - 3.3</td>
<td>348</td>
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<tr>
<td>190, 191, 192</td>
<td>Chronic Obstructive Pulmonary Disease with MCC, with CC or without CC/MCC</td>
<td>2.8 - 4.2</td>
<td>343</td>
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<tr>
<td>291, 292, 293</td>
<td>Heart Failure and Shock with MCC, with CC or without CC/MCC</td>
<td>2.5 - 4.6</td>
<td>313</td>
</tr>
<tr>
<td>811 &amp; 812</td>
<td>Red Blood Cell Disorders with MCC or without MCC</td>
<td>2.5 - 3.6</td>
<td>305</td>
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<tr>
<td>682, 683, 684</td>
<td>Renal Failure with MCC, with CC or without CC/MCC</td>
<td>2.5 - 4.7</td>
<td>213</td>
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<tr>
<td>917 &amp; 918</td>
<td>Poisoning and Toxic Effects of Drugs with MCC or without MCC</td>
<td>2.1 - 3.5</td>
<td>197</td>
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<tr>
<td>193, 194, 195</td>
<td>Simple Pneumonia and Pleurisy with MCC, with CC or without CC/MCC</td>
<td>2.9 - 5.0</td>
<td>193</td>
</tr>
<tr>
<td>689 &amp; 690</td>
<td>Kidney and Urinary Tract Infections with MCC or without MCC</td>
<td>3.2 - 4.3</td>
<td>188</td>
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<tr>
<td>64, 65 &amp; 65</td>
<td>Intracranial Hemorrhage or Cerebral Infarction with MCC, with CC or without CC/MCC</td>
<td>2.5 - 4.7</td>
<td>178</td>
</tr>
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</table>

Top 10 Medical DRGs Total Paid Claims: $10,524,133.53

<table>
<thead>
<tr>
<th>Status Code</th>
<th>Status Code Description</th>
<th>Patient Volume</th>
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<tr>
<td>1</td>
<td>Home or Self Care</td>
<td>8,703</td>
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<tr>
<td>6</td>
<td>Home Health</td>
<td>870</td>
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<tr>
<td>3</td>
<td>SNF</td>
<td>266</td>
</tr>
<tr>
<td>65</td>
<td>Transferred to a Psych Hospital or Psych Unit</td>
<td>135</td>
</tr>
<tr>
<td>50</td>
<td>Hospice - Home</td>
<td>120</td>
</tr>
</tbody>
</table>
Review of the
Part B Inpatient Billing Final Rule
Part B Inpatient Billing

- The “Old” Rule and the “New” Rule
- Billable and Non-Billable Services
- UR Self-Audit
- When Do You Bill?
- Patient Status and Patient Liability
- Examples
For Many Years, Hospitals Have Been Able to...

- Bill **limited** Part B services for inpatients
- On a 12x type of bill
- When there is no Part A coverage for inpatient services

The Old Rule
The “Old” Rule

- Limited Part B billing applied when there was no Part A coverage due to:
  - Benefit days exhausted
  - Patient not eligible for Part A coverage
  - Admission not medically necessary
The “Old” Rule

- Claims subject to timely filing
- Medicare defined services billable as “Part B Only” services
- Defined by description and revenue code

Source: See Medicare Benefit Policy Manual, Chapter 6, section 10 and Medicare Claims Processing Manual, Chapter 4, section 240 for list of services
The “Old” Rule

- Limited “Part B-Only” services included diagnostic services, rehabilitative therapy, some orthotic/prosthetic devices, some screening services and a few other types of services.
- Did not include drug administrations, surgeries, most drugs, or therapeutic coronary or peripheral interventions.
Why Change the Rules?

- Medicare overwhelmed with appeals
- ALJs awarding providers Part B payment
- No payment for medically necessary services provided in “wrong” setting
When Did The Rules Change?

- March 23, 2013 — CMS published Ruling 1455-R — effective immediately
- October 1, 2013 — date the Part B Inpatient Billing Final Rule (included in 2014 IPPS Final Rule) became effective
Ruling versus Final Rule

Under the Final Rule

1) Hospital can determine inpatient admission is not medically necessary through a self-audit and choose to submit Part B inpatient claim

2) Timely filing requirements apply to claims with date of service on and after October 1, 2013
Who Is Affected?

- Short-term acute care hospitals paid under IPPS
- Hospitals paid under OPPS
- Long term care hospitals
- Inpatient psychiatric facilities
- Inpatient rehabilitation facilities
- Critical access hospitals
- Children’s hospitals
- Cancer hospitals
- Maryland waiver hospitals
If inpatient admission is not medically necessary, the hospital may submit a Part B inpatient claim for "all" Part B services provided to the patient during the admission.

BE CAREFUL — it depends on what your definition of "all" is.
MLN Matters Article SE1333 provides temporary billing instructions for Part B Inpatient billing.

Originally published September 16, 2013

Minor revisions in revenue code table October 23, 2013
Services Billable on Part B Inpatient Claim

- Services furnished to the inpatient that would have been reasonable and necessary if the patient had been treated as an outpatient
- Services after the order for inpatient admission
- Now includes surgeries, drugs and therapeutic services such as coronary and peripheral interventions
Services Billable on Part B Inpatient Claim

- Still includes rehabilitative therapy services — physical therapy, occupational therapy and speech language pathology services
- Did not finalize proposal to exclude these types of services
Services Billable on Part B Inpatient Claim

- Therapy services must follow all Part B regulations:
  - Practitioner certification of plan of care
  - Therapy caps, caps exception process and manual review threshold
  - Functional limitation status reporting
Services NOT Billable on Part B Inpatient Claim

- **Routine inpatient** services (room & board charge) including:
  - Room charges,
  - Dietary services,
  - Nursing services,
  - Minor supplies,
  - Social services, and
  - Equipment/facility use.
Services NOT Billable on Part B Inpatient Claim

- Services received from floor nurses including
  - IV infusions and injections,
  - blood administration and
  - nebulizer treatments.

- These services are not separately billable Inpatient Part B services.
Services NOT Billable on Part B Inpatient Claim

- Excludes services requiring an outpatient status
  - Diabetes self-management training (DSMT)
  - Outpatient visits (includes ED visits)
  - Observation services
- These services generally not furnished after inpatient order anyway
Services NOT Billable on Part B Inpatient Claim

- SE1333 includes a chart of non-billable revenue codes

- When a revenue code can be sometimes covered, sometime not covered, providers should use the HCPCS to determine if the service is covered
Revenue Code Comments

Non-Covered Revenue Codes

- 390 — blood product processing
- 391 — blood administration
- 450 — ED services
- 762 — observation

Revenue Codes Not on List

- 260 — infusions
- 410/412 — respiratory services
- 460 — pulmonary function
Outpatient services prior to admission billable on Part B outpatient claim

Three-day window billing rule only applies when there is Part A coverage

Not a new rule
Part B Outpatient Claim

- No Part A coverage — bill Part B outpatient services provided prior to admission on Part B outpatient claim (13x type of bill)
- Includes ED visits and observation services provided prior to inpatient admission order
If a hospital inpatient admission is determined to not be medically necessary after a patient’s discharge, the hospital may submit a Part B inpatient claim for all services provided to the patient during the admission.
Not Medically Necessary

Bill extended Part B services only when inpatient admission is not reasonable and necessary

Does not apply when there is no Part A coverage due to

- benefits exhausted
- patient not eligible for Part A
Who makes the determination the inpatient admission is not medically necessary?

- CMS or Medicare contractor — claim denial
- Hospital may appeal denial or submit Part B claim
Not Medically Necessary

Who makes the determination the inpatient admission is not medically necessary?

Expanded in Final Rule to include Hospital — Utilization Review (UR) “self-audit” after patient discharge
Prior to Discharge

If UR review prior to discharge determines inpatient status is not medically necessary, follow Condition Code 44 criteria to change patient’s status to outpatient.
Hospital UR Self-Audit

- Must follow Medicare Conditions of Participation UR guidelines

“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.”
Medicare CoP UR Guidelines

- Code of Federal Register - 42 CFR 428.30
- Determination that admission is not medically necessary must be made by
  - one physician member of UR committee if attending physician concurs or
  - two physician members of UR committee
Medicare CoP UR Guidelines

- Physician responsible for patient care must be consulted
- Patient must be notified in writing within 2 days of the decision
Codes on the Claim

HCPCS codes to describe the services provided such as:
- Surgeries
- Drugs
- Therapeutic procedures
- Diagnostic services

Diagnosis codes — need to consider:
- Coding / re-sequencing Part B services as separate episode
- LCD diagnosis requirements for medical necessity of services
Bill Part B inpatient claim only when there is no current Part A claim

Either one or the other — NOT BOTH!
No Active Part A Claim

Before Part B billing, Part A claims must be:

- Canceled by the provider (if billed prior to self-audit decision)
- Denied by Medicare or
- Appeals withdrawn by provider
Claims Related to Part B Rebilling

- Part A No-Pay/Provider Liable Inpatient Claim
- Limited Part B Inpatient Claim
- Expanded Part B Inpatient Claim
Part A No-Pay/Provider Liable Claim

110 Type of Bill

Used when hospital self-audit determines that inpatient admission is not medically necessary

Must submit no-pay/provider liable inpatient claim (110) first and receive denial before submitting Part B inpatient claim (12x)
Part A No-Pay/Provider Liable Claim

Claim must include

- Non-covered days
- The services from admission through discharge
- The appropriate patient status
- Occurrence Span Code “M1” and dates of service
- Non-covered charges for all services rendered
- All diagnosis and procedure codes
Part A No-Pay/Provider Liable Claim

- Must include Occurrence Span Code “M1” and the inpatient admission dates of service indicate provider liability period
- After Remittance Advice issued, a Part B Inpatient Claim may be submitted
Limited Part B Inpatient Claim

12x Type of Bill

Bill only limited Part B Only service

Used when patient benefit days exhausted or patient not eligible for Part A coverage
Expanded Part B Inpatient Claim

- Use when Part A claim is **denied** as not reasonable and necessary
  - Denied by Medicare contractor upon review
  - Denial of no-pay claim submitted by hospital after self-audit
- Type of bill 12x
Expanded Part B Inpatient Claim

Claim must include:

- A treatment authorization code of A/B Rebilling submitted by a provider
- A condition code "W2" attesting that this is a rebilling and no appeal is in process
- The original, denied inpatient claim (CCN/DCN/ICN) number
When Do You Bill?

- Timely filing limits apply to services with dates of service on and after October 1, 2013.
- Both Part B inpatient and outpatient claims must be filed within one calendar year after the date of service.
Extension of Ruling Timeframes

Follow Ruling timeframes after October 1, 2013 for:

- Denials to which CMS-1455R Ruling originally applied (March 23, 2013)
- Inpatient claims with date of admission before October 1, 2013 that are denied after September 30, 2013
Extension of Ruling Timeframes

Ruling timeframes are 180 days after date of receipt of:

- Appeal dismissal notice
- Final appeal denial decision
- Remittance with initial or revised determination
Patient Status

- Patient’s status remains inpatient
- Cannot change status after discharge
- Days do not count toward patient’s utilization days if no Part A payment is made
SNF Qualifying Admission

- Three-day inpatient stay qualifies patient for skilled nursing facility (SNF) stay even if no Part A payment made unless there was a “substantial departure from normal medical practice”
- Care can be medically necessary, even if admission is not
- Admissions solely to “qualify” not acceptable
Patient Liability

- Patient is liable for Part B deductible and co-payments and self-administered drugs.
- Hospital must refund Part A payments received from the patient and other insurers.
- Part B liability may be greater than Part A liability — patient or their secondary insurance responsible for balance.
Patient Liability

Must hospital bill patient if balance due from patient?

Governed by the beneficiary inducement and anti-kickback laws; falls under jurisdiction of OIG
Appeals Process

- Appeals process remains the same
- Appeal adjudicators may only consider the claim they are reviewing
- They may not order Part B payment when a Part A claim is denied as not medically necessary
Claim Examples

- Comparison of payment under “old” rule (limited Part-B-only services) to payment under “new” rule (expanded Part B services) for Part B inpatient claim
- Payment rates are Medicare unadjusted national payment rates for 2013
- Payment will be different under 2014 OPPS rule
Example 1: Patient has a positive stress test as an outpatient and is then admitted as inpatient for elective cardiac catheterization and possible coronary stent placement. Stent placed and patient stays overnight post-procedure and discharged home the next morning. Inpatient admission is determined to not be medically necessary.
## Claim Example One

<table>
<thead>
<tr>
<th>DOS</th>
<th>HCPCS</th>
<th>HCPCS Description</th>
<th>Qty</th>
<th>Part B IP Bill under Old Rule</th>
<th>Part B IP Bill under New Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/7/2013</td>
<td>36415</td>
<td>Venipuncture</td>
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<td>$3.00</td>
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<td>6/7/2013</td>
<td>80053</td>
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<td>6/7/2013</td>
<td>85025</td>
<td>CBC with differential</td>
<td>1</td>
<td>$10.69</td>
<td>$10.69</td>
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<tr>
<td>6/7/2013</td>
<td>93005</td>
<td>EKG</td>
<td>1</td>
<td>$26.67</td>
<td>$26.67</td>
</tr>
<tr>
<td>6/7/2013</td>
<td>93458-59</td>
<td>Left Heart Catheterization</td>
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<td>$2,649.52</td>
<td>$1,324.76</td>
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<td>6/7/2013</td>
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<tr>
<td>6/7/2013</td>
<td>C1874</td>
<td>Drug Eluting Stent</td>
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<tr>
<td>6/7/2013</td>
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<td>Angimax injection, 1 mg</td>
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<td>6/8/2013</td>
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<td>$11.63</td>
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<td>6/8/2013</td>
<td>93005</td>
<td>EKG</td>
<td>1</td>
<td>$26.67</td>
<td>$26.67</td>
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<tr>
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<td></td>
<td>$2,742.71</td>
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</tbody>
</table>
Example 2: Patient with exacerbation of COPD seen and treated in ER then admitted as inpatient for further treatment. Patient discharged the next day. Inpatient admission is determined to not be medically necessary.
## Claim Example Two

<table>
<thead>
<tr>
<th>DOS</th>
<th>HCPCS</th>
<th>HCPCS Description</th>
<th>Qty</th>
<th>Part B OP Claim</th>
<th>Part B IP Bill under Old Rule</th>
<th>Part B IP Bill under New Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/9/2013</td>
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<td>Basic Metabolic Chem Profile with Ionized Calc</td>
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<td>Nebulizer Breathing Treatment</td>
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<td>96365-59</td>
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<td>$26.67</td>
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<td>6/10/2013</td>
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<td>6/10/2013</td>
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<tr>
<td>6/10/2013</td>
<td>J0696</td>
<td>Rocephin injection, 250 mg</td>
<td>4</td>
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</tbody>
</table>

Total: $537.67 $78.99 $78.99
CMS will host a third, follow-up call in its Special Open Door Forum (ODF) series to allow hospitals, practitioners, and other interested parties to ask questions on the physician order and physician certification, inpatient hospital admission and medical review criteria that were released on August 2, 2013 in the FY 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) final rule (CMS-1599-F) and corresponding medical review instruction.

CMS has set up an “Inpatient Hospital Review” webpage on their website under “Medical Review and Education” at:

References

Source: Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations

September 5th, 2013 Guidance from CMS: Hospital Inpatient Admission Order and Certification

CMS Open Door Forums: Final Rule CMS-1599-F: Discussion of the Hospital Inpatient Admission Order and Certification, 2 Midnight Benchmark for Inpatient Hospital Admissions

September 26, 2013

November 12, 2013
References

- CMS November 1, 2013 Downloads:
  - Selecting Hospital Claims for Patient
  - Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013
- MLN Matters Article SE1333: Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims
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