Centers for Medicare & Medicaid Services

Special Open Door Forum:

CMS Rule 1599-F: Inpatient Hospital Admission and Medical Review Criteria (2-Midnight Provision) and Part B Inpatient Billing in Hospitals.

Thursday, August 15, 2013

3:00pm – 4:00pm Eastern Time

Conference Call Only

CMS will host a Special Open Door Forum (ODF) call to allow hospitals, practitioners, and other interested parties to give feedback on the physician order and physician certification, inpatient hospital admission and medical review criteria, and Part B inpatient billing provisions that were released on August 2, 2013 in the FY 2014 Inpatient Prospective Payment System (IPPS) final rule (CMS-1599-F).

The final rule instructs the physician on when an inpatient hospital admission should be ordered and certified, and clarifies for the practitioner and facility when inpatient hospital admissions are generally appropriate for Medicare Part A payment. The new rules are intended to address concerns about some Medicare beneficiaries having long stays in the hospital as outpatients and improve program integrity. Under the rule, if a physician expects a beneficiary's surgical procedure, diagnostic test or other treatment to require a stay in the hospital lasting at least two midnights, and admits the beneficiary to the hospital based on that expectation, it is generally appropriate that the hospital receive Medicare Part A payment. The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status, but permits the physician to consider all time a patient has already spent in the hospital as an outpatient receiving observation services, or receiving care in the emergency department, operating room, or other treatment area in guiding their two-midnight expectation.

We finalized our proposal to continue applying the timely filing restriction to the billing of all Part B inpatient services, under which claims for Part B services must be filed within 1 year from the date of service. However, we will permit hospitals to follow the Part B billing timeframes established in CMS Ruling-1455-R after the effective date of the final rule (October 1, 2013), provided (1) the Part A claim denial was one to which the Ruling originally applied; or (2) the Part A inpatient claims has a date of admission before October 1, 2013, and is denied after September 30, 2013 on the grounds that although hospital outpatient services would have been reasonable and necessary, the inpatient admission was not. In the final rule, we also discussed appeals, beneficiary liability and other impacts of our final policies.

You can find the final rule by going to: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html

Feedback and questions on the two midnight provision for admission and medical review can be sent to IPPSAdmissions@cms.hhs.gov. Questions on Part B inpatient billing and the clarifications regarding the physician order and certification should be sent to the subject matter staff listed in the final rule.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/081513InpHosAdm2MidnightProvSODF.mp3

Files Size: 14.5 MB

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Jennifer Dupee
August 15, 2013
3:00 p.m. ET

Operator: Good afternoon, my name is (Denise) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services IPPS Rule 1599, Two Midnight Provision Special Open-door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

(Jennifer Dupee), you may begin your conference.

(Jennifer Dupee): Hi, good afternoon everybody. My name is (Jennifer Dupee), I'm Nurse Consultant in the Provider Compliance Group here at the Centers for Medicare & Medicaid Services, and I just wanted to go around the room here at CMS just to give you all an idea of who we have attending today. I know we also have a couple of people on the line, so start …

(Dan Duvall): (Dan Duvall), Medical Officer, Payment Policy.

Mike Handrigan: Mike Handrigan, Medical Officer for Provider Compliance Group.

Jennifer Phillips: Jennifer Phillips, Nurse Consultant for Provider Compliance Group.

George Mills: George Mills, Director, Provider Compliance Group.

(Jennifer Dupee): And on the line from CMS.

John McInnes: John McInnes, Director of the Division of Outpatient Care.

(Jennifer Dupee): All right, thank you very much. So the purpose of today's call is to give an overview of three related policies that were published as part of the 2014 Inpatient Prospective Payment System Final Rule. The first being the Part B Inpatient Billing and Hospitals, the second being the Physician Order and Certification Requirements for Inpatient Admission, and the third is the Inpatient Hospital Admission and Medical Review Criteria. We're also going to be discussing future plans for implementing these policies in the coming weeks, and discussing how we're hoping to involve stakeholders in these plans and also how we will be addressing any questions and concerns as they may arise in the coming weeks.

We will begin our discussion today with an overview of the Part B and Patient Billing and Hospitals and the Physician Order and Certification Requirements, both of which will be presented by John McInnes, the Director of Division of Outpatient Care and the CMS Ambulatory Policy Group. So I am going to go ahead and hand it over to John, thank you.

John McInnes: Thank you. John McInnes here, the Division of Outpatient Care. I am just going to briefly summarize the provisions dealing with the rebilling of services as under Part B for reasonable and necessary denials, Part A claims. And I'm also going to briefly discuss the requirements for an order in inpatient certification.

So very briefly, it's been a long-standing policy in Medicare when a Part A claim is denied, the hospitals can re-bill for some of the services under Part B. You know, up until this most recent activity including an administrator ruling

and then this final rule, the number of services have been quite limited such that the amount of Part B rebilling has been very limited.

But what this rule does is it greatly expands the different benefit categories and number of different services that can be re-billed under the Part B rebilling, so if a hospital has a Part A claim that is denied, or they proclaim a self-audit and determine that a Part A claim is not appropriate, they can bill just about all the services that can be provided as an outpatient on a Part B inpatient claim to Medicare and get paid for those services. There are some exceptions and there are a few caveats.

Some of the exceptions are – in other words, services that cannot be re-billed are services that cannot be provided as an inpatient and need to be provided only – or can be provided only to outpatients. And that includes observation services, that's uniquely an outpatient service, possible outpatient visits, those reports can only be provided in hospital outpatient departments.

And something known as Outpatient Diabetes Self-Management Training, the description of that benefit category is limited to outpatient, but it's actually a fairly small list of exceptions and so this expansion of rebilling really includes just about (inaudible) the patient could receive in the hospital.

Now for dates of service admissions after the effective date of the final rule, which is October 1st, the normal restriction on the filing of claims, one year timely filing will apply. So any rebilling will have to take place within one year of the date of service.

So with that, I'll just move briefly to the requirements for an order and certification. Now this – in the IPPS final rule represented a codification of law standing requirements of course an order has been required for inpatient admission for a long time, and also the statute has required certification of the inpatient stay, but we've made the requirements more clear and put them in regulation, and I'll just briefly describe what is required.

So the regulations say that a patient is formally admitted as an inpatient pursuant to the inpatient – pursuant to an order for inpatient admission, and

this must be provided by a physician or other qualified practitioner, and it must be documented in the medical record.

So what we mean is that the order must be furnished by somebody's who is a qualified and licensed practitioner who has admitting privileges as the hospital as permitted by state law and someone who is knowledgeable about the patient's hospital course medical plan and current condition. So somebody who is going to be involved in the care of the patient, and that can't be delegated to somebody who is not described by those requirements.

And with respect to the certification, these requirements are outlined in CFR 424 and we specify that the certification begins with the order for admission in the medical record and the other items of the certification as listed in the regulation 424.13, beginning with the order but also including reasons for the hospitalization and the estimated time that the patient will remain in the hospital and plans for the post-operative care, if that's necessary. And that needs to be completed, except for in some special circumstances for outliers by the date of discharge. And again, so those are now in regulations.

And that concludes my brief summary of those parts of the IPPS final rule and after the two-midnight summary, we'll take questions on those.

So with that, I'll hand it back over to (Jen Dupee).

(Jennifer Dupee): Great, thank you, John. So I am going to give a brief overview of the inpatient hospital admission and medical review criteria.

To start things off, we just wanted to provide a little bit of background about some of the issues that we've had with the inpatient/outpatient hospital claims in the past years. Reviews of inpatient hospital claims by Medicare review contractors have consistently shown high improper payment rates, because while the underlying service is provided in the hospital were reasonable and necessary, the services could have been provided on an outpatient basis.

More specifically, in 2012, the comprehensive error rate testing contractor, which is responsible for calculating the improper payment rate and the Medical fee for service program found that inpatient hospital admissions for

one day stays or less had an improper payment rate of 36 percent. The rate then dropped for two-day stays to approximately 13.2 percent, and three day stays to 13.1 percent. And these improper payments that have been identified by the comprehensive error rate testing program have been supported by similar findings by the Office of Inspector General and also the Department of Justice.

In addition, CMS has recognized that the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours, while still small, has increased from approximately 3 percent in 2006 to 8 percent in 2011. And this trend is concerning to CMS because of the potential financial impact on Medicare beneficiaries.

So now I am going to go over what the regulation that was published as part of the 2014 IPPS final rule outlines. So the final rule specifies that surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital payments under Medicare Part A when first the physician expects the patient to require a stay that crosses at least two midnights and second, the physician admits the patient to the hospital based on that expectation.

And conversely, surgical procedures, diagnostic tests and other treatments are generally inappropriate for inpatient hospital payment under Medicare Part A when the physician does not expect the patient – when the physician expects to keep the patient in the hospital for a limited period of time, but does not cross two midnights. Because this guidance is based on the physician's expectation of the beneficiary's length of stay, CMS recognizes that there may be unforeseen circumstances that may result in (a) length of stay that is shorter than the physician's original expectation at the time the inpatient order was written.

Such circumstances may include the beneficiary being transferred to another hospital, beneficiary death, or the beneficiary leaving against medical advice. We emphasize in the final rule that it is very important that the occurrence of these circumstances be clearly documented in the medical records so that we

can understand upon review what exactly happened during that beneficiary's stay.

An exception to these time based criteria is the inpatient only procedures. These procedures will not be subject to the two-midnight admission guidance; an admission associated with these procedures will always be deemed reasonable and necessary provided that the procedure itself was reasonable and necessary.

We emphasize in the final rule that the physician's expectation for a two-midnight stay or less must be based on medical factors and physician judgment, and these also must be documented. Such factors would include the patient history and co morbidities, the severity of signs and symptoms, the current medical needs of the beneficiary, and the risk of an adverse event happening during the time period for which hospitalization is being considered.

This final rule is applicable to all acute care hospitals, critical access hospitals, long term care hospitals, and inpatient psychiatric facilities. This policy does not apply to inpatient rehabilitation facilities, which have separate and distinct admission guidelines. The effective date for these guidelines will be for dates of admission that occur on or after October 1st of 2013.

I wanted to get into a couple of concepts that are encompassed in this rule that have promoted a few questions lately from the public, and that we also tried to address in the final rule as best as we could to differentiate these concepts. The first is what we refer to as the benchmark. The benchmark refers to the time that may be taken into account by the physician when he or she makes a determination of when an inpatient order should be written, based upon the expectation of the beneficiary should be admitted as an inpatient.

And we specify in the final rule that the two-midnight benchmark clock begins when the beneficiary begins receiving hospital services. Now this can include observation care and care that the beneficiary receives in the emergency department, operating room or other treatment areas in the hospital.

So in other words, the physician is able to take into account the time that the patient was receiving hospital care as an outpatient, when deciding whether the two midnights of hospital care will be required and therefore an inpatient admission is generally appropriate.

Now while the physician may take into account the time the beneficiary spent as an outpatient for this purpose, this will not turn into inpatient time once the order is written. The order will still begin the inpatient admission, and the time preceding the order will remain outpatient time. This means that outpatient time does not count as inpatient time for purposes of qualifying for skilled nursing facility coverage and rather this time may only be considered for the limited purpose for determining if the expectation of a stay less than at least two midnights in the hospital is reasonable.

The other concept that we introduced in the final rule is what we refer to as our presumption. And basically, this refers to how medical review will be conducted under the revised inpatient hospital admissions policy.

Under the presumption, CMS medical review contractors will not focus on claims that are more than two midnights after the admission order is written and the inpatient admission begins, because it will be presumed that these inpatient stays were medically necessary. Instead, the focus of medical reviews will be on inpatient hospital claims with lengths of stay lasting less than two midnights. However, we did emphasize that the presumption may be lifted and inpatient claims of greater than two midnights may still be the focus of inpatient status medical review efforts if there is evidence of abuse of systematic delay for purposes of surpassing the two midnight threshold.

We also recognize that there are claims that may fall outside of the presumption, because part of the hospitalization was spent as an outpatient, such as when the inpatient order was written after the first night was spent in observation status. Medicare review contractors will review these claims under the same guidance CMS has given to providers and that the outpatient time may be taken into consideration when admitting a patient based on the reasonable expectation that they will require a stay lasting at least two midnights.

So that is basically our overview that we wanted to provide you today of the inpatient admission guidelines. We would now like to shift our focus to the plans that we have regarding implementation of the medical review criteria. First, as many of you know, we have set up a special e-mail address, ippsadmissions@cms.hhs.gov, and that is in the announcement for this open door forum, to which we encourage all stakeholders to submit questions and comments. We are working our way through these messages on a daily basis and are using them as one of several bases for question and answer documents, our Medicare manual guidance, and other educational materials we are developing as part of implementing this rule.

We also understand that October 1st is quickly approaching, and various issues do need to be addressed. Early and thorough direction is our goal as we work our way through this process, so this may include additional open door forums, Listserv messages, lists of questions received to date, and other forms of outreach and also keeping you updated on time frames for important milestones.

So our overall goal is to effectuate an intensive and nationally coordinated education program, and as part of this it is really important that we receive feedback from all stakeholders about (inaudible) methods, education and outreach that you think would be most effective in making this as clear as possible.

So with that, we did want to open up the lines for some basic questions that maybe did not – that maybe were not covered during our discussion. As we said, most of our questions we are actually receiving into our IPPS admissions mailbox, and we are putting all of those together and formulating our responses so we make sure that we are responsive and are able to circulate those questions among all the areas of CMS that need to give their input into these various questions. So I think we'll go ahead and open up the lines.

Operator: And as a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other

participants time for questions. If you require any further follow-up, you may press star, one again to rejoin the queue.

Your first question comes from (Kate Tow), University of Rochester. Your line is open.

(Kate Tow): Based on what you just said, is the patients, if they're not – if they are going to be admitted, the expectation is that they are going to be here for more than two midnights; if they don't meet InterQual criteria, but their provider still wants them to be an inpatient admission and expects that they are going to be there for two midnights, will that still be OK?

(Jennifer Dupee): This is a question that we've received from several people; we are actually working on coming up with a response that addresses this issue, because we recognize that with the two-midnight expectation, and the use of InterQual or other review guidelines, it may be approached in a different manner than is approached by the hospital with other commercial payers. So that is one question and answer that we will be addressing in the near future.

Operator: OK. Your next question comes from the line of Joanna Kim with – I'm sorry, yes, Joanna Kim with American Hospital. Your line is open.

Joanna Kim: Hi, well we really appreciate the sensitivity around getting this guidance out as quickly as possible since October 1st is approaching very quickly; an obviously the sooner it comes out the better for hospitals. Do you have any sort of idea on when exactly the guidance has been released? And then also in follow-up to that, going forward, will there be a way for hospitals and other stakeholders to provide input on how the implementation is going on an ongoing basis? That's all.

Jennifer Phillips: Hi, yes, this is Jennifer Phillips, and we definitely appreciate that October 1st date is quickly approaching and so as just mentioned, we are daily monitoring that IPPS admissions mailbox. And so, you know, this call is really a first in a series of, you know, educational forums. We do understand that the more stakeholder input and stakeholder understanding that we effectuate with the rule, the better the rule will be.

So with that being said, you know, within that next couple of months, expect additional information. And the IPPS mailbox can be used on a continuing basis, just to keep an open line of communication with CMS, because we do consider your input very valuable.

Joanna Kim: OK, thank you.

Jennifer Phillips: Thank you.

(Operator): Your next question comes from (Kathleen Massey) with Arnett Health. Your line is open.

(Kathleen Massey): Can you hear me?

(Jennifer Dupee): Yes, we can.

(Kathleen Massey): Oh, OK. My question is with the two-midnight rule – and I just want to clarify, if you admit a patient to the hospital for observation, and then that patient continually gets worse, and you realize you are on the second or third day of observation, which observation is only intended to be 48 hours or less; and at that time, you change the patient to an inpatient, because it becomes obviously they are going to need a longer length of stay.

Well, according to the rules, then the patient really doesn't become an inpatient until that order is written on the second or third day and then if they are discharged on the third or fourth day, they won't have the two-midnight stay. How is CMS going to deal with those issues? Because we've seen a lot of our denials in the – in the RAC recovery – the recovery auditor system, a result of that; that they looked like a one-day stay, according to when the admission order was written, but the patient had actually been here for a day or two prior, and you know, best guess that the patient would do well, and they did not, and ended up actually requiring inpatient status.

(Jennifer Dupee): So under the final rule, and it's somewhat difficult, you know, examples are good, but, you know, we can't be too specific because it depends on some circumstances. But in the situation that you described, under our policy, we would expect that the physician, once he or she develops the expectation that

that beneficiary needed to stay that second midnight, the inpatient order should have been written, meaning that the inpatient stay would have started on that – before the second midnight. So if it's the – the inpatient order under our guidance, should not have been written on the third day, it should have been written on the second day, before the beneficiary stayed for the second midnight.

George Mills: Yes, and – this is George Mills – but the thing people need to understand is that yes, there is going to be some short one day stays that will now be outpatient, but there is going to be a greater number of observation situations just like you described. The actual net effect of this regulation is to increase the number of inpatient stays; that is part of what we're trying to deal with with this reg, is to get away from people being in observation for long periods of time.

And as (Jen) said, after that first midnight, if there is an expectation that they need to additional midnight, write the order to admit and then that would be acceptable under our rule, because they will have been there two midnights.

(Kathleen Massey): So this is a patient overall that needs three nights in the hospital, but you don't realize that until the second day. So then they still may not have the two midnights if they end up going home late on the third or fourth day. I just think that it makes it pretty confusing for hospitals, and really this happens when patients come in on a weekend and you don't have the case management and the utilization review team at full strength that you might have during, you know, during a Monday through Friday scenario.

I guess what I'm hearing from you is, this patients needs to be totally evaluated on their second day so that they don't go into that second midnight, and you're absolutely sure whether that's an in-patient or an observation patient.

George Mills: Right – this is George – again, what we're saying is, is that when we talk about two midnight, it also can include the midnight that they were on observation. So that is one midnight, so then the next morning, the doctor looks at the patient and says I know they are going to be here at least another midnight, and then writes an order to admit. And then the two-midnight rule

has been met. That is why we're saying, we don't believe that there should be observation periods that are really more than a day under this policy, if there is an expectation you are going to stay an additional midnight.

That is the point I am trying to make is that another fact of this rule is actually that Medicare admissions will increase, not decrease. What will decrease will be short day, one day surgeries where the person comes in, has a minor surgery, stays overnight and is discharged first thing in the morning. That is outpatient under this rule.

(Kathleen Massey): So when you do your data mining to pull out those less than two-midnight stays, how are you going to know which one of those are really two midnights, because the first midnight was observation?

(Jennifer Dupee): And this is what we were trying to describe between – the difference between the benchmark and the presumption. If we have a case like that, with the presumption, you are correct, that if the inpatient order is written not until the second day, that will be on our system, potentially a one day stay. However, when we do the claims review, our contractors are given the same directive that we are giving to all of the hospitals and providers, that that outpatient time can be appropriately be counted towards that expectation of a two-midnight stay.

(Kathleen Massey): OK, that's it, thank you.

George Mills: We're working on a way to identify that easier than through the claim.

(Jennifer Dupee): Yes, and any suggestions that anybody may have about this very issue going forward, we'd be more than happy to accept those into our email box.

Operator: OK. Your next question comes from (Andrew Walker) with (Walker and Associates). Your line is open.

(Andrew Walker): Thank you. One of the questions I had with regard to the benchmark is to what extent will reviewers then look behind the two midnights and look at the medical records to evaluate the medical condition of the patient, the risk of adverse consequences.

Right now, we have a 24-hour benchmark which says if you are over 24 hours, you should admit; but the reviewers tend to ignore that benchmark and focus on medical conditions, the potential for adverse consequences; those types of issues. Are providers still at risk under the circumstances that a patient is in observation, the next morning the physician believes it is going to be over 24 hours, orders inpatient – we now are in the benchmark, not the presumption. Are reviewers going to come back and now start arguing in each of those cases that they could have remained in observation based upon those other factors?

George Mills: Well, that's specifically not what we've said we were going to do in the reg; that we will count the observation day as one midnight and the one midnight as an inpatient towards meeting the two-midnight presumption. So that is our plan, I mean, we keep getting this question like, what are you going really do with the auditors? We're not going to tell auditors to look at one day stays; because under this rule, other than the exceptions, inpatient only (less) the other exceptions, most of those don't meet the presumption. So those are going to be potentially there.

But under the rules that will be given to auditors, those will be two midnights, and they should not be denying those, saying that they should have been outpatients.

(Jennifer Dupee): And we're also developing guidance on how these clinical factors should be taken into account as part of the development of the expectation of the beneficiary needs to stay in the hospital for two midnights.

(Andrew Walker): OK, thank you.

(Jennifer Dupee): Thank you.

Operator: Again, to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow-up question to allow other participants time for questions.

Your next question comes from the line of (Ashton Shots) with the Mayo Clinic. Your line is open.

(Ashton Shots): Hi, I actually withdrew my question; I think that our questions were e-mailed to the IPPS web address, it really goes to having that reasonable expectation of the midnights as well as if it is going to be – if crossing over (inaudible) …

(Jennifer Dupee): I'm sorry, we're having a really hard time hearing you.

(Ashton Shots): … midnight is going to impact us if we really believe that they don't meet inpatient criteria. So we really look forward to additional transmittals and correspondence with CMS going forward.

(Jennifer Dupee): OK, we did receive your questions and we do – and we will definitely get back to you, and thank you for forwarding those to us.

Operator: Your next question comes from the line of (Patty Dockey) with Memorial Hospital. Your line is open.

(Patty Dockey): Hi, you mentioned before the special circumstances of transfer, death, or AMA, but what you didn't say is what you are going to do with those. You did say that death needed to be clearly documented; how are those going to be handled?

(Jennifer Dupee): Those are the circumstances in which, if a beneficiary comes in and is admitted based upon the expectation that they would require a two-midnight stay and then one of these things happens in the interim, that interrupts that projected time of care, we are saying that that can be taken into consideration upon medical review. Because this is based upon an expectation, those types of things can happen, that – you know, unexpectedly shortened the anticipated length of stay.

So when the reviewers are taking a look at that, they can take that into account and deem that that actually was inappropriate inpatient admission.

(Patty Dockey): That's your instruction to the reviewer?

George Mills: Yes.

(Jennifer Dupee): That is the instruction to the providers and to the reviewers, and we are developing more concrete guidance as we're going along here.

(Patty Dockey): Thank you.

(Jennifer Dupee): Thank you.

Operator: Your next question comes from the line of (Carlton Diller) with Woods Hospital. Your line is open.

(Carlton Diller): Yes, thank you for your time. My question pertained to the order and certification requirements. A lot of time we have advance practice nurses or residents who are not yet – they don't have independent admitting privileges putting in orders. Does it need to be the attending of record or somebody that has admitting privileges that puts in the order? And if so, can the residents and/or advance practice nurses put it in under the attending physician's name after talking to him or her?

John McInnes: Yes, hi, this is John McInnes. There has been a question already regarding the residents and we're going to issue a question and answer on that. I think that the hang up might be regarding the language in the regulation that says a practitioner who has admitting privileges at the hospital and how that is being interpreted. So the – we're going to have to address that, because I think that it is anticipated that certainly residents working with attending, you know, physicians could admit the patient. And these regulations weren't designed to not allow that.

(Carlton Diller): Because in the case of physician extenders, like advanced practice nurses, or physician's assistants that do not have admitting privileges?

John McInnes: Yes, that is a little bit – I think that's a little bit trickier and we'll have to address that through guidance. If there is – if the hospital does not permit that, then it may not be – there may be situations that may not be in compliance with the regulation. But there also may be ways in which they can assist the attending physician if the attending physician comes later and

countersigns or provides some documentation in the medical record that, you know, indicates that they would be the genesis of the order to admit.

(Carlton Diller): Even if it would be done after the first midnight?

John McInnes: Well, yes – I think what we're getting into here is sort of a situation similar to what we had anticipated with a verbal order – it's similar to that, where you know, there was an instruction in the medical record, and that is – the initial documentation is provided by someone who is, you know, documenting what amounts to a verbal order or instruction and later on that – the countersignature, the acknowledgement in the medical record is provided.

Now if the patients is formally admitted, then you know, you know, the first midnight really wouldn't effect whether or not the regulations for admissions were satisfied. We are going to have to entertain, I think, some of these more common situations in Q&A; but thanks for your question.

Operator: Your next question comes from the line of (Tammy Lockary) with Union General Hospital. Your line is open.

(Gayle): Yes, my name's (Gayle) and I work in the Medicare billing department, and I was wondering about observations and outpatient billing, can anyone there answer a question about like surgeries and observation hours being billed under 131 or 121?

John McInnes: I think that is outside of the scope of the call, but if you send an e-mail in, we can answer your question.

(Gayle): Thank you, and what was the address again, the …

(Jennifer Dupee): It's ippsadmissions – that's one word – @cms.hhs.gov.

(Gayle): Thank you so much.

Operator: Your next question comes from the line of (Emily Ackerman) from Sharp HealthCare. Your line is open.

Hello, (Emily Ackerman). Your line is open.

(Emily Ackerman): Hi, yes, sorry about that. Considering that you are appropriately expecting in-patient (admission) volumes to go up and observation to go down in this – with this new rule. Can you give us any guidance on what data you would be looking at to identify abuse or systematic delay that might cause the revocation of the two-midnight presumption and will that revocation be listed at the individual provider level, or just in general?

George Mills: Well, it would be at the individual provider level, and people on the phone might be familiar with our PEPPER reports that are sent to facilities throughout the year from our PEPPER resources contractor. So we would be using data like from there to look. I mean, it is not going to be day one or even the first month that in terms of the two midnight, because again, part of it is that we are expecting that there will be an increase in two-day stays because of this rule.

So it is something that we will be working on and I would not expect it to be immediate where we are starting to look at it, because that is one of the questions. We are expecting some increase, but the question is – we're going to look at our data and see those that look different from the, you know, the peer group. So it won't be like October 1st we'll start looking at the two days, but we will use data and we will also use the CERT contractor who pulls a systematic random sample to inform us as to what to look for.

So we are going to use data, it is not going to be right off the get go, but we will use data, like historical billing data, and the PEPPERs an other kind of data to look for those changes in billing behavior.

(Emily Ackerman): Thank you.

Operator: Your next question comes from (Andrea Dawns) from Memorial Hospital. Your line is open.

(Andrea Dawns): I have a question on the Part B; is the final rule the one that CMS 1455-R proposal replaces, and then if that is the case, on these RAC reviews where they review the case they have up to three years to review it and they come back and we want to bill Part B, we can't do that because it is not under timely

(inaudible) for example. A case that's reviewed from 2010 is now 2013, they've denied it for not meeting inpatient criteria, we agree in one of those Part B's, is that not – is it going to be a (over timely) filing – on the RAC reviews also?

George Mills: Well, again, this is George – and John chime in. OK, people have to remember, under this rule admissions on – I mean before October 1st can be re-billed after a denial regardless of how long that it occurs after the claim – you know, the date of the claim. For admissions on or after October 1st, where we have this new policy, the two-midnight policy, it is only 12 months. So our expectation is we have better to guidance, it is much clearer, that is a lynchpin date, so that's why it is only the 12 months to re-bill based on the new two-midnight policy.

But for the older – before October 1st, it is more expansive the rebilling rights, after October 1st, after the implementation of this new rule, it is only 12 months. And I didn't know if John wanted to add anything?

John McInnes: No, I think that that is correct. And that is what we said in the final rule, so if the patient is admitted prior to October 1st and of course the denial comes later, then the expanded time frame that is in effect under the ruling, the rebilling ruling, is in effect, but for admissions October 1st, it is one year timely filing.

(Andrea Dawns): OK, thank you for that clarification.

Operator: Your next question comes from the line of (Anne Marie Courtesy) with Medical Center. Your line is open.

(Anne Marie Courtesy): Hi, I just want a little clarification regarding the certification. I understand that you are going to look for an inpatient order, so but for the certification, do you expect documentation in the record that speaks to the reasons for the hospitalization, the estimated time we expect the patient to be in inpatient status? Is that what you are looking for?

John McInnes: Well, that's how the – that is what is specified in the regulation and that comes from a statutory requirement. We are going to develop that a bit more

in guidance in terms of you know, how we believe that could be satisfied in the record.

(Anne Marie Courtesy): OK, look forward to that. Thank you.

Operator: Again, to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Your next question comes from Ben Reynolds from UPMC. Your line is open.

Ben Reynolds: Yes, I am sorry; I thought I withdrew my question. But since I have a little bit of time, I just want to be clear as I am – I'll make sure that I get my mind around the intent of the regulation as it related to ordering of the initial in-patient admission. The language is very clear about the licensed practitioner has to have admitting privileges at the hospital as permitted by state law. Is there – do we anticipate that there will be any – do we anticipate that the clarification on this will allow our residents and advance practice providers to be able to do this, I just want to make sure that I was hearing this correctly. Thank you.

John McInnes: Yes, well, I don't know at this point whether it is going to allow for every type of – I don't think it would allow for every type of physician extender, but I think what we are going to have to do is provide some sort of definition around our interpretation of admitting privileges, if that term means something different in the context of specific hospitals and that becomes too much of a limitation. So I don't – at this point, I do not know because we have not decided that, (inaudible) that is what we intend to do. I don't know at this time know to what extent and how many different types of folks that that will cover.

Operator: OK. Your next question comes from (Heather Clarke) with Fulton County Health. Your line is open.

(Heather Clarke): Hi; we are a critical access hospital and while we are not under IPPS, we do – we are subject to RAC audits and other types of audits; and so with the two-

midnight stay presumption, our two midnights are going to be on different claims, possibly. Because the outpatient is billed on 851 and the inpatient portion on the 111 type of bill, so is there any way that you are going to be able to cross match and be able to tell without pulling an audit and reviewing records that the two midnights was actually met?

George Mills: Well, yes, we will. But second of all RACs have not audited any (CAHs) because (CAHs) aren't paid under the prospective payment system and so the count audit that would be done would be significantly different that the audit as it – compared to an IPPS hospital. There is this impression that RACs has been auditing (CAHs) and they haven't audited one in terms of this short day stay. There have been claims that have been denied, but those have generally been coding issues and things like that.

I don't expect there to be much (CAHs) audits of inpatient short stays by RACs at any time in the near future at all, but if there was, there is this data to do exactly what you are saying.

(Heather Clarke): OK, well we have had DRG reviews for inpatient stays from our RACs.

George Mills: OK, well we can look into that, but (CAHs) haven't been approved because of the way that (CAHs) are paid is not the same as a DRG paid hospital.

(Heather Clarke): OK, thank you.

George Mills: Yes, because they could – because it might have been a coding issue. So, I mean, what we are talking about here is short stays, whether it has been inpatient or outpatient. So that is what I am referring to there. But it doesn't mean coding or that there is a duplicate payment or an automated review, those are the thing that we've seen (CAHs) reviews by RAC. But in terms of the short case stay issue, our data shows that there has been none. So I am not sure how that is happening, but – thank you.

Operator: Your next question comes from the line of Rick Lash with Cedars-Sinai Medical. Your line is open.

Rick Lash: Thank you. Our question is, for expanded Part B billing for facility self-audited accounts, is the ability to bill based upon a specific date of service, or is it after the implementation date of October 1st?

John McInnes: I'm sorry, can you say that again – I didn't understand.

Rick Lash: Yes. OK. We are talking about self-audited accounts, and the question is, when can we start billing for them? Is it based on a specific date or is it after the implementation date of October 1st?

John McInnes: Yes, after the implementation date.

Rick Lash: OK, great. Thank you.

John McInnes: Yes.

Operator: Your next question comes from the line of (Bridgett Sully) with – I'm sorry (Inaudible) Medical. Your line is open.

(Bridgett Sully): Thank you. My question is about the patient who comes in as an observation and then they are going to be there another 24 hours, do they have to meet criteria to be changed to an inpatient, or just because of the fact that they are going to stay another 24 hours make them an inpatient?

(Jennifer Dupee): Based on our guidance, we would expect that if the beneficiary needs to be in the hospital, receiving hospital services, in the expected length of stay, it should be greater than two midnights, that is an appropriate inpatient admission. Like we've said, we are going to come out with more concrete guidance about how these other clinical judgment factors that have, you know, sometimes been part of the determination of inpatient versus outpatient will factor into this new policy.

But like I said, it is based on the expected length of stay, and there requirement that the beneficiary needed hospital (services).

George Mills: Yes, so if (any stayed) one night in observation, but then the beneficiary's daughter had to fly from Detroit to come and pick them up – unless you are getting some services, then that wouldn't count.

(Bridgett Sully): Right.

George Mills: (Inaudible) policy, so if the records show they needed medical care, then and there was an expectation and an order then it would meet the two night presumption.

(Bridgett Sully): So a CHF patient that just needs another day of IV diuretics doesn't meet the inpatient level of care, according to InterQual, but still needs to be in the hospital, the physician could write an order, change them to an inpatient and would just – the fact that they need to stay another 24 hours wouldn't be enough?

Daniel Duvall: Right. As long as the patient medically needs to stay for an additional 24 hours, it does not matter whether InterQual criteria or Milliman or any other types of criteria say it should be an outpatient level of care, inpatient level of care, an ICU level of care. What matters is that the patient needs to stay at the hospital for medical reasons, and that stay is going to cross the second midnight.

(Bridgett Sully): OK, well, we have a lot of RAC audits related to a patient being in observation one day and then getting admitted as an inpatient on that second day, and that – the RAC auditors are saying that even that second day of care should have been provided as an outpatient.

Daniel Duvall: Yes, well – that is why we are having this rule and we are clarifying it …

(Bridgett Sully): OK, great.

(Inaudible)

(Bridgett Sully): Thank you.

George Mills: … InterQual and Milliman are just tools, they are not Medicare policy; the RACs and MACs and CERT use them, but they are not definitive on Medicare rules and regulations and coverage decisions are what is definitive, not the InterQual or Milliman. So – but again, as – this question came up earlier, but

we'll get more definitive, written advice about what happens when there is a conflict with InterQual or Milliman tools.

George Mills: And remember that we are specifically giving instructions for how we are implementing the revised benchmark, starting October 1st, so what we are talking about on this call does not apply to existing audits, existing reviews of past services. This is strictly talking about applying these guidelines after October 1st.

(Bridgett Sully): Thank you.

Operator: Your next question comes from the line of Jennifer Wheeler with Baptist St. Anthony. Your line is open.

Jennifer Wheeler: Hi. I actually sent several questions but I would like this one answered. It is my understanding that the physician cannot write just admit, it has to specify inpatient, is that correct?

Daniel Duvall: We have not issues any guidance to that effect. So far we have said that there must be an order for admission. We will be working on continued guidance on exactly what needs to identify that order as intending for inpatients, but we have not said anything along those lines.

Jennifer Wheeler: OK, can I – can you answer one more question?

Daniel Duvall: You get two.

Jennifer Wheeler: OK, good deal. So If a patient begins as observation and then they convert to inpatient, because we – the doctor says they are going to be here longer than two midnights, we'll still go back and add the observation hours to that claim – to that inpatient claim like we are currently doing, correct?

Daniel Duvall: You are still adding the costs of the observation hours to it, you make sure that the date of admission is the date that the order is actually written, so …

Jennifer Wheeler: Correct.

Daniel Duvall: … so (continue) what you are doing right now.

Jennifer Wheeler: OK, same thing. But we can count midnight as far as when they become an inpatient, like the girl – the example earlier. But that does not count for (SNF) qualifying stay, until they become an inpatient?

(Jennifer Dupee): Correct.

George Mills: Yes, you are not an inpatient until there is an order.

Jennifer Wheeler: OK, thank you.

George Mills: Yes, you know, that is – it does not address that, and it is not retroactive. There is no retroactive application here.

Jennifer Wheeler: Thank you.

George Mills: Thank you. Before you take the next call, I know there has been a lot of RAC questions, and this is George – I just wanted to go over what our expectations are going to be for RAC.

We made it clear to RAC that we believe that this rule will clarify our policy, and we believe that people will move forward and we are preparing the RACs to have a significant decline over time in the number of inpatient cases that they are reviewing, and in fact, you will see as new record limit going up within the next week or so in terms of record reviews, in terms of post and then pre-pay. People have asked us, we've got a lot of questions in the inbox, well what are the RACs going to look at?

Again, we will MACs and RACs both will probably look at one day stays because there is a two-night presumption, but they will be able to sort out things like transfers, deaths, discharge against medical advice, because that is on the claim in terms of when we are looking at that. So in terms of what MACs and RACs will look at, they will be looking at one day stays, two-day stays; we'll use data to look at people who look like they are aberrant, but we do agree that there is going to be some increase in admission; two-day admission for sure, because of the change in rules, so we will do that.

I will say RAC – people will say, what are they going to do, continue to look at in the past, before October 1st. I will tell you that our guide is to focus one day short minor surgery. That has always been our policy, that that is outpatient. They have been focusing on it, they will continue to focus on it.

So bill one day minor surgery, you are going to get audited. So that is the advice here, but we are going to put things up in writing, I know everybody keep saying are you really going to do what you said in the (reg) and yes, we will.

But again, our expectation is that over time, RAC inpatient review will decline, and I just wanted to make people clear of that, and we are going to put something up in writing on the internet in the near future, so I will refer it back to the operation. Thank you.

Operator: Your next question comes from the line of (Karen Smith) from Main Line Health. Your line is open.

(Karen Smith): Thank you. The initial speaker said that certification per inpatient admission begins with the order includes reasons and the record must include reason for hospitalization and estimated time and that it must be documented by the time the patient is discharged; but something else that I'm hearing when the second speaker said that the order needs to include all of those items. So can you clarify what you would expect to see when the order for inpatient – the order for inpatient admission is written in the record?

John McInnes: Yes, the certification is something more than just the order, it actually – the order is the beginning for the first part of the certification.

(Karen Smith): Yes.

John McInnes: So the order is, you know, the instruction in the medical record to admit the patient as an inpatient and that is the beginning of certification. So it is a part of the certification, but it is not the entire certification. Does that answer your question?

(Karen Smith): It does, but with the order, should it be documented at that time, the estimated time the patient is expected to be in the hospital, or if the contactor see that the account is two midnights long, would that be OK?

(Jennifer Dupee): From the medical review standpoint, this is one thing that we are going to by clarifying in the near future; exactly what type of documentation we are going to be expecting to see to support this two-midnight expectation. So definitively look out for that.

(Karen Smith): OK, thanks.

(Jennifer Dupee): Sure, thank you.

Operator: Your next question comes from the line of (Bob Bakins) from University. Your line is open.

(Bob Bakins): Good afternoon; there was a lot of discussion, or some discussion, with respect to the transferring in hospital, but I am not finding guidance with respect to the receiving hospital.

So for example, by way of illustration, if there is an acute to acute transfer and then upon arrival and after additional work up, the attending physician determines that the patient in fact turns out not to be a clinical candidate for the intervention they were planning, and subsequently not two midnights in our hospital. Is this an outpatient? Is this an inpatient? Do the days in hospital one count towards the days in hospital two, the recipient?

(Jennifer Dupee): These scenarios are some – are scenarios that we have been discussing internally and what I would ask is actually, I think that it would be helpful for us to receive even more examples of certain situations that we probably need to address in the coming weeks. You know, we just haven't gotten that far yet as far as the transfer are concerned, but we definitely intend on addressing all of those different types of situations.

(Bob Bakins): I appreciate it, thank you.

(Jennifer Dupee): Thank you.

Operator: Your next question comes from the line of (Angela Cummings) from (Lakeson) Health. Your line is open.

(Angela Cummings): Hi, there. I have a question for patients who are admitted as an inpatient from the beginning, but then get better and then the next day they are able to go home to another setting for whatever reason. Should be by trying to downgrade those to observation prior to the patient leaving and going through the Code 44 process, or if it was just that the patient got better but they were expected to stay there two nights from the beginning, should we leave them as inpatients?

Jennifer Phillips: Hi, this is Jennifer, and we actually did receive similar questions to this during the comment period. We would just remind you that two-midnight benchmark is based on the physician's expectation. And so if the physician's expectation is one that the facility finds a reasonable one and, you know, there was, for instance an interruption of care or some other unforeseen circumstance that, you know, did not interrupt that reasonable expectation, but otherwise they did not have a two-midnight length of stay, we would not anticipate that you would have to use condition Code 44. However, if you did for some reason determine that the physician disagreed with their own original decision and you know, the condition Code 44 conditions were met, then of course, you could follow those guidelines.

(Angela Cummings): OK, and in follow-up to that. What if we discover after the patient has already been discharged, that the inpatient order wasn't substantiated through internal audit. We at that point can't meet condition Code 44, but as part of the rebilling, our understanding is that potentially we could re-bill those cases as observation, is that possible, and if so, would we still have to notify that patient or would there be an obligation to give that outpatient notice even once the patient is gone?

Daniel Duvall: In an instance like that, the patient was an inpatient, you didn't use condition Code 44 prior to discharge, therefore, you can't bill it as an observation, because the inpatient stay was an established fact. That would be one that you could bill as a Part B inpatient, and then you are going to follow the guidance

that we would be – we were giving out in terms of a case that is identified through self-audit and being billed as a Part B inpatient.

(Angela Cummings): OK, OK, great. So we can do that and we don't have to meet Code 44 then?

Daniel Duvall: If Code 44 is applicable, you should use Code 44 before discharge. If Code 44 is not applicable, and the expectation was a valid expectation support in the records, you would leave the patient as an inpatient. If you find out after discharge that it really should not have been inpatient, then that is when you would re-bill. So it is three separate possibilities depending on the individual case.

(Angela Cummings): Great, thank you very much.

(Jennifer Dupee): Thank you. And I think we'll probably have that be our last question, we have kind of gone over our time. Again, this is (Jennifer Dupee), on behalf of all of us here at CMS, I just want to really thank everybody for attending this afternoon's call. We've had a really great turn out and we are really looking forward to working with all of you in the future and encourage you to please send us your questions and comments to the IPPS address, ippsadmissions@cms.hhs.gov; and you'll definitely be hearing from us in the coming weeks. Thank you.

Operator: This concludes today's conference call. You may now disconnect.

END