Ohio Hospital Association

Medicare Inpatient Admission Standards: Two Midnight and Physician Certification Rules

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Overview

1. Medicare Inpatient Admission Regulations and Guidance
   - Two Midnight Rule
   - Physician Certification Rule

2. Hospital Decision Process: Appeal Denied Admissions or Rebill; Self-Deny Short Stays and Rebill

3. Compliance Strategies
Background – Medicare Law and Guidance

Medicare Benefits Policy Manual, Chapter 1, Section 10 – Definition of “Inpatient”

“An Inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. . . . The physician or other practitioner responsible for a patient’s care is responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a **24-hour period as a benchmark**. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting.”
Medicare 2014 Final IPPS Rule (CMS-1599-F) (August 19, 2013) introduces the “Two Midnight Rule” as the new Medicare inpatient payment standard: Surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital payment under Medicare Part A only when:

- The physician expects the patient to require a hospital stay that crosses at least two midnights, and
- Admits the patient to the hospital based on that expectation.

42 CFR 413.2(e)(1)
Medicare 2014 IPPS Final Rule – Two Midnight Rule, cont’d

• “The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event.”

• “The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.”

42 CFR 412.3(e)
Two Midnight Rule: Scope

• Scope of Rule: Traditional Medicare
  – Not Medicare Advantage
  – Not Ohio Medicaid
• Facilities Covered
  – Acute Care Hospitals
  – CAHs
  – LTCHs
  – Inpatient Psychiatric Hospitals
**Two Midnight Rule - Unforeseen Circumstances**

Exceptions to the Two Midnight Requirement for Inpatient Admission – **Unforeseen Circumstances**

Unforeseen circumstances may result in a shorter beneficiary stay than the physician’s expectation (that the beneficiary would require a stay greater than two midnights)

- Death
- Transfer
- Departure against medical advice (AMA)
- Unforeseen recovery
- Election of hospice care

Such claims *may* be considered appropriate for hospital inpatient payment.

The physician’s expectation and any unforeseen interruptions in care must be documented in the medical record.
Two Midnight Rule – Exceptions

In certain cases, the physician may have an expectation of a hospital stay lasting less than two midnights, yet inpatient admission may be appropriate in the following circumstances:

• Medically Necessary Procedures on the Inpatient-Only List
• Other Circumstances
  – As Approved by CMS and outlined in sub-regulatory guidance
  – New Onset Mechanical Ventilation (This exception does not apply to anticipated intubations related to minor surgical procedures or other treatment)
  – Additional suggestions being accepted at IPPSAdmissions@cms.hhs.gov (subject line “Suggested Exception”)

In certain cases, the physician may have an expectation of a hospital stay lasting less than two midnights, yet inpatient admission may be appropriate in the following circumstances:
Two Midnight Rule: The Benchmark and The Presumption

The Two Midnight Rule creates both a benchmark and a presumption—

Physicians use the Two Midnight **Benchmark** to determine inpatient status

Medicare Auditors use the Two Midnight **Presumption** to select inpatient claims for audit
Two Midnight Rule: The Benchmark Physician LOS Expectation

The **Two Midnight Benchmark** describes the physician’s expectation at the time of admission and how CMS will review claims under the Two-Midnight rule

- Contractors **will include the time the beneficiary spends receiving outpatient care** in their review decision (includes outpatient care in a hospital-based outpatient department whether on campus or off campus)

- If total time the beneficiary is expected to spend receiving medically necessary hospital care (includes both outpatient care and inpatient care) equals--
  - **0-1 Midnight:** Review contractor will review claim to see if the beneficiary was admitted for an inpatient-only procedure or if other circumstances justify inpatient admission per CMS guidance (e.g., new onset ventilation) (Note: admission to ICU does not by itself justify an inpatient admission). Otherwise, Part A payment will be denied.
  - **2 or More Midnights:** Review contractor will generally find Part A payment to be appropriate.
Start Clock for Benchmark

Two-Midnight Benchmark “clock” starts when hospital care begins, and includes time spent receiving medically necessary care in

– Observation

– Emergency department, operating room, and other treatment area services

The following time is **not** counted toward the benchmark

– registration and initial triaging activities (such as vital signs)

– excessive wait times
Two Midnight Rule: The Presumption Selection of Claims for Medical Review

How will claims be selected for review under the two-midnight rule

- If a claim shows two or more midnights after the time of formal inpatient admission—
  - the contractor will presume for claim selection purposes that inpatient admission is appropriate
  - This claim will not be the focus of medical review.
- Exception: Medicare contractor will monitor claim patterns for evidence of **systematic gaming or abuse**, such as **unnecessary delays** in the provision of care to surpass two inpatient midnights
  - Statistical drops in the number of 0-1 Day Stays; spikes in the number of 2 Day Stays after 10/1/2013.
The Two-Midnight Presumption starts with the inpatient order and formal admission.

“Remember that while the total time in the hospital may be taken into consideration when the physician is making an admission decision (i.e. expectation of hospital care for 2 or more midnights), the inpatient admission does not begin until the inpatient order and formal admission occur.” MLN Connects January 14, 2014 Presentation
Occurrence Span Code 72

1. Effective 12/1/2013, Occurrence Span Code 72 may be used to designate “Contiguous outpatient hospital services that preceded the inpatient admission”

2. Voluntary code, but CMS encourages hospital use

3. Hospitals may use Occurrence Span Code 72 on inpatient claims to report the number of midnights the beneficiary spent receiving outpatient services in the hospital from the start of care until formal inpatient admission
Inpatient Admission Order and Certification

Medicare 2014 IPPS Final Rule

• Adopts a new “Admissions” regulation, 42 CFR 412.3, to require a written inpatient admission order
• Amends the Inpatient Conditions of Payment regulation, 42 CFR 424.13, to require a physician inpatient certification in accordance with 42 CFR 412.3
• Both requirements are **conditions of payment**

See CMS Guidance: “Hospital Inpatient Admission Order and Certification” issued on September 5, 2013 and updated on January 30, 2014
Content of Certification

Content of Physician Certification

- Authentication of Physician/Practitioner’s Admission Order, including certifying that services were reasonable and necessary
- Reason for Inpatient Admission
- Estimated or Actual Required Length of Stay
- For CAHs, statement that the patient is expected to be discharged or transferred within 96 hours (outpatient and swing bed time does not count toward 96 Hour Rule)
- Plans for Post-Hospital Care, if appropriate

Note: Inpatient Rehab Hospitals have separate (more rigorous) certification requirements, see 42 CFR 412.606
Timing of Certification

Certification begins with the inpatient admission order.

The Certification must be completed, signed, dated and documented **prior to patient discharge**.

Note: 2015 Proposed IPPS Rule would allow the physician certification for inpatient admissions to CAHs to be completed no later than one day before the date on which the claim for payment is submitted.

CMS notes that “Generally good medical record documentation **may** fulfill components required for certification.”
Certification Format

No specific procedure or format is required or provided by CMS. CMS indicates that certification *components* may be found in various parts of the medical record (i.e., physician progress notes, etc.). Although no specific statement as to “certification” is required, referencing certification and all content components will be helpful.

But Note: “[T]here must be a separate signed statement for each certification.” *CMS Hospital Inpatient Admission Order and Certification Guidance*

Encourage physicians to sign a separate statement that summarizes the information from the medical record supporting the certification components, i.e., the reasons supporting the physician’s decision that inpatient services were medically necessary and consistent with the two-midnight rule.
Authorized to Sign Certification

- Physician who is a doctor of medicine or osteopathy
- Dentist as specified at 42 CFR 424.13(d)
- Podiatrist as authorized under state law
- Certifying doctor must be responsible for the beneficiary or have sufficient knowledge of the case—
  - Surgeon or physician on-call
  - Surgeon responsible for major procedure
  - Dentist functioning as admitting physician of record or surgeon for major dental procedure
  - In the case of admissions by a non-physician/non-dentist licensed by state with admitting privileges, a physician member of hospital staff who has reviewed file (such as a physician member of the utilization review committee)
  - ED physician or Hospitalist
- Certifying physician does not need to have admitting privileges
2014 Final IPPS Rule adopts 42 CFR 412.3

“[A]n individual is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission…This 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.”
Who Can Furnish an Admission Order

The Admission Order must be written by a qualified physician or other practitioner--

- Licensed by the state to admit inpatients
- Granted privileges by the hospital to admit patients
- With “sufficient knowledge” about the patient’s condition

Not required to be the certifying physician
Residents and Non-Physician Practitioners

- **Admitting Authority:** Qualified Admitting physician/practitioner may include practitioners (including medical residents) who (i) are exercising independent judgment, (ii) are authorized by law to admit inpatients without another physician’s approval and (iii) have admitting privileges (no countersignature required)

- **Delegated Authority:** Medical residents (working within a residency program), non-physician practitioners (e.g. PAs, NPs) or physicians, without admitting privileges, may act as a proxy to issue “bridge” admission orders if—
  - authorized under state law;
  - allowed by hospital bylaws and policies; and
  - ordering physician approves decision and countersigns order prior to patient discharge

Example: ED physician without admitting privileges must have order countersigned by admitting physician prior to patient discharge
“Sufficient Knowledge” to Write the Admission Order

Who has “sufficient knowledge” to write the admission order?

- Admitting physician of record
- Physician on call
- Primary or covering hospitalist
- Primary care practitioner treating the patient
- Surgeon responsible for major procedure
- Emergency or clinic practitioners caring for the beneficiary at the point of admission
- Others qualified to admit and actively treating the beneficiary (UR knowledge based on the medical record does not suffice)
Verbal Admission Orders

- Practitioners without admitting authority, such as nurses, may be permitted to accept and record verbal orders at their hospital
- Verbal order must identify the qualified ordering practitioner
- Qualified ordering practitioner must directly communicate the order
- Qualified ordering practitioner must countersign the order as written to authenticate the order
- Inpatient time starts with the verbal order, if authenticated prior to discharge
- State laws, hospital policies and bylaws, rules and regulations governing verbal orders must be met (See 42 CFR 482.24(c)(2))

Note: If a verbal order is not authenticated then the “hospital stay may be billed to Part B as a hospital outpatient encounter,” because patient was never an inpatient.
Standing Orders and Protocols

- A standing order may not serve as an order for inpatient admission
- A protocol or algorithm may be used in considering inpatient admission (See 42 CFR 482.24(c)(3))
- Only the ordering practitioner or practitioner acting on the ordering practitioner’s behalf (e.g., resident) may make and take responsibility for an admission decision
Timing and Specificity of Admission Order

- Time of Admission tied to time of order and formal admission process
  - If order written in advance, inpatient admission does not occur until formal admission of the patient by the hospital
  - If patient formally admitted prior to order being documented, inpatient stay begins with the order

- No specific language required for the order, but it is in the best interest of the hospital that the admitting practitioner use language clearly expressing his/her intent to “admit” as an “inpatient”
  - In “extremely rare circumstances” inpatient admission may be inferred by the Medicare contractor *in its discretion* from the medical record even in the absence of clear language
  - Avoid “admit to 7W” because MAC will not have the same understanding as hospital personnel that “7W” is limited to inpatient admissions
Transfers

• Pre-transfer time and care provided to beneficiary at the initial hospital may be taken into account to determine whether the two midnight benchmark was met
  – Clock starts for transfers when the care begins at the initial hospital
  – Excessive wait times or time spent in the hospital for non-medically necessary services must be excluded

• Records may be required from the initial hospital to support the medical necessity of the services provided and to verify when the treatment commenced
  – Claim submissions for transfer cases will be monitored and any billing aberrancy identified by CMS or review contractors may be subject to targeted review
  – CMS contractors to ensure compliance, deter gaming or abuse

• The initial hospital should continue to apply the two midnight benchmark based on the expected length of stay within the initial hospital’s facility

CMS 2 Midnight FAQ 2.2
Ohio Medicaid

Ohio Medicaid Rules on Inpatient Admission:

- The inpatient admission order must be written by a physician in an area or on a sheet designated as “Physician Orders”
- The order can be written by the attending physician or an Emergency Department physician
- Standards of Care dictate that a complete admission order include: date, time, level of care, diagnosis, physician of record, and signature of admitting physician
- When there are conflicting orders with respect to patient status, the last order written is considered to be the valid order
- An order to admit to inpatient status may not be written on day of discharge

See Permedion’s Ohio Medicaid Quality Monitor, Spring 2012
Two Midnight Rule Implementation—Probe and Educate

On November 4, 2013, CMS directed contractors to begin a “probe & educate” prepayment review of a small number of inpatient claims for inpatient admissions of less than two midnights beginning with admissions on October 1, 2013.

The MACs are to use the probe review as an educational tool; but inpatient admissions not meeting the new guidelines will be denied Part A payment.

CMS has extended this prepayment “probe and educate” period through September 30, 2014.
Rule Implementation – Probe and Educate

Prepayment Review under new Admissions Standards

Medicare Administrative Contractors will conduct patient status reviews using a “Probe and Educate” process for acute care, LTCH and inpatient psychiatric facilities for dates of admission on or after October 1, 2013 but before September 30, 2014

- MACs will select a sample of 10 claims for prepayment review from most hospitals (25 claims for large hospitals)
- Based upon the results of these initial reviews, MACs will deny claims not meeting the requirements for inpatient status, conduct educational outreach efforts, and repeat the review process where necessary
Probe and Educate, cont’d

Results of the initial probe audit may lead to increased prepayment review, based on error rate:

• **Minor Concern**: A provider with a low error rate and no pattern of errors, defined as 0-1 errors out of 10 claims or 0-2 errors out of 25 claims. MACs will educate the provider via the results letter indicating the reasons for denial of the inpatient claim, but will not conduct further review.

• **Moderate-Significant Concern**: A provider with a moderate error rate, defined as 2-6 errors out of 10 claims or 3-13 errors out of 25 claims. MACs will offer 1:1 telephonic provider education in addition to the written review results letters, and will continue further probe reviews.

• **Major Concern**: A provider with a high error rate, defined as 7+ errors out of 10 claims or 14+ errors out of 25 claims. MACs will offer 1:1 telephonic provider education in addition to the written review results letters, and will continue further probe reviews, with potential of an expanded probe of between 100-250 claims for continuing non-compliance.

See MLN Matters Number: SE1403
Probe and Educate, cont’d

• Denied claims may be appealed or rebilled as inpatient Part B claims (after admission) and outpatient Part B claims (prior to admission)

• CMS has instructed MACs to wait 45 days after educating hospitals on their compliance with the two-midnight rule under the “Probe and Educate” program before making additional documentation requests. The 45-day period is intended to give hospitals additional time to implement compliance strategies before the next audit.

• If “probe and educate” audit turns up zero errors or only one error, the hospital will not be subject to any more prepayment reviews under the two-midnight rule for claims with dates of services of October 1, 2013 through September 30, 2014.
Re-Review of Denials

CMS 2-24-24 Update to “Selecting Hospital Claims for Patient Status Reviews: Admissions On or After 10/1/2013”

• CMS requests MACs to re-review all claim denials under the Probe & Educate process during the period of **October 1, 2013 – January 30, 2014**, to ensure the claim decision and subsequent education is consistent with the most recent CMS clarification (on January 30, 2014, CMS updated initial September 5, 2013 guidance).

• MAC may reverse its decision and issue payment outside of the appeals process if the claim is determined payable on re-review.

• MAC may reopen and review claims in the appeal process, and decide to pay the claim or return the appeal to the appeal process.

• CMS urges providers to work with their MACs to determine if a claim has undergone final adjustment prior to submitting an appeal.

• CMS will waive the 120 day timeframe for level 1 appeals received before September 30, 2014 for Probe & Educate denials that occurred on or before January 30, 2014.
Role of Interqual and Milliman

CMS Guidance: While UR committees may continue to use commercial screening tools to help evaluate the inpatient preadmission decision, the tools are not binding on the hospital, CMS or its review contractors. “We are anticipating that most hospitals will choose not to use Interqual or Milliman to make the decision about whether or not to write the inpatient order. Instead, we’re expecting that most hospitals are going to look to the guidance in this rule about the physician’s expectation of a 2-midnight or more stay in the hospital requiring the hospital-level of care.”

But See CMS FAQ (“2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after 10/1/2013”) Q4.1—What documentation will Medicare contractors expect to support expectation of 2-midnights? A4.1: Expected LOS and underlying medical necessity of care at hospital must be supported by complex medical factors such as history and comorbidities, severity of signs and symptoms, current medical needs and risk of adverse event.

Note: Other payers may continue to apply commercial screening tools.
CMS Examples of Common Denials

• Missing or flawed inpatient admission order—Admission order did not clearly express intent to admit as inpatient
• Short-stay procedures not on the inpatient-only list—Patient underwent procedure with average LOS of less than two midnights
• Short stays for medical conditions when the record fails to support an expectation of two midnights—patient presented with dizziness and physician’s notes indicate that the physician intended to observe the patient overnight to monitor the effects of a medication change
• Physician attestation statements without supporting medical record documentation—preprinted statement that patient expected to require two midnights of hospital care was not supported by medical record entry—“discharge in morning if stable”
Two-Midnight Rule Implementation – Post-Payment Reviews

Post-Payment Patient Status Reviews

• In general, CMS will not conduct post-payment patient status reviews for claims with dates of admission October 1, 2013 - September 30, 2014.

• Recovery Auditors will not conduct pre-payment or post-payment patient status reviews for claims with dates of admission October 1, 2013 - September 30, 2014.

• Congress, at Section 111 of the Protecting Access to Medicare Act of 2014, (i) extended the Probe and Educate period and the ban on post payment reviews through March 31, 2015,and (ii) delayed the 0.2% reduction in hospital inpatient reimbursement through March 31, 2015.

Note: CMS withdrew Transmittal 505 (2/5/2014) which would have provided new authority to deny a claim for professional services based solely on the conclusion that the related inpatient claim or diagnostic test claim was not reasonable and necessary (CMS has indicated that this Transmittal will be reissued).
Reviews Not Impacted by Post-Payment Audit Delay

MACs, Recovery Auditors and the Supplemental Medical Review Contractor will continue other types of inpatient hospital reviews including:

- Coding reviews
- Reviews for the medical necessity of a surgical procedure provided to the hospitalized beneficiary
- Inpatient hospital patient status reviews for dates of admission prior to October 1, 2013 (based upon prior guidelines)

Recovery Auditor post-payment inpatient hospital patient status and medical necessity reviews may continue, but are limited to claims meeting the following criteria:

- Zero or one day utilization day stays
- Dates of admission prior to October 1, 2013
- Currently approved complex issues
Hospital Options: Part A to Part B Billing

Available Hospital Options for Obtaining Payment for Inpatient Claims denied by Medicare contractors or self-denied

1. File an administrative appeal of the Part A denial (n/a self denials)
2. Submit Outpatient Part B bill using Condition Code 44
3. Submit Outpatient Part B bill for services provided prior to denied inpatient admission and Inpatient Part B bill for services provided after admission (MedLearn Matter SE1333)
Administrative Appeals Process

**Level 1** – Redetermination to the Hospital’s Medicare Administrative Contractor – File within 120 days of initial determination (i.e., denial)

**Level 2** – Reconsideration to the Qualified Independent Contractor (Maximus Federal) – File within 180 days of Level 1 decision; Record must be complete at this level

**Level 3** – Appeal to Administrative Law Judge – File within 60 days of QIC decision (Note: Office of Medicare Hearing and Appeals 12/24/2013 Letter-- Effective on July 15, 2013, OMHA temporarily suspended assignment of requests for ALJ hearings for at least 24 months)

**Level 4** – Appeal to Medicare Appeals Council – File within 60 days of ALJ decision

**Level 5** – Appeal to U.S. District Court – File within 60 days of Medicare Appeals Council decision
CC 44: Criteria to Submit Outpatient Bill for Hospital-Initiated Patient Status Change

Condition Code 44

CMS Transmittal 299 (September 10, 2004)

**Condition Code 44** - See Medicare Claims Processing Manual, Chapter 1, Section 50.3.

Condition Code 44 permits the hospital to change the status of the patient from inpatient to outpatient and to submit an Outpatient Claim (Bill Type 131) for all services provided during the hospitalization.
CC 44: Criteria for Changing Patient Status, cont’d

CC 44 may be used only if all the following requirements are met:

- The UR committee determines that a patient was admitted erroneously;
- The patient status change is made prior to patient discharge;
- The hospital has not submitted a claim to Medicare for the inpatient admission;
- A physician responsible for the care of the patient concurs with the UR committee’s decision;
- The physician’s concurrence is documented in the patient’s record; and
- The patient must be notified in writing of the change in status.

One physician member of the UR committee may make the determination for the committee that the inpatient admission was not medically necessary if that physician is different from the “concurring” physician.

CC 44 does not permit retroactive physician orders. For example, observation requires a physician’s order. Changing patient status per CC 44 will not infer an order for observation.

If hospital changes patient status, then the patient’s treating physician should make a similar change to make hospital and physician claim submission consistent.
CC 44: Changing Patient Status, cont’d

CMS FAQ

Q: May a hospital change a patient’s status using Condition Code 44 when a physician changes the patient’s status without utilization review (UR) committee involvement?

A: No, the policy for changing a patient’s status using Condition Code 44 requires that the determination to change a patient’s status be made by the UR committee with physician concurrence. The hospital may not change a patient’s status from inpatient to outpatient without UR committee involvement. The conditions for the use of Condition Code 44 require physician concurrence with the UR committee decision. For Condition Code 44 decisions, in accordance with 42 C.F.R. 482.30(d)(1), one physician member of the UR committee may make the determination for the committee that the inpatient admission is not medically necessary. This physician member of the UR committee must be a different person from the concurring physician for Condition Code 44 use, who is the physician responsible for the care of the patient. For more information, see the Medicare Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.3.2.
Option to Submit a Part B Inpatient Bill – For Admissions Prior to October 1, 2013

CMS RULING 1455-R

Historically, CMS took the position that if a hospital’s Part A claim for inpatient admission was denied, the hospital was not permitted to bill an outpatient claim and could only submit a Part B inpatient claim (Bill Type 121) for certain limited diagnostic services.

ALJ and Medicare Appeals Council decisions permitted hospitals appealing Part A denials to recover Part B outpatient reimbursement for medically necessary services.

CMS Ruling 1455-R (March 13, 2013) allows for some expansion of Part B rebilling and applies to--

- Part A claims denied for lack of medical necessity that were on appeal or could be timely appealed as of March 13, 2013
- Part A claims for admissions denied after March 13, 2013, and preceding October 1, 2013
- Part A claims for admissions preceding October 1, 2013 and denied after October 1, 2013

CMS Ruling 1455-R does not apply to self-disallowed Part A claims.
CMS 1455-R, The Rebilling Process

CMS 1455-R: The Process for rebilling denied Part A claims:

- If an appeal is pending, the hospital may withdraw the appeal and submit a claim for Part B payment.
- If no appeal is pending but the time for filing appeal has not expired, the hospital may elect to submit a claim for Part B payment and forgo the appeals process.
- The hospital cannot submit a claim for Part B payment and pursue an appeal for Part A payment for the admission.
- The one-year timely filing deadline will **not** bar rebilling. The hospital has 180 days to submit a Part B claim from either the date the hospital receives notice that an appeal has been dismissed or the date the hospital receives notice of a final and binding unfavorable ruling.
CMS 1455-R, The Rebilling Process, cont’d

CMS 1455-R: The Process for rebilling denied Part A claims, cont’d

• When a hospital rebills as a Part B claim, the hospital should use condition code “W2”, which designates that the claim is a duplicate of a previously submitted and denied Part A claim; there is no appeal, and any amounts collected from the beneficiary on the Part A Claim will be refunded to the beneficiary.

• Patient status remains inpatient as of the time of inpatient admission and is not changed to outpatient. (May have to submit two bills if patient received outpatient services prior to inpatient admission: Outpatient Part B (TOB 131) and Inpatient Part B (TOB 121)

• 3 Day Window does not apply.

• All services on the Inpatient Part B claim are payable as if the patient had been treated as an outpatient with the exception of the services that specifically require an outpatient status: outpatient visits, ER visits, and observation services.
Option to Submit a Part B Inpatient Bill – Medicare 2014 IPPS Final Rule

Rebilling Option Per the Final Rule 1599-F (October 1, 2013 and after)
The Final Rule adds new regulation 42 CFR 414.5, “Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied” applicable to inpatient admissions on and after October 1, 2013, that were--

- Denied for lack of medical necessity; or
- Adjusted by the hospital as the result of self-audit.

Notes:

- One year timely filing requirement will apply to rebilling for both denials and self-adjustments. Part B “rebill” must be submitted within 1 year of date of service. 42 CFR 414.5(c).
- Section 414.5 removes the ability of the ALJ and Medicare Appeals Council to offset Part B reimbursement against Part A denials on appeal for admissions on and after 10/1/2013.
- Hospital waives appeal rights on Part A claims if hospital chooses to submit a Part B bill.
Rebilling Process Under the Medicare 2014 IPPS Final Rule

MLN Matter No. SE1333-Part A to Part B Billing of Denied Hospital Inpatient Claims

Part A to Part B rebilling requirements:

- Hospitals are required to maintain documentation to support services billed as Part B inpatient services.

- For self-denied claims, hospitals must first cancel the Part A claim.

- Hospitals may then submit a Part B inpatient claim (TOB 121) for inpatient services that would have been reasonable and necessary if the beneficiary had been treated as an outpatient, except for services that require an outpatient status.

- Hospitals must submit a separate outpatient claim (TOB 131) for outpatient services rendered prior to inpatient admission.
Rebilling Self-Audit Denials – The Part A Provider Liable Claim

Hospitals must submit a “Part A Provider Liable Claim,” which indicates the following information:

- TOB 110 in Form Locator (“FL”) 4
- Non-covered days
- Services from admission through discharge
- Appropriate patient status
- Occurrence Span Code “M1” and dates of service
- Non-covered charges for all services rendered
- All diagnosis codes
- All procedures codes

After the inpatient claim has processed and a Remittance Advice has been issued, a Part B inpatient claim (TOB 12X) can be submitted. Note: Part B rebill must be submitted within 1 year of date of service.
Rebilling Denied Part A Claims
MedLearn Matters No. SE1333

For Part A Inpatient admissions denied as not reasonable and necessary or self-denied, hospitals shall submit a qualifying Part B Inpatient Claim (TOB 12X)

- Include all supporting diagnostic codes
- A treatment authorization code of A/B Rebilling to be submitted by the hospital
- Providers billing an 837I shall place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01=G) as follows: “REF*GI*Rebilling~”
- Use Condition Code “W2” attesting that this is a rebilling and no appeal is in process
- Include the original, denied inpatient claim (CCN/DCN/ICN) number
  - Providers billing an 837I shall place DCN in the Billing Notes Loop 2300/NTE in the format: “NTE*ADD*ABREBILL12345678901234~”
  - For DDE or paper claims, providers shall place the word “ABREBILL” plus the denied inpatient DCN/CCN/ICN shall be added to the Remarks Filed (FL 80) using the format: “ABREBILL12345678901234”.

Note: The numeric string “12345678901234” is a placeholder and should be replaced with the original claim DCN/ICN numbers from the inpatient denial.
Scope of Part B Inpatient Billing

Per 42 CFR 414.5(a), CMS will allow Part B payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient rather than admitted as an inpatient—

- Services paid under Hospital Outpatient PPS that do not require outpatient status
- PT/OT/Speech Language Pathology Services
- Ambulance Services
- Non-implantable DME and prosthetics and orthotics
- Clinical Diagnostic Laboratory Services
- Screening and Diagnostic Mammography Services
- Annual Wellness Visit
Exclusions from Inpatient Part B Services

Inpatient Part B Services do not encompass:

- Services that specifically require an outpatient status such as outpatient visits, emergency department visits, observation services, and diabetes self-management training (DSMT); and

- Inpatient routine services included in the hospital’s daily service charge (room and board), such as dietary, nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of equipment and facilities for which separate charge is not customarily made. Examples include floor nurse IV infusions and injections, blood administration and nebulizer treatments.

See MLN Matter Number SE1333 for a list of Revenue Codes not covered under Inpatient Part B Medical Necessity Denials.
Opposition to the Final Rule: AHA Lawsuits

The AHA and certain hospitals have joined in filing two lawsuits in the U.S. District Court for the District of Columbia challenging the 2014 IPPS Final Rule

**Case 1:14-cv-00607** challenges the validity of the 0.2 percent hospital inpatient payment reduction in FY 2014 based on the CMS “estimate” that the two-midnight rule will increase hospital inpatient reimbursement. The complaint claims that the CMS payment reduction is based upon flawed methodology and assumptions and implemented outside the regulatory process. (Note: 0.2% payment reduction also subject to PRRB individual or group appeal.)

**Case 1:14-cv-00609** challenges—

- The Two-Midnight Rule as undoing decades of Medicare policy and permitting the government to supplant treating physicians’ judgment
- The One Year Filing Limit as depriving hospitals payment for medically necessary services when Part A claims are denied, noting that most RAC denials do not occur within the one-year time limit
- The Written Admission Order/Certification as inconsistent with the Medicare statute which requires written certification only for extended hospital stays
Two-Midnight Rule Impact on Beneficiary

• Potential Increased Beneficiary Liability for 20% Part B Copay and 100% of the cost for self-administered drugs

• CMS has indicated that even patients receiving ICU services are not considered appropriate for inpatient admission unless the physician expects the stay to last two midnights. This could lead to very large copayment obligations.

• Qualifying stay for SNF Part A coverage: Time spent in the hospital receiving outpatient services (e.g., observation) counts towards the Two-Midnight Benchmark for admission purposes, but does not count towards the required 3-day inpatient stay for SNF coverage.

• General beneficiary confusion as to patient status and payment obligations (especially with regard to rebilling Part A to Part B).
Impact on Beneficiaries: Co-Insurance and Deductibles

Any Co-Insurance or Deductible collected for the Part A claim must be refunded to the beneficiary.

CMS in the preamble to the Final Rule refused to provide authority for hospitals to

- offset Part B beneficiary liability against Part A deductible, or
- waive the Part B beneficiary liability for copayments and non-covered items and services.
Hospital Obligation To Self Audit Inpatient Claims

Patient Protection and Affordable Care Act, P.L. 111-148, Section 6402, 42 U.S.C. 1320a-7k(d)

Reporting and Returning of Overpayments—

In general. If a person has received an overpayment, the person shall within 60 days of “identifying” the overpayment—

(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

The term “overpayment” means any funds that a person receives or retains under title XVIII (i.e. Medicare) or XIX (i.e. Medicaid) to which the person, after applicable reconciliation, is not entitled under such title.
Hospital Obligation to Self Audit Inpatient Claims, cont’d

**Question**: Is existing CMS guidance clear and consistent enough to “identify” an overpayment under the Two-Midnight and Physician Admission/Certification Rules?

**Note**: 2015 Proposed IPPS Rule asks for public input on an alternative payment methodology for short stay inpatient cases that also may be treated on an outpatient basis, *including how to define short stays for very sick patients.*

**Conundrum**: Self-deny and rebill Part B claims or potentially lose ALL reimbursement under the one-year timely filing deadline.
Self Audit/Voluntary Refund Option

• Consider the Self Audit of zero – one day stays
• Consider voluntary refund of questionable inpatient admissions (repay difference between inpatient vs. outpatient services for admissions prior to 10/1/13) to avoid total denial by RAC and potential inability to rebill as outpatient services.
  – Query as to how to treat claims in the “delayed enforcement period”
  – For admissions after 10/1/13: Self-audit and rebilling must occur within one year of date of admission if the hospital is to receive any Part B reimbursement
  – Not clear if sampling is an option
Compliance Strategies: Build a Compliance Team

**Build a team** of medical, legal and IT personnel for educating providers and ensuring compliance:

- Health Information Management/Coders
- UR/Case Management
- Admissions
- Patient Financial Services
- Compliance
- Physician Advisor
- Legal Counsel
Compliance Strategies

Be Proactive - Educate

• Educate staff, including physicians, on (i) the new CMS inpatient definition; (ii) admission and certification requirements; and (iii) the distinction between admission to inpatient status and admission to observation

• Stress the importance of clear wording and documentation reflecting intended patient status and admission orders (i.e. “admit as inpatient;” “place in observation”)

• Provide UR Committee education on the use of Condition Code 44 and provide resources for concurrent review and intervention by case managers and UR Committee

• Provide Patient Accounting personnel education on rebilling Part A claims as Part B claims
Be Defensive – Document: Clear and complete documentation is the best defense against Part A claim denial

- Consider preparing a separate “Inpatient Admission Certification Statement Form” to assist physicians in complying with these new requirements
  - Avoid “canned” certification statements
  - Certification must be supported by the medical record
- In the absence of a certification form, encourage physicians to sign a separate statement that summarizes the information from the medical record supporting the certification components, i.e., the reasons for the physician’s decision that inpatient services were medically necessary and consistent with the two-midnight rule
- Physician should document if patient recovers or is discharged “sooner than expected”
- Document the exact time of initiating outpatient treatment for purposes of the two-midnight benchmark
Compliance Strategies, cont’d

Be Proactive: Implement Defensive Policies and Procedures

• Consider implementing a protocol or assigning additional case management personnel to assist physicians in managing patient status to effectively transition patients to either inpatient status or discharge

• Assign personnel to review all records prior to inpatient discharge to ascertain authentication of the admission order and completion of the certification statement

• Develop a protocol for reviewing short stay admissions; correct inappropriate admissions prior to patient discharge

• Scrutinize inpatient admissions for surgical procedures with average LOS of less than two midnights

• Consider using physician advisors to resolve disagreements between admitting physicians and case management nurses and/or UR committee

• Review and if necessary revise Hospital/Medical Staff policies on admitting privileges and verbal orders

• Monitor changes in Medicare guidance regarding inpatient status and medical necessity
QUESTIONS

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