Agenda

- IPPS Final rule – inpatient status changes
- Proposed OPPS – changes to reporting hospital evaluation and management codes
- Medical Necessity battles
- ICD-10 transition
- RAC update
IPPS Final rule – inpatient status changes
CMS Policy Changes Related to Short Stays

- CMS Rule 1599-F
  - In reaction to 3 pressures, CMS has established this rule to provide a “balanced approach and global solution”
    - Observation vs. IP status pressures
    - High error rate for IP stays
    - Rapid increase of RAC reviews
- CMS recognizes that the new rule is a complicated process that requires flexibility
  - 3 month period for hospitals to put the staffing and system changes in place without fear of enforcement
  - Probe and education program
CMS Policy Changes Related to Short Stays

• **Probe and Education Program**
  – MACs will focus on review less than 1 IP midnight for status reviews
  – Will pick 10 claims for small hospitals, 25 claims for large hospitals
  – Perform claim review for services admitted between 10/1/13 and 12/31/13
  – Results will be shared with providers via education
  – During the period – no RAC pre or post payment reviews for status
  – January 2014 – Study results
CMS Policy Changes Related to Short Stays

• CMS Rule 1599-F
  – Services designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician
    (1) expects the beneficiary to require a stay that crosses at least two midnights, and
    (2) admits the beneficiary to the hospital based upon that expectation
  – Timing for two midnights begins when the beneficiary starts receiving services in the hospital
    • This would include outpatient care received while the beneficiary is in observation status,
    • In the emergency department
    • In the operating room, or other treatment room
Physician certification is required for payment under Part A

- Order is a critical element
- Requirements for the physician certification are found in 42 CFR Section Part 424 subpart B and 42 CFR 412.3
Inpatient Status – Physician Certification

- Physician Certification includes the following:
  - Authentication of the practitioner order
    - Physician certifies that IP services were ordered in accordance with Medicare regulations governing the order
    - Includes certification that services are reasonable and necessary
    - In the case of services not specified as IP only that services are appropriately provided as IP services in accordance with the 2-midnight benchmark under 42 CFR Section 412.3(e)
  - Reason for the inpatient services
  - Estimated time the beneficiary requires or required in the hospital
  - The plans for posthospital care, if appropriate (42 CFR section 4 CFR section 424.13)
  - For IP CAH services the physician must certify that the beneficiary may be reasonably expected to be discharged or transferred within 96 hours of admission to CAH
Inpatient Status – Physician Certification Timing

- Certification begins with the order for IP admission
- It must be completed, signed, dated and documented in the medical record prior to discharge
  - Exception – outlier cases which must be certified and recertified as provided in 42 CFR 424.13 and
  - Exception – certification of CAH inpatient which is required no later than 1 day prior to the date on which the claim for payment for the IP CAH services is submitted.
Inpatient Status – Authorization of Certification

• The certification or recertification may be signed only by one of the following
  – A physician who is a doctor of medicine or osteopathy
  – A dentist in the circumstances specified in 42 CFR 424.13(d)
  – A doctor of podiatric medicine if his or her certification is consistent with State Scope of Practice

• Physician must have sufficient knowledge of the case to serve as “certifying physician”
  – The admitting physician of record
  – The physician on call for the admitting physician of record
  – A surgeon responsible for a major surgical procedure on the beneficiary
  – A dentist responsible for a major dental procedure
  – A physician member of the hospital staff who has reviewed the case (UR)
Inpatient Status – Certification Format

- Per 42 CFR 424.11 no specific procedures or forms are required for certification and recertification
- The provider may adopt any method that permits certification
- The certification statements may be entered
  - On forms
  - On notes
  - On other records that the appropriate individual signs or
  - On a special separate form
- There must be a separate signed statement for each certification or recertification
In the absence of specific certification or recertification forms, the following must be contained in the medical record:

- Admission order must be signed or countersigned by the certifying physician.
- The requirement to certify the reasons the services are medically required will be met by:
  - The diagnosis and plan documented inpatient admission assessment or
  - The inpatient admitting diagnosis and orders.
- The estimated time requirement will be met by the inpatient order written in accordance with the 2-midnight benchmark, supplemented by physician notes and discharge planning instructions.
Inpatient Status – Certification Format

- The post hospital care plan requirement will be met by either physician notes or the discharge planning instructions
- The CAH 96 hour expectation will be met either by
  - Physician notes or
  - Actual discharge within 96 hours
Proposed OPPS – changes to reporting hospital evaluation and management codes
2014 Proposed Outpatient Rule – Medicare

- CMS wants to eliminate visit levels and instead have facilities report three G-codes:
  - One for office visits
  - One for Type A ED visits
  - One for Type B ED visits

- No change for Professional Component Coding
- No change for other payers
Medical Necessity Battles
Short Stay

- **What is a short stay?**
  - Inpatient admissions lasting less than two days

- **What is the compliance issue?**
  - While services provided during the stay may have been medically necessary, it was not necessary to provide them on an inpatient basis
  - **Examples:**
    - Stays following cardiovascular procedures
    - Stays following minor surgeries and diagnostic procedures
    - ED visits followed by short stays (observation)
CMS is increasing the scope of cases being targeted for compliance audit, pushing hospitals to manage processes up front to avoid denials.

**Medical**
- Chest Pain
- Syncope (fainting)
- Dehydration
- Back Pain

**Surgical**
- Cardiac Procedures
- Mastectomy
- Prostatectomy
- Laparoscopic Appendectomy

**Gray Area:** Cases that require individual assessment due to unclear medical necessity.
Cases that are clearly appropriate for Inpatient setting or clinical need:

- Acute MI
- Coronary Artery Bypass Graft
- Open Appendectomy
- Acute Intracranial Bleed
- Heart Valve Transplant
- Respiratory Failure
- Inpatient only list
“Gray Matter” – Medical Necessity

- Cases that are clearly appropriate for Outpatient setting:
  - Scheduled Transfusion
  - Injection / Chemotherapy
  - Skin Biopsy
  - Tympanostomy Tube Placement
  - Dilation & Curettage
Short Stays – Hot Topics

• RACs have been actively reviewing short stays for years

• Approved items are on the RAC’s website listed as “approved items”

• Hospitals nationwide are reporting a 70% appeal success rate before reaching ALJ level

• DOJ is looking for patterns with short stays that may show knowledge

• CMS Ruling 1455-R (March 13, 2013)
  – allows for “expanded” Part B rebilling after medical necessity denial of Part A stay
Observation

- Observation is a patient **status, not a patient location**
- Observation can (and does) occur anywhere
- Observation defined:
  
  - “Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

  — CMS Transmittal 1745, 290.1 – Obs. Services Overview
Documentation required for observation:

- “Explicit” physician risk assessment
- A physician order (with date and time)
- Timed, dated and signed notes
- Periodic physician visits
- Periodic monitoring by nursing and other staff
- Initial direct physician (or NPP) supervision
- Statement of stability for general supervision
- “Carve outs” for time under active monitoring other than by nursing unit
Observation - Time

- G0378 is billed per hour, rounded to nearest hour
- Bill all hours for a single encounter on one line.
  - The line-item date of service is the date the patient is admitted to observation care.
- Calculating Observation Time:
  - Begin: Observation care is initiated per doctor’s order
  - End: All medically necessary services related to observation are complete
    - This may be prior to the patient’s actual physical discharge from the hospital
Observation - Time

• Subtract time during diagnostic procedures (i.e. colonoscopy) and therapeutic procedures (i.e. chemotherapy) that require “active monitoring”
  – This may include drug administration services

• Documenting hours of observation
  – Physician’s order to start observation time
  – Beginning and end of procedures with active monitoring must be documented to subtract time
    • Example - push injection

• Nurse’s notes that observation related care is complete
  – Generally ends at time discharge instructions are complete
Extended Observation

• “Extended recovery” and “outpatient in a bed” are not Medicare terms; they are terms developed by hospitals to distinguish between certain outpatient areas or ways to classify patients for billing purposes.

• Medicare recognizes 3 statuses
  – Inpatient
  – Outpatient
  – Non-patient
Extended Recovery

Extended recovery

- Routine monitoring following a surgical procedure
  - Not related to an identified complication (observation)
  - Timeframe is dependent on the procedure
- Billed under revenue code 0710 not 0762
- No HCPCS
- May be billed on same claim with observation, if medically necessary/covered
  - But not for same time period
Extended Recovery

Extended recovery (cont.)

- No separate payment is available
  - Payment is made as part of the separate payment made for the surgical procedure
- Non-OPPS hospitals are paid the cost of medically necessary extended recovery services
Clinical Documentation Improvement (CDI)

• IP vs. OBS issue
  – What can we do to get it right up front?
  – MD documentation is key—So what do we do?
  – Clinical Documentation Improvement
    • “. . . screening criteria must be used by the UM staff to screen admissions . . .
    • The criteria used should screen both severity of illness (condition) and intensity of service (treatment).
    • Cases that fail the criteria [for admission] should be referred to physicians for review.
Clinical Documentation Improvement (CDI)

- Recognize that this is about daily tactics:
  1. Case Management applies current, strict admission criteria to 100% of the medical cases placed in hospital beds, and documents this review in an auditable format (Milliman or InterQual)
  2. ALL cases that do not pass criteria (regardless of admission order status) are referred to a Physician Advisor who is an expert in CMS rules and regulations and clinical standards of care
  3. The Physician Advisor reviews the case, speaks with admitting physician when needed, makes their recommendation based upon UR standards, and documents the decision in auditable format in the patient chart or in UR documentation
  4. Attending physician changes order, as appropriate
  5. Should run 7 days a week/365 days a year
Clinical Documentation Improvement (CDI)

- **Operational strategies**
  - Adopt and stay current with accepted industry guidelines
    - InterQual®/Milliman (MCG)

- **Physician documentation education**
  - Do not document “Observe” in any H&P if intent is Inpatient
  - Document what the patient is at risk for
    - “I’m uncomfortable sending the patient home because…”
    - “The patient is at risk for…”
    - “Failed outpatient treatment”

- Care coordination to assist at point of entry
ICD-10 Transition
Overview of ICD-10

• International Classification of Diseases (ICD) is the official system used in the U.S. to classify and assign diagnosis and inpatient procedure codes to health conditions and procedures.

• The U.S. has been using ICD-9 (Ninth Edition) since 1979 – 34 years
  – The current system is outdated and is no longer able to allow for assignment of codes for new treatments and technology
  – Limited specificity – cannot accurately describe the diagnoses and inpatient procedures for care delivered today

• While the U.S. is preparing for the transition to ICD-10, many other countries have implemented ICD-10 and are already looking to move to ICD-11

• U.S. must transition to ICD-10 by October 1, 2014
Overview of ICD-10

Why transition to ICD-10?

• Current coding system can’t take healthcare into the future – today’s data needs are dramatically different than they were 30 years ago

• ICD-10 will advance healthcare in many ways, with benefits across five major categories:
  • Quality measurement
  • Public health
  • Research
  • Organizational monitoring and performance
  • Reimbursement
Overview of ICD-10

- ICD-10 better describes acuity, complexity and laterality
- There are 68,000 diagnosis codes in ICD-10-CM (clinical modification) compared to 13,000 diagnosis codes in ICD-9-CM
- ICD-10-CM format example:
  
  - S52 Fracture of forearm
  - S52.5 Fracture of lower end of radius
  - S52.52 Torus fracture of lower end of radius
  - S52.521 Torus fracture of lower end of right radius
  - S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture
ICD-10 Humor


- Hurt at the opera: Y92253
- Stabbed while crocheting: Y93D1
- Walked into a lamppost: W2202XA
- Walked into a lamppost, subsequent encounter: W2202XD
- Asphyxiation due to being trapped in a discarded refrigerator, accidental: T71.231D
- Spacecraft crash injuring occupant, initial encounter: V9542XA
ICD-10 Impacts Across the Health Care Industry
ICD-10 Implementation Timeline

COMMUNICATION & OUTREACH
Sep 2010 - Mar 2015

PLANNING & ANALYSIS
Jul 2009 - Feb 2013

DESIGN
Dec 2011 - Feb 2013

DEVELOPMENT
Dec 2012 - Apr 2013

TESTING
Apr 2013 - Sep 2014

IMPLEMENTATION
Oct 1, 2014
# ICD-10 Implementation Timeline for Small-Medium Practices at a Glance

<table>
<thead>
<tr>
<th>Task</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>PLANNING</td>
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<tr>
<td>Identify resources</td>
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<td>Create project team</td>
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<td>Assess effects</td>
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<td>Create project plan</td>
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<td>Secure budget</td>
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<tr>
<td>COMMUNICATIONS</td>
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<tr>
<td>Inform staff</td>
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<tr>
<td>Contact vendors</td>
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<td>Contact payers</td>
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<td>Monitor vendor prep</td>
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<td>Monitor payer prep</td>
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<tr>
<td>TESTING</td>
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<tr>
<td>High-level training for test</td>
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<tr>
<td>team</td>
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<tr>
<td>Level 1: internal</td>
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<td>Level 2: external</td>
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<tr>
<td>COMPREHENSIVE TRAINING</td>
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<td>Documentation</td>
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<tr>
<td>Coding</td>
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**DEADLINES:**
- Q3 2014
- Q1 2015
- Ongoing practice before “go live”
ICD-10 Cost Impact

- ICD-10 often described as the “unfunded mandate”
- Almost every aspect of business operations will be impacted, requiring training and significant financial resources:
  - Clinicians and ancillary staff
  - Health Information Management (HIM)
  - Information technology (IT)
  - Finance
  - Decision support
  - Clinical documentation
  - Administrative staff
- Very few areas not impacted (cafeteria, housekeeping, laundry, maintenance, fundraising)
ICD-10 Cost Impact

- Estimates of the industry cost to implement ICD-10 vary widely, ranging from $6 billion to $14 billion. Several large hospital systems estimate the transition to cost more than $100 million.

- The total cost to implement ICD-10 is estimated to be between $83,000 for a small physician practice to more than $2.7 million for large physician practices.

- There are cost considerations that could be difficult to estimate, such as:
  - Cost differentiation between productivity and accuracy for coders
  - Costs associated with recruitment or use of external coding resources
  - Changes to reimbursement that could occur after the cutover
  - Impact on denials, accounts receivable and discharged-not-final-billed at the cutover
Sir, your team with the quick fix for our ICD-10 conversion has arrived.
The Recovery Audit Program was established by CMS to identify and correct Medicare improper payments (both overpayments and underpayments) made on claims of health care services provided to Medicare beneficiaries.

Run as a demonstration program between 2005 and 2008, resulting in:

- $900 million in overpayments returned to Medicare Trust Fund
- $38 million in underpayments returned to health care providers

Now a permanent national program operating through four Recovery Audit Contractors (RACs) in four regions of the country.
RAC Regions

Region A: Performant Recovery

Region B: CGI Federal

Region C: Connolly, Inc.

Region D: HealthDataInsights, Inc.
### Medicare RAC Region B Web Site

#### RACB Issues

<table>
<thead>
<tr>
<th>Issue Name</th>
<th>Issue Type</th>
<th>Claim Types</th>
<th>States</th>
<th>Date Approved</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Other Vascular Procedures with MCC MS-DRG 255 (Medical Necessity Excluded)</td>
<td>Complex</td>
<td>Inpatient</td>
<td>MN, WI, MI, IL, IN, OH, KY</td>
<td>9/10/2013</td>
<td>Details</td>
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<tr>
<td>MS-DRGs without COMCC and LOS greater than or equal to GMLOS (Medical Necessity Excluded)</td>
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<td>Inpatient</td>
<td>MN, WI, MI, IL, IN, OH, KY</td>
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<td>DME Home Blood Glucose Testing Supplies</td>
<td>Semi-Automated</td>
<td>DME</td>
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<td>9/5/2013</td>
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<td>Comprehensive Outpatient Rehabilitation Facilities Pre-Payment Review—Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold</td>
<td>Complex</td>
<td>Comprehensive Outpatient Rehabilitation Facilities</td>
<td>MI, IL, OH</td>
<td>8/1/2013</td>
<td>Details</td>
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<td>Home Health Pre-Payment Review—Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold</td>
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<td>Home Health</td>
<td>MI, IL, OH</td>
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<td>Outpatient Rehabilitation Facilities Pre-Payment Review—Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold</td>
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<td>Outpatient Hospitals Pre-Payment Review—Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold</td>
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<td>Outpatient Hospitals</td>
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<td>Outpatient Professional Pre-Payment Review—Manual Medical Review of Outpatient Therapy Claims above the $3,700 Threshold</td>
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<td>Skilled Nursing Facility</td>
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<td>8/1/2013</td>
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<tr>
<td>Minor Surgery and Other Treatment Billed as an Inpatient Stay (Medical Necessity)</td>
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</table>

[https://racb.cgi.com/Issues.aspx](https://racb.cgi.com/Issues.aspx)
RACTrac Initiative

- The American Hospital Association (AHA) created RACTRAC—a free, web-based survey—in response to a lack of data provided by CMS on the impact of the RAC program on America’s hospitals.
- Results reported quarterly
- 2,452 hospitals have participated in RACTRAC since data collection began in January of 2010.
- Participants continue to report dramatic increases in RAC activity
- AHA’s RACTRAC website: http://www.aha.org/ractrac
Wrap up, questions and answers
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