



MLN Connects™

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services
2-Midnight Benchmark:
Discussion of the Hospital Inpatient Admission Order and Certification
MLN Connects National Provider Call
Moderator: Aryeh Langer
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This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Operator: At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Aryeh Langer. Thank you. You may begin.

Announcements and Introduction

Aryeh Langer: Thank you. As Victoria said, this is Aryeh Langer from the Provider Communications Group here at CMS, and as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on the 2-Midnight Benchmark for Inpatient Hospital Admissions.

MLN Connects Calls are part of the Medicare Learning Network. During this call, CMS subject-matter experts will provide an overview of the inpatient hospital admission and medical review criteria that were released on August 2, 2013. A question-and-answer session will follow the presentation.

Before we get started today, there are a few items that I'd like to quickly cover. You should have received a link to the slide presentation for today's call in an email today. If you have not seen this email, you can view or download today's call presentation from the Call Details web page, which can be found by visiting www.cms.gov/npc. Again, that URL is www.cms.gov/npc. On the left side of that page, select "National Provider Calls and Events," then select today's call by date from the list to access the call details web page. The slide presentation is located in the Call Materials section.

I'll also note that this call is being recorded and transcribed, and an audio recording and written transcript will be posted to the Call Details page that I just referenced when it is available. An announcement will be placed in the MLN Connects Provider eNews at that time.

And finally, registrants were given the opportunity to submit questions in advance of today's call. We thank those of you who took the time to do so. We will address some during the presentation today. While we are not able to address all of them, they may be used for future presentations, to develop frequently asked questions or other educational materials.

If you would like to submit a question after the call, please send that email to ippsadmissions@cms.hhs.gov. Again, ippsadmissions@cms.hhs.gov. Please note, the 2-Midnight website can be accessed at go.cms.gov/InpatientHospitalReview. Again, that's go.cms.gov/InpatientHospitalReview.

At this time, I'd like to turn the call over to Jennifer Dupee from CMS. Jennifer?

Presentation

Jennifer Dupee: Hi, good afternoon or good morning to you all. This is Jennifer Dupee. I'm a nurse consultant in the Provider Compliance Group here at CMS. We just wanted to quickly go over the agenda for today, and then I will pass it on to some of the subject-matter experts here.

So the focus of the call today is on a few different topics. The largest is probably the order and certification clarifications that were published on the CMS website on January 30th. So we have outlined here on this first slide the elements that will be covered in today's presentation. We're also going to touch on transfers, which is a new topic under the 2-midnight rule that we just came out with clarification a couple of days ago. And we're also going to be going over some updates that we have put on the website as well, which include the extension of the Probe and Educate period, and also the plan for re-openings and appeals of claims that have undergone review as part of the Probe and Educate program.

So I think that we're ready to go ahead and start with the order and certification clarifications, so I'm going to hand it over to Dan Schroder.

Order and Certification Clarifications

Daniel Schroder: Hi, thank you, and I just want to reiterate that clarifications were published on the CMS website. The first clarifications were published on September 4th of last year, and then a further re-clarification was published on January 30th. They're available on the website. I am going to go through these slides somewhat quickly to leave some time for questions at the end, but I just want to hit some of the major points.

The background is that Section 1814 of the Act requires physician certification of medical necessity on services to be provided on an inpatient basis. There have not been specific changes to our certification requirements, but with the implementation of the 2-midnight rule, it's been necessary to clarify and sometimes expand upon what some of those requirements are or may look like.

The biggest change is the inclusion of an order to admit as a critical element in inpatient coverage, and it is part of the certification, not only the inpatient order but also the necessity to make sure that it's properly authorized and certified or – by a qualified physician or a non-physician practitioner with the ability to admit.

First, we'll start off with the content of the certification order. Like I said, the first major component is the authentication of the practitioner order. The other requirements of certification—there are reasons – the reason for inpatient services—this can be the diagnosis section of the order. We've expanded in our clarifications a little bit to explain what types of things might be in a typical medical record that can meet this requirement, as well as many others in this section.

The next major point is the estimated or actual required time of hospital time. Just to clarify, this does not require a presumption or a complete estimate based at the time of

the order. A physician does not have to state how much time they expect a patient to be in the hospital. It would be acceptable for a physician to – or ordering practitioner to state that a patient – that time as an inpatient was medically necessary, and that can be documented by the medical record.

There's also a requirement to address plans for post-hospital care and discharge planning. We have a few requirements that are somewhat different for critical access hospitals. I'm sure there'll be questions about that, but essentially it's a statutory requirement that admissions to a critical access hospital, the physician must certify that the patient can be safely discharged or transferred within a 96-hour period of time. We've added a few clarifications to explain that time as an outpatient or time in a swing bed would not count towards this 96-hour period. There's also a few clarifications on what's required for inpatient rehabilitation facilities. I'll refer you to the guidance for more details on that.

Next slide: Timing of the certification. The certification as a concept, as a document, begins at the time of the order. We say that the certification must be completed, signed and dated, and documented in fulfillment of just generally good medical documentation. We're making sure to say that the certification does not in itself have to be a specific checklist or statement. It can be satisfied in a great number of ways. We did not prescribe exactly what a certification statement must look like, but it should be well documented in the medical record if there isn't a very clear statement. And also, the certification must be completed prior to discharge. I'm sure there'll be some questions about that; we can go into that later.

The next part is who's authorized to sign the certification. In most cases, it would be a physician or a doctor – doctor of medicine or osteopathy. There are also some situations where a dentist or a doctor of podiatric medicine may also be authorized, if authorized under state law. The requirement is that the physician must be knowledgeable of the patient course and have the authorization to certify the medical – the certification document.

If we – we have a slide here about determining sufficient knowledge. We give some examples of physicians and some non-physician practitioners who we would consider to have sufficient knowledge. That would be an on-call physician, someone who's responsible for a major surgery; in some cases, dentists and other non-physician practitioners.

We included some discussion about hospital review staff, UR staff. Essentially we stated that a UR staff physician would be authorized and would be qualified to make a certification statement. However, in certain circumstances, it – part of their duties – of UR staff could conflict with their ability to also certify a case. Essentially we're trying to specify that if you're acting as a UR staff person in the hospital, you probably cannot also certify that an inpatient stay was met.

And we also have some sections there that an ED physician or hospitalist can also be qualified to complete the certification.

Next slide. As I've stated before, there is no specific procedure or format. We've received questions on whether a certain statement is necessary, or is this statement correct or is the statement necessary? I think the general guidance is that we are – we're not prescribing exactly what a certification statement would look like. We're not even saying that a specific certification statement is required; it probably would be helpful in the medical record. But we're stating that all requisite information is included in the medical documentation—for example, the physician progress notes, medical record, other forms of documentation. This may fulfill the certification requirement if it could meet the standards of medical review.

Again, a statement saying something to the effect that “I certify ... et cetera, et cetera, that the – this qualification is met, this qualification is met” probably would be helpful. We would say that it would not be in itself justification for a proper inpatient stay, but it could be helpful, and it's – if the medical record otherwise indicates an inpatient admission, the certification statement might not be necessary, specifically, but there – we'll move on.

We'll move on to the order section. This is the part that is – might be considered a – somewhat change in policy, although many of the tenets are – very long-standing policies. It's always been CMS's policy that a formal admission order is necessary for an inpatient stay.

There's some language in there. For instance, this first word, “formal admission pursuant to an order”—that was intended to qualify that an order can be placed in advance of an actual admission—for example, a preplanned surgery, or there's some delay in between the time an admission order was made and when the patient actually arrived at the facility. That's the intent of that section. We've received a lot of questions on what formal admission means. I think formal admission, it's – by a dictionary definition, means that the hospital has taken some steps to intake the patient and begin treatment.

The order must be completed by a qualified physician or practitioner, and inpatient time begins when that order is made. We have a note here that “the 2-midnight benchmark states that the physician should account for total contiguous time in the hospital in formulating expected length of stay. This does not mean that the order for admission may be retrospective.”

To clarify, the 2-midnight policy requires a physician to say that a patient has or will require medically necessary care that would span 2 midnights. We would allow that physician to use time before an inpatient order. For example, if they were in outpatient status, observation status overnight, we would consider – allow that physician to consider that time when making an inpatient order. However (we'll probably explain this a little bit further), that time in observation is not considered an inpatient day for Medicare purposes; however, they still can use that time to justify an inpatient admission.

Moving on to the next slide—I think we’re on 14, Qualifications of Ordering and Admitting Practitioner. First bullet point: Must be written by a practitioner – physician or a practitioner that is licensed by the state to admit privileges, is granted privileges by the hospital, and is knowledgeable of the patient course. The ordering physician – the ordering practitioner is not required to be the certifying physician – practitioner/physician. They can be different people.

“Medical residents, physician assistants, nurse practitioners, and other non-physician practitioners or practitioners without admitting privileges may act as a proxy if authorized under state law, and ordering physician approves and accepts” the decision and countersigns. To elaborate a little bit here: We intended to allow – we’re informed that many hospitals would have residents in many cases, or ER physicians in other cases, that may not have specifically delegated admitting privileges by the hospitals but are – typically create admission orders that are then later countersigned.

In some cases – in some rare cases, they may be verbal orders. In other cases, they just may be made on behalf of a physician that does have admitting privileges. We would just like to say that we acknowledge that practice, and in interpreting our policy, we would consider those to be valid admission orders. The initial order, the initial inpatient time would begin when that valid order was – began when that valid order was placed. However, we would not consider it to be a valid order until it is properly authenticated and countersigned in the medical record by a physician that does have admitting privileges.

Moving on to verbal orders, there are certain circumstances where verbal orders are appropriate. Practitioners – “Ordering practitioner must directly communicate the order and must countersign the order as it was written to authenticate it.” “Inpatient time starts with the verbal order if authenticated,” and “State laws, hospital policies and bylaws, rules, and regulations must be met.”

Standing orders: “Order for inpatient admission may not be a standing order.” We are – acknowledge that protocols and algorithms may be used and may be beneficial when considering if an inpatient admission is necessary. However, only the ordering practitioner or practitioner acting on his behalf may make and take responsibility for an inpatient admission decision.

Moving on: Physicians with Sufficient Knowledge to Write the Order. I’ve already gone through some of these, but it would be the admitting physician of record, physician on call, primary or covering hospitalist, primary care physician, practitioner, surgeon responsible for a major procedure, ER or clinic practitioners caring for the beneficiary at point of admission, and others qualified to admit and are actively treating the patient.

Timing. We state that at or before the time of inpatient admission is when an inpatient order must be written. We do not allow retroactive inpatient admission orders. If someone has been in the hospital under observation for 2 days, and then it’s determined

that a – the patient met inpatient status, the inpatient order may not be backdated to include any time prior to the day that the inpatient order was determined.

“If formally admitted prior to order being documented, inpatient stay....”—OK, I just said that, sorry. There – again, there’s no specific language that’s required for an inpatient order, there’s no magic words, there’s no checkbox that’s necessary. However, it should be clear to anyone looking at it that inpatient status is intended.

We’ve had many questions in the past where hospitals may use code words such as, you know, “admit to Tower One” or “admit to such and such status,” that’s not clearly intended to be inpatient. If there’s any question on whether a patient is an inpatient, the – the – we would recommend that a hospital should revise guidelines to make it evidently clear that inpatient order was intended and was placed in the medical record.

We also have reiterated our long-standing policy that in certain circumstances inpatient orders may be defective or missing. In cases where inpatient orders were clearly intended, we use, you know, some examples of, you know, very serious cases where there was no legitimate way that a patient could have been treated other than in inpatient status.

In these situations, we’ve given leeway to Medicare contractors to infer an admission – inpatient admission order even if one is not present. We continue with that policy; however, we strongly encourage hospitals to have those inpatient orders, have them clear, have them in the medical record, and have them signed and authenticated prior to discharge.

Again, I expect to have some questions, so I want to move on, so I’ll turn it back over to Jennifer Phillips to talk about transfers.

Transfers

Jennifer Phillips: Hi, good afternoon, everyone. I am on slide 20, and as you know, CMS recently released their transfer guidance. This information is available at go.cms.gov/InpatientHospitalReview, and Inpatient, Hospital, and Review are each capitalized, but one word.

So what CMS released was that if you have a beneficiary transferred from Facility A to Facility B, Facility B may take into account the time the beneficiary was receiving care in Facility A in making their 2-midnight expectation. We still expect you to continue excluding excessive wait time or time spent in hospital for non–medically necessary services.

If your facility is – receives an additional documentation request in which Medicare has decided that your claim will be subject to medical review, and your facility receives the transfer beneficiary without sufficient documentation to support the time the beneficiary spent receiving care at the initial hospital, we would expect your facility to receive the medical record from the transferring hospital to send to CMS as well for review. This

way, the medical reviewer will be able to look at the documentation and support the physician's decision when he received the transfer beneficiary to admit them based, on a 2-midnight expectation for time the beneficiary spent receiving care at both facilities.

This process has helped CMS ensure compliance and to deter gaming or abuse. This is just a reminder, on slide 21: "The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility." So for the transferring hospital, the admission decision remains unchanged; it's just a general 2-midnight benchmark application.

And moving on to slide 22. So this slide discusses if your facility has an emergency department that is established as a provider-based practice location of the hospital, CMS does not pay to move the patient from an off-campus location of the Medicare hospital to the campus of the same Medicare hospital.

Therefore, if you have a provider-based off-campus ED operating under the same CMS certification number as the unit to which you transferred to, it is the same for Medicare purposes as transferring the beneficiary of an on-campus ED to a specified floor within that hospital facility also operating under that same CMS certification number. The total time in the hospital should be counted for the purposes of the 2-midnight benchmark when this is being taken into consideration.

So that is the – pretty much the transfer policy, a quick overview. And at this point, I will turn it over to Jennifer Dupee to talk about some additional updates that were posted to the website yesterday.

Additional Updates to the Website

Jennifer Dupee: Hi, everyone again. Some of this might be relatively old news, but it has come out since we had our last MLN Connects Call, but we have discussed it in other forums like open-door forums, so this should be relatively quick.

First, back in January we did announce that CMS extended the Probe and Educate review process for an additional 6 months. So this means that now we will be going through September 30th of 2014. So what this means is that the MACs will continue to select claims for review with dates of admission between, now, March 31st, 2014, and September 30th, 2014.

Keep in mind that the number of claims that will be undergoing review under this process will not change under the extension; it's just that we will have more time to finish these reviews and education. MACs will conduct – will continue to hold educational sections in accordance with the original plan. And also, importantly, the recovery auditors and other Medicare review contractors generally will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission between October 1st, 2013, and October 1st, 2014.

We say “generally” because some reviews may still be done. For example, the comprehensive error rate testing contractor that is responsible for doing a subsample of reviews to calculate the improper payment rate can still select their very small sample of inpatient claims for that purpose. And also, some of our fraud – fraud units can conduct reviews as appropriate.

More recently, a couple of days ago, we had a couple more updates. The first is that CMS will be requesting or has requested that the Medicare administrative contractors re-review all claim denials under the Probe and Educate process. This will be done to ensure that the claim decisions and subsequent education are consistent with the most recent clarifications on the order and certification guidance.

The MAC may reverse their decision and issue payment outside of the appeals process if it determines that a claim is payable upon re-review. Therefore, we do encourage providers to work with their MACs to determine if a particular claim has undergone final adjustment—in other words, it has been re-reviewed—before submitting an appeal request.

To ensure that the re-review process does not affect the ability of a provider to timely appeal a denied claim, we are waiving the 120-day timeframe for filing redetermination requests. However, these need to be received before September 30th, and the claim denials need to have been made on or before the additional order and certification guidance was issued on January 30th, 2014. And also just along those lines, the claim denials under the Probe and Educate process that did occur on or before January 30th for which an appeal has already been filed will also be subject to re-review.

A couple other updates: We did post a new document on our website that is entitled “Medicare Inpatient Hospital Probe and Educate Status Update,” and that’s in the Downloads section at the bottom of the page. And that just provides some initial data collected from the inpatient Probe and Educate process and gives some examples of some common denials that we have found during this period. We’re planning on making updates to this document regularly for your purposes.

And we also did make some updates to our other documents that have been out there for a while. For example, our question-and-answer document has been updated to include information about transfers and such, and also, our selection – Selecting Hospital Claims for Patient Status Reviews document has been updated to reflect the extension of the Probe and Educate period. And the Reviewing Hospital Claims for Patient Status document has also been updated for our transfer policy and also more minor clarifications.

So I think that that’s all the updates that we have for right now. We can answer any particular questions you have during our Q&A session.

Keypad Polling

Aryeh Langer: Thank you, guys, very much for a very informative presentation. Before we move into the Q&A session, we pause for a few moments to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today. Please note, there will be silence on the line while we tabulate the results. Victoria, we're ready to start the polling, please.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you're the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you're the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.... Please continue to hold while we complete the polling.... Please continue to hold while we complete the polling.

Thank you. I'd now like to turn the call back over to Aryeh Langer.

Question-and-Answer Session

Aryeh Langer: Thank you. Our subject-matter experts now will take your questions. I'd like to remind everyone again that this call is being recorded and transcribed, so before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions as possible, we ask that you limit your questions to one per person. If you have more than one question, please press star 1 after your first question is answered to get back into the queue, and we'll address additional questions as time permits. Victoria, we're now ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you're asking your question, so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

One moment for your first question. Your first question comes from the line of Helen Holmes.

Helen Holmes: Hi. I just wanted to clarify what you said about, you know, who's qualified to write the admitting order when you spoke about the ED physicians. If an emergency room doctor doesn't have official admitting privileges, but they write them

for the attending whom they've spoken to on the phone, does that still have to be countersigned by the attending, or not?

Daniel Schroder: Yes. This is Dan. Yes, it would need to be countersigned. The admission order to be considered valid would need to be signed by someone who has admitting privileges by the hospital, which typically would not be a resident or a ED doctor ...

Helen Holmes: Not a resident, an actual ER attending—so, OK.

Daniel Schroder: ER attendings typically do not – from what we understand, typically do not have admitting privileges at the hospital. So we would say yes, there would need to be a countersigned order. I believe there – we had a lot of discussion about bridge orders, that we would consider that to be a type of initial admission order, but our policy would be that it would need to be countersigned by someone with admitting privileges.

Helen Holmes: OK, thank you.

Operator: Your next question comes from the line of Kathy Stratman.

Kathy Stratman: Hi, on the same – kind of following up with the prior question, that countersignature, does it need to be done prior to discharge?

Daniel Schroder: The guidance we've provided is yes, that it does need to be provided prior to discharge. We have some patient liability considerations, especially if transferred to skilled nursing after discharge, that we wanted to ensure that the status of the patient was fully known before that they – before they were moved to another facility. So the answer is yes, that all inpatient admission orders would need to be properly authenticated and countersigned and verified prior to discharge.

Kathy Stratman: Taking into consideration I'm calling from a small critical access hospital where that resident may have documented phone discussion with the attending Friday night at 11 o'clock at night, and the patient is discharged Saturday or Sunday. You know, that physician needs to come in physically to the hospital to co-sign that order. No ifs, ands, or buts about it.

Don Thompson: This is Don. I guess if they have no access, if there's no electronic health record that they can access, then yes, they would have to come ...

Kathy Stratman: OK.

Don Thompson: ... physically into the hospital.

Kathy Stratman: OK, OK. Thank you so much.

Michael Handrigan: This is Dr. Handrigan. I just have a question for you. Are you saying that routinely you have your attending physicians admit patients to the hospital that they never see while they're in the hospital?

Kathy Stratman: Sorry, I was in the process of hanging up. So was that a question for me?

Michael Handrigan: Yes, I'm sorry. Just a follow-up question.

Kathy Stratman: Actually, probably what would happen, the more I think about it—one of the other on-call physicians would be making rounds so they would have to co – you know, they could co-sign it. So, you know, when I asked the question, you know, the more I thought about it, it's like—ehh, ain't going to happen, you know. I don't know that we would have that much of a problem, but, yes, our attending who's here definitely would see that patient, I'm assuming.

Daniel Schroder: Yes, this is Dan again. Just to clarify, that would be acceptable.

Kathy Stratman: OK.

Daniel Schroder: It's not that – if there's a verbal order, an initial order made on behalf of another physician, another person with admitting privileges could go ahead ...

Kathy Stratman: Right. Yes, yes.

Daniel Schroder: ... and co-sign that order or countersign that order. It wouldn't have to be the same person.

Kathy Stratman: OK, thank you.

Operator: Your next question comes from the line of Christina Hughes.

Christina Hughes: Hi, this is Christina Hughes calling from Powers Pyles Sutter and Verville. I just want to clarify that for ED physicians who do have admitting privileges, do they have to have a countersignature on the order?

Daniel Schroder: No, if they have admitting privileges, they're considered a practitioner who can admit and the order would be valid.

Christina Hughes: Thank you very much.

Michael Handrigan: But that also implies that they are the admitting physician responsible for the patient in the hospital.

Christina Hughes: Whoa. Is that an implication, or is that an actual requirement? If they're handed off to an attending, does that then invalidate their admission order, even

though they have the admitting privileges and otherwise meet the requirements for ordering physicians under the clarification?

Michael Handrigan: No, once that pass-off occurs, then that's legitimate, but I'm just saying if the admitting physician is the ED physician, they're the admitting physician.

Christina Hughes: OK, thank you.

Operator: Your next question comes from the line of Jen Toporek.

Jan Toporek: Hi, I have a question regarding the re-review of the probes. Our facility and some other facilities that I've spoken to are getting denials saying medical records not received when we're not receiving an ADR, and when I called our MAC, they said that these would be part of the re-review which – I don't understand what's going to happen at that point of re-review. Are they then going to see they never requested our records?

Jennifer Dupee: Hi, this is Jen Dupee. The MAC is correct that those will be subject to the re-review. I would imagine that perhaps this would be on a case-by-case basis. It's our understanding that there have been instances where there have been no records received, and then after another look by the MAC, actually we were able to locate them. So what we would encourage you to do is just work directly with your MAC to see what the particular situation is and see if there's anything that can be done to remedy this particular problem.

Jan Toporek: OK, as long as you understand that they have never sent us a letter requesting the records, so we didn't send them, because normally we get a letter requesting, for the other probes. We have on some probes received a letter, but there are several that we're getting denials on that we never received a letter requesting the records.

Jennifer Phillips: Hi, this is – Hi, this is Jennifer Phillips. This sounds like a little bit of a unique situation to us. And so if you'd like, you could go ahead and send us an email to the IPPS admissions mailbox.

Jan Toporek: OK.

Jennifer Phillips: But I would also say that if you've alerted your MAC and they already are aware of it, then we anticipate that if they don't have the records, they will work with you to receive them.

Jan Toporek: OK, all right. I will submit to the email. They're telling me it's going to go in that re-review status, but I don't know that they're aware they didn't send us a letter.

Jennifer Dupee: OK, we'll look out for that. Thank you.

Jan Toporek: Thank you.

Operator: Your next question comes from the line of Alice Hinkle.

Alice Hinkle: Hi, this is Alice from Ephrata Hospital. I would like clarification on your definition of small and large hospital. We are approximately 130 beds, and we've already received 11 requests, and it was our understanding that we would get 10 requests for a Probe and Educate.

Jennifer Phillips: Hi, this is Jennifer Phillips. And so it sounds like it's a two-part question. So the first part—and you'll have to excuse me, I'm going off memory here, but the definition of small or large hospital facility was based on a 2000 – the same definition that the recovery auditors used in the 2009, and it's based on how many DRG payments that particular facility received.

And so it, of course, sounds like your hospital is a small facility, and so I think the second part of your question is why you've received 11 medical records requests. And so if the MAC inadvertently requested a record that should have been excluded from the Probe and Educate sample per CMS's instructions, we have told them to go ahead and close that claim and request an alternate medical record that's suitable for review.

So if – you know, if this – you continue to have any issues, I encourage you to reach out to the MAC, or of course, you could reach out to CMS, but it's probably just a situation where the medical record that was initially requested was not reviewable, and so they requested a replacement.

Alice Hinkle: So do I hear you saying that they may have requested 11 because 2 of the original 10 weren't reviewable?

Jennifer Dupee: Yes. So that would be the case. So if they needed to – sorry, this is Jennifer Dupee – so if 2 of the claims were excluded from the original 10, then you would anticipate that another 2 would be requested.

Alice Hinkle: OK, thank you. I'll be putting in for another question then, thank you.

Operator: Your next question comes from the line of Bill Gutekunst.

Bill Gutekunst: Hello, this is Bill, Southeastern Health. We have hospitalists that see these observation patients and inpatients, and we have a written communication from our regional CMS office that we're to hold their professional billing until the patient is discharged, and make all of their professional codes match the discharge status, whether it's inpatient or outpatient. And we think that's incorrect, that it's the status of the patient at the time the hospitalist sees them that drives their professional fee codes and payment.

So if they're in observation, we feel the hospitalist should use the outpatient E&M code, and then after the admission is written, the hospitalist should use the inpatient E&M

codes. Can you refer this to CMS's physician section? And if necessary, I can email our documentation telling us otherwise.

Daniel Schroder: Yes, we might need to refer this to someone else, but I – personally, from my understanding, I think you have the right interpretation—that if – the physician professional code should follow the current status of the patient. So if I'm getting it right, you're saying that the – you're being told to hold your coding until the final determination of inpatient or outpatient was made?

Bill Gutekunst: Yes, that's correct, and there is even an FISS edit that checks for that incorrect direction.

Daniel Schroder: Yes, we're going to have to follow up on this one.

Bill Gutekunst: It would be much appreciated, because everybody who has hospitalists is involved in this.

(Off-mike comments)

Daniel Schroder: Yes, if you – it would be helpful if you could send an email to the IPPS admissions website ...

Bill Gutekunst: I would be glad to, with the documentation attached.

Daniel Schroder: Yes, that would be great, and we could get this moving. But I believe your interpretation is correct at this time.

Bill Gutekunst: Very much appreciate it.

Daniel Schroder: OK, thank you.

Bill Gutekunst: Have a good day.

Operator: Your next question comes from the line of Joseph Dawood.

Joseph Dawood: Hello. In your January 30th guidance, there was a small paragraph that notes that if a patient is awaiting opening of a SNF bed, that they could still – still justify their stay as an inpatient. So my question is if, say, a patient has surpassed or crossed the 2 midnights and into the third day, but did not finish out the required 72 hours to go to a SNF—let's say that third day, a bed is available—can they be kept into the third day to qualify, or do they have to be discharged that day, supposing they do have that need for a skilled nursing facility?

Michael Handrigan: I think, you know, the way the guidance reads, it says that beneficiaries "already appropriately an inpatient can be kept in the hospital as an

inpatient if the only reason they remain in the hospital is that they're waiting for a post-acute SNF bed." That's the statement in the guidance.

Joseph Dawood: Yes, but I'm trying ...

Michael Handrigan: "The physician may certify the need for continued inpatient admission on this basis." That's the direct quote.

Joseph Dawood: Yes, but does that – is that – can that be interpreted as you can keep them until they qualify? If they already have qualified as an inpatient, can you keep them so that they can get that SNF, or you have to discharge on the third – you know, after completing the 2 midnights, to a SNF, regardless of whether they will qualify or not?

So in other words: OK, I took – I brought in a patient. I certified clear inpatient. They crossed the 2-midnight, this is the third day, and I feel they need a skilled nursing facility. But if I sent them out today, even though a bed is available, they will not be able to – they will have to pick up the charge for the SNF stay, can I ...

Michael Handrigan: The guidance certainly doesn't say you can keep them for the sole purpose for qualifying for the SNF stay. It says if you're waiting for a bed that's unavailable, they're waiting for a post-acute SNF bed, the physician may certify the need for continuing patient admission on this basis. You can't keep them an extra day for the sole purpose of qualifying for the SNF stay.

Joseph Dawood: OK. May I ask a second question, very quick one? I think you can answer it right away.

Jennifer Dupee: Sure.

Joseph Dawood: How do you treat transfers – when you say you count the prior hospital's time in figuring out whether the patient qualifies – whether the patient will count towards the 2 midnights or not. But how do you treat ambulance transfers to the second facility? Do – does billing have to stop at that point, or what if it's just a short, brief period, an hour, or maybe perhaps what if it is longer—what do you do with that?

Jennifer Phillips: For the purposes of – I'm sorry, this is Jennifer Phillips – for the purpose of the 2-midnight benchmark, ambulance time does not count. We – our instruction just counts the hospital time at the initial facility.

Joseph Dawood: OK, thank you so much.

Operator: Your next question comes from the line of Gerald Novik.

Gerald Novik: Thank you very much. This session was the best so far. My question is: In these transfers, somebody has a non-STEMI, stays in a community hospital for 3 days, comes over to us, we do a cath. We can find three things: Number one, it's a normal cath;

number two, he needs a stent or a – three, a balloon, and then we keep him overnight and send them out the next day. We can count that, as I’m hearing, as an inpatient admission based on the fact he stayed there 3 days.

Now, you mentioned something that, if the days in the – who has to certify that the days in the other hospital were proper, in that could he have been transferred to us in a day? We certainly don’t have that information. We have the records, but how do I – how do I bring it in?

Jennifer Dupee: I apologize. We’re just having a quick sidebar on this question. This is a great question.

Gerald Novik: OK.

Jennifer Phillips: Hi, this is Jennifer Phillips. Thank you for your patience.

Gerald Novik: Thank you, Jennifer.

Jennifer Phillips: We think that that’s actually kind of a two-part question that you asked. So the certification of the Hospital A, we’ll call it, admitting practitioner remains unchanged. So divert to the certification rules that Dan mentioned earlier.

The receiving physician still needs to look at the medical documentation. That’s why we really wanted to stress that we think it’s important for the receiving facility to know what care that beneficiary receives. Otherwise, it would be difficult to support that 2-midnight expectation.

Gerald Novik: May I – may I continue my question, Jennifer? It’s the same physician in both hospitals, number one. And number two, sometimes these people come over – these patients come over with a nitroglycerin drip or with other drips, and sometimes we have a negative cath and send them home the same day. Do I bring them in as an outpatient, or do I bring them in as an inpatient?

Michael Handrigan: This is Dr. Handrigan. If you’ve admitted the patient at Hospital A for the purposes of the rule-out, and they’ve spent beyond 2 midnights at the other hospital, it’s an inpatient-to-inpatient transfer—that’s OK. And we would expect that you would bill that as a DRG in both places.

Your question about the original medical necessity of the services provided at Hospital A is a separate question. It’s a different question than satisfying the benchmark. All services in items paid for by Medicare have to be medically reasonable and necessary.

Gerald Novik: Yes, but ...

Michael Handrigan: So you still have to establish the necessity for those services in the medical record.

Gerald Novik: But may I – I'm a physician advisor at the second hospital, but I don't have to certify that, I can just bring him in. They can bring him here as an inpatient, and we can send him home the same day, the next day, whatever, and it's going back to – the onus goes back to the first hospital, that it was properly expedited there. Is that correct?

Michael Handrigan: Well, the underlying services need to be medically necessary.

Gerald Novik: No, I understand that.

Michael Handrigan: That is ...

Gerald Novik: Patient had a non-STEMI.

Michael Handrigan: Right. So presumably, that is a reasonable admission at the first hospital, followed by a reasonable admission for the diagnostic cath at the second hospital. But as you know, there are – every patient is a little bit different. So you – at the second hospital, if you're admitting that patient, you still bear responsibility to evaluate that patient when they get to your facility...

Gerald Novik: Well, of course.

Michael Handrigan: ... and medically justify that the services that you provide.

Gerald Novik: All right, thank you very much.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Valerie DeVine.

Valerie DeVine: Hi, this is Valerie. I just want to clarify, because our hospital had directed us that nurse practitioners were not permitted to sign the orders, but based on what I'm seeing and hearing today, if they're licensed by the state and have admitting privileges, the nurse practitioner is permitted to sign the inpatient order?

Daniel Schroder: Correct. You're saying they – if they have license by the state and have admitting privileges, they are qualified to sign the admission order. They would not be eligible to sign the certification, however; there would still need to be a physician to review that.

Valerie DeVine: OK.

Daniel Schroder: The necessity for a physician to review that.

Valerie DeVine: OK. And is there anywhere in the rules, the regulations that you could direct me to the section so I can actually have that rule on that?

Daniel Schroder: Sure. If you want to go to the January 30th guidance—sorry, my pages are all kind of messed up here, it's in the – part B – oh, thank you. It's on page 4, part B, Qualification of the Ordering/Admitting Practitioner, and A, subsection A, it says residents and non-physician practitioners who are authorized to make initial – OK, that's initial determinations. OK, you're saying they actually have admitting privileges, correct?

Valerie DeVine: Yes, yes.

Daniel Schroder: Yes, I mean, that's just under 2, that we say “the order must be furnished by a physician or other practitioner (‘ordering practitioner’)” who is licensed by the state, granted privileges, and knowledgeable of the patient's hospital course. It says nothing about a medical role; it just says that they are licensed and granted privileges. So just on page 4 of subsection B, subsection 2.

Valerie DeVine: OK, but they can or cannot sign the certification?

Daniel Schroder: They cannot sign the certification; that's a statutory requirement that limits it to physicians or DOs and in certain circumstances, dentists and podiatrists.

Valerie DeVine: OK. OK, thank you.

Aryeh Langer: Thank you very much.

Operator: Your next question comes from the line of Larry Field.

Larry Field: Good afternoon. I had a question as far as the language that appears in some of the additional guidance. In the original IPPS rule, it had the greater than 2 midnights medically necessary hospital *services*. We're starting to see more of the information of greater than 2 midnights of medically necessary hospital *care*. Is that inadvertent or purposeful? Because they mean different things.

Jennifer Dupee: Hi, this is Jen Dupee. From our viewpoint, we consider those to be one and the same. We are referring to the same thing for the purposes of the 2-midnight benchmark.

Larry Field: Then could we request that it goes back to the original, and that's consistent in all the further guidance, and that the past guidance gets corrected to say hospital *services*?

Jennifer Dupee: We will take a look at that, yes.

Larry Field: Thank you.

Operator: Your next question comes from the line of Judy Olson.

Judy Olson: Hi, this is Judy Olson.

Aryeh Langer: Hello?

Judy Olson: Hello, are you there?

Aryeh Langer: Yes, go ahead, please.

Judy Olson: OK, thank you. I was wondering—on the countersignature, if you do have an ED physician that is not available or does not have admitting privileges, and it needs to be countersigned, I understand it's before discharge. However, if the medical record system that you have for the order closes out, does that have to be actually countersigned on the original order, or can it be elsewhere on that medical record?

Daniel Schroder: Hi, this is Dan. I'm seeing some heads shaking in the room. I think to be perfectly in line with conditions of participation and Medicare rules, that it should be countersigned on the original document, the original order. It should be clear, not ambiguous. To give some background, you would not be allowed to have somewhere in the medical record, a statement saying, "I basically countersign and concur." You can't do that batch, kind of, affirm all separate orders in one statement.

Along those lines, it should be countersigned directly on the original order. We have had questions in the past that have come in through email, specifically about, you know, certain EHR systems that can't – that aren't built in a way that would allow that type of direct countersignature. I think it would – if there – a potential workaround has been discussed, about having separate statements other – where – other places in the medical record and whether that would be sufficient. I think our official answer is that that would not be appropriate, but if it's the only thing that's possible, it would be better than nothing. But the official stance would be that the EHR system should be modified in a way to allow the countersignature directly on the initial order.

Judy Olson: OK, thank you for your time.

Operator: Your next question comes from the line of Sharon Miles.

Sharon Miles: Yes, hi, good afternoon. On the update on the FAQ that was released on February 24th, question Q13, your answer states that if a claim is determined to be not reasonable and necessary, we could go ahead and re-bill part – inpatient Part B. However, what if the services were reasonable and necessary, but we failed to obtain the certification by getting the order co-signed prior to being discharged? What kind of billing recommendation should we have?

Michael Handrigan: At that point, there was no admission. There was no inpatient admission if there was no valid countersignature, so you could bill that as an outpatient, outpatient Part B.

Sharon Miles: Outpatient Part B? OK.

Michael Handrigan: Yes. There never was admission if there was no signature – countersignature.

Sharon Miles: OK, thank you.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Ruth Honig.

Ruth Honig: Hi, this is Ruth Honig from Garfield Medical Center. In the latter dated January 30th, 2014, you used the term *recertification*. What is recertification?

Daniel Schroder: Hi, this is Dan. The best explanation is, you know, we often try to use language in these Frequently Asked Questions that can apply in multiple circumstances. Re-certification primarily refers to an outlier process. We might not have the staff people in the room to properly go through that requirement, but for the most part, it – we’ve gotten questions on whether this is some new requirement on – to general hospital stays and no, it is not a new requirement. It’s just – it’s a way of us kind of merging guidance that could apply in multiple situations. So if your concern is that there’s some new requirement of recertification, it is no new requirement.

Ruth Honig: So let me ask you, if a patient goes from inpatient to observation, we had a certification for inpatient, but then it got code 44 and changed to OG, do we have to quote “recertify” that OG with another set of orders and another attestation? Or no, that’s not what you mean by ...

Daniel Schroder: No, no, that’s not what we mean. I don’t think there’s a certification requirement for outpatient services, not the same as inpatient. So no, it doesn’t require – apply to that. It was – it’s really language intended to apply to certain cases of outlier recertification. Certain policy areas, I’m not 100 – I’m not – wouldn’t consider myself a subject-matter expert on, so I don’t want to speak too much about it, but it is not a new requirement on – for anyone else.

Ruth Honig: OK. So if I can make a recommendation like someone has earlier, you guys might want to look at your terminology, because this January 30th letter defines quite a few things like certification, et cetera, but then it doesn’t define that term that’s then used.

Daniel Schroder: Thank you for the comment; we’ll consider it.

Ruth Honig: Thank you.

Operator: Your next question comes from the line of Debbie Bravos.

Leo Reyes: Hi, this is Dr. Reyes. I'm the PA for our system. I just want to clarify about a question earlier about a patient who was classified under 2-midnight rule in another hospital, cardiac patient, goes to another facility for cardiac cath, turned out to be normal, discharged on the second day, and the answer we – I heard was yes, that still falls under 2-midnight rule in spite of the fact that the patient had a normal cath for the second hospital.

And then somebody said there was a clarification later on, but that you have – still have to reevaluate that patient in the receiving hospital as to the appropriateness of care, as to whether that supersedes, or what supersedes the determination of 2-midnight rule, or you have to have – you can disregard 2-midnight rule and say OK, this is now an outpatient procedure on my hospital, because I don't see anything that is inpatient related.

Michael Handrigan: So I can imagine two situations. The first situation is where the – your patient is admitted to the first hospital with the expectation of being there more than 2 midnights. They spend more than 2 midnights at that hospital, and they are transferred as an inpatient to an inpatient bed at the second hospital for the purposes of further diagnostic workup. In that case, that would be an inpatient-to-inpatient transfer, and the benchmark would have already been satisfied at the first hospital.

The second situation that I can imagine, that happens frequently, is your patient is seen at the first hospital and kept over for the first midnight to undergo diagnostic evaluation, and transferred prior to the second midnight. At that time, it's an outpatient or ED transfer to the second facility. At that time, the second facility can account for the time spent at the first facility in satisfying the 2-midnight benchmark in making their determination about whether to admit the patient at the second facility or to provide diagnostic care and discharge. Does that help clarify your question?

Leo Reyes: Not really. I mean, I determine the patient – I'm the receiving hospital. I say OK, there's nothing – this patient is stable, there's no heparin drip, there's no other cardiogenic drugs. (Inaudible) doesn't fit my criteria for my determination for inpatient at my second hospital? I cannot see the reason why keeping him inpatient despite of the fact that he was determined at 2-midnight rule from the other hospital. All I'm doing right now is doing – I am doing a cath and discharge the patient.

Michael Handrigan: So in the patient that you're describing, just to make it more objective, let's say that at the first hospital they spent 1 midnight, and they were transferred either from an observation status or from the emergency department. They may or may not have had a small troponin leak, but there was no obvious MI going on. They were otherwise stable, and your anticipation once they got to your facility was that they would undergo a routine cath, and if the cath were negative, then you would send them home.

Leo Reyes: Correct.

Michael Handrigan: That's a pretty typical patient, and it would be reasonable at that time for you to say, "his is likely not to surpass a second midnight" and not admit that patient at that time. However, if they got to the – your facility and they were unstable, and it was clear to you that it was more likely to be a complicated procedure and they would require care following the procedure, it would be reasonable for you at that time to say, "I'm going to admit this patient" in advance of the procedure and send them to whatever setting in the hospital you're going to send them after the procedure, with the anticipation that they would then pass the second midnight. That would be an appropriate inpatient admission. So you have flexibility in how you manage these patients.

Leo Reyes: You're not – what I – perfect, we're not bound for the determination of 2-midnight rule from the other hospital then. That's exactly what we're doing. Thank you.

Michael Handrigan: No, you have flexibility.

Leo Reyes: Thank you very much. Perfect.

Michael Handrigan: Sure thing.

Leo Reyes: That's what we are doing right now. Thank you.

Operator: Your next question comes from the line of Case Ronan.

Tom McCarter: Hi, this is Tom McCarter. In regard to the re-review process by the MACs, the appeals process is already fairly confusing and delayed. Am I hearing that current MAC Probe and Educate denials that are in the appeals process will now be removed and re-reviewed by the MACs? This further delay would be unacceptable to providers that already have millions of dollars of revenue held up in this process.

For the case – in these cases, this would mean that the MACs have already had an opportunity to review the case and deny. They would then re-review and deny, and then that case in the appeals process would go again to the MAC as the first step in the appeals process. It doesn't seem like they should require three strikes to get this right.

Jennifer Phillips: Hi, this is Jennifer Phillips. Just to clarify, so they would not need to request a second redetermination in the situation that you mentioned. Essentially, what is occurring is the MAC contractors are re-reviewing claim denials made prior to January 30th, 2014. If the MAC changes their decision, they will go ahead and let the provider know that that claim has been reopened and that it was decided that it was a payable claim. If they do not change their decision and that claim already has a pending redetermination, it will proceed with the redetermination that was already requested.

Tom McCarter: So just a follow-up: It won't be removed from the appeals process; this will be done while it remains in the appeals process, so my clock is ticking forward?

Jennifer Phillips: I'm not sure what you meant by your clock, but yes, correct.

Tom McCarter: Not coming out of the appeals process to re-review so that I would have to restart that process, that's what I mean by my clock. I know that you've extended the deadline on that first level of appeal beyond 120 days if we would need to do that, but I don't want to prolong that appeals process. I don't consider that first value step – the MAC who denied it in the first place to be valuable. I want to get it to the second level and the third level as fast as I can. I don't want a delay in that process.

Jennifer Phillips: Understood, yes. As I stated earlier, you can always follow up with the IPPS admissions if you have additional questions, but that appeal – if the reopening decision remains unchanged, we'll proceed with the redetermination that was already requested, if that is the case.

Tom McCarter: Excellent. Thank you very much.

Aryeh Langer: We'll take our next question, please.

Operator: Yes, your next question comes from the line of Gwen Smith.

Gwen Smith: Yes, I wanted to ask the question, I am from a very rural facility that has only, like, 32 beds. I'm the only utilization review person here. And sometimes, like when we have holidays and things like that, the patient will come in with an on-call physician not paying attention to the fact that the ER doctor sent them up as an OBS patient or an inpatient, and they come in as an OBS when they should have been in. And then I can't change them if they've left before I get back on the following work day—say it be a Monday or Tuesday, depending on the holiday. So I'm understanding that I cannot change those once they're discharged, right?

Michael Handrigan: Just to be clear, so there was never an inpatient order written?

Gwen Smith: Right.

Michael Handrigan: And after the fact, you want to make them an inpatient?

Gwen Smith: Well, they would have met inpatient criteria. So it means that the facility ...

Michael Handrigan: But there was no inpatient order?

Gwen Smith: Right, right.

Michael Handrigan: No, if there was no inpatient order, you can't retroactively create an inpatient order after they've been discharged...

Gwen Smith: OK. Suppose they were admitted as ...

Michael Handrigan: ... if I understand the question.

Gwen Smith: So suppose they were admitted as an inpatient and should have been OBS. I still can't change it, right?

Daniel Schroder: Correct.

Gwen Smith: OK, thank you.

Operator: Your next question comes from the line of Ronda McNeill.

Your next question comes from the line of Tina Calderwood.

Tina Calderwood: Yes. My question is, our local UR director at our Tyrone Hospital – we see patients here in our office, and doctor has determined that the patient needs to be placed either in observation or as an inpatient. She is telling us that we cannot do direct admissions or observations from our office, that the patient must run through the emergency room. Is that correct?

Michael Handrigan: There's nothing in the new inpatient rule that states that or implies that.

Tina Calderwood: OK, because the doctor has seen the patient here in the office and has done outpatient testing. And even with testing, she will refuse us a direct admission, whether it will be observation or inpatient. She is stating the patient has to run through the emergency room first.

Michael Handrigan: That seems to be a local issue between you and your hospital facility policies. So that's not a CMS issue.

Tina Calderwood: Right, that's not a CMS regulation, correct?

Michael Handrigan: Correct.

Tina Calderwood: OK. And then how many – like, how many days are patients allowed to be in observation? Is it up to 48 hours, or can it be extended beyond 48 hours?

Jennifer Dupee: This is Jennifer Dupee. We actually have a Q&A that is pretty on point with this question, which is basically whether there is a requirement to admit a patient when it's clear that they will need to stay past the second midnight for medically necessary hospital care or hospital services. And our answer to that is while it's not a requirement that the beneficiary be admitted, it is encouraged by CMS.

One of the purposes of this rule was to alleviate some of the issues that we've had with extended observation stays. Obviously, those have some ramifications for beneficiary cost sharing and other issues that go along with it, so I do encourage you to take a look in

the latest Q&A. I'm trying to see if I can find it quickly, which one it is. I'll take a look, and in the next question if I – I'll let you know.

Jennifer Phillips: Question 4.10.

Jennifer Dupee: Thanks.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Laurie Signorelli.

Laurie Signorelli: Hello. I'm wondering if you can clarify something for us. We seem to remember that early on in talking about the 2-midnight rule, there were some discussion that observation days would count towards the 3-day qualifier. Has that changed?

Michael Handrigan: The 3-day qualifier starts with the inpatient order.

Laurie Signorelli: OK.

Michael Handrigan: Which is different from the 2-midnight benchmark.

Laurie Signorelli: OK. So it starts from the inpatient admission order. OK. All right, just checking. Thank you.

Jennifer Phillips: Thank you.

Operator: Your next question comes from the line of Dru Cavanaugh.

Dru Cavanaugh: Hi, I just have a quick question. In your introduction, you talked about difference – content of certification for a critical access hospital, but I didn't really hear it discussed in your presentation. So I was just wondering what that is.

Renate Dombrowski: So there's a separate requirement for payment for inpatient critical access hospital services, and it's a statutory requirement that the physician certify at the time of admission that they expect the individual to be discharged or transferred to a hospital within 96 hours after admission. And I want to...

Dru Cavanaugh: OK.

Renate Dombrowski: ... reinforce that it's an expectation.

Dru Cavanaugh: OK, no problem. Thank you.

Renate Dombrowski: Sure.

Operator: Your next question comes from the line of Denise Lukens.

Denise Lukens: Yes, hello. I have a question about the recent Q&A that is dated 2/24, where it talks about that, you know, none of the 2-midnight inpatients will be reviewed but if there's evidence of systemic gaming or abuse. How are you going to determine that if you're not reviewing any records? And for instance, like, all those past things that were targeted like back pain, syncope, that may have stayed 2 midnights, so how are you going to determine we're being abusive?

Jennifer Phillips: Hi, this is Jennifer Phillips and I apologize, I don't know offhand which question, but there is a question in the FAQ document that touches on that a bit. CMS and the MACs will be looking for billing aberrancies such as those provided, or anything – any other aberrancies such as those provided through the FATHOM or PEPPER report, as well as CERT data, information of that nature.

Denise Lukens: OK. So you will, like, look at PEPPER reports and see if our 2-day stays climb, or something like, that in certain diagnoses? This is not very clear of how you would determine that.

Jennifer Dupee: As we have – sorry, this is Jen Dupee. I mean, as we have now, we have the discretion to look at various data analysis and change around our focus as we find it to be appropriate under the 2-midnight rule. I don't know if there's much more we can specify other than that.

Denise Lukens: OK, thank you.

Operator: Your next question comes from the line of Scott Patterson.

Scott Patterson: Hi, I just had a quick question. If we perform an inpatient-only procedure on a patient, but we fail to get the inpatient order on the chart before discharge, in that rare circumstance can we infer that that patient was inpatient and bill it as such?

Daniel Schroder: Sorry. We have to reiterate that it is necessary – that inpatient order is a critical component of an inpatient stay. In the case of an inpatient-only procedure, that would probably be a case where a contractor would be able to infer an inpatient order through medical review, that there really wouldn't be any other reasonable way to treat a patient consider we – considering that that procedure we consider only to be done – able to be done safely in an inpatient setting. But to answer your question on whether there should be an order not, there should be an order, and that's the guidance that is based on our regulations and on our statutory requirements that we would have to stay with.

Scott Patterson: OK. So we – I mean, usually we get an inpatient order, but there are instances where we may not, and that – that would be a rare instance. So that's why I was asking.

Daniel Schroder: Yes, I mean, it would be a rare ...

Scott Patterson: So then contractors can ...

Daniel Schroder: I would imagine it would be a rare instance, and that's part of the reason we give MACs discretion, but if you're asking for a formal statement or a semi-informal statement from CMS, our statement is that an inpatient order is a critical component of the inpatient stay.

Scott Patterson: Right, OK. OK, thank you.

Operator: Your next question comes from the line of Sharon Maxwell.

Sharon Maxwell: Hello. We're calling from Munson Medical Center, and I had a follow-up question. A previous caller asked about nurse practitioners who are licensed by the state and have admitting privileges, and you reiterated our understanding that that practitioner can sign the order but cannot sign the certification. So our follow-up question is, is a co-signature on the inpatient order required in that instance?

Daniel Schroder: No. I think what you're asking is that we – as part of the certification, we say that the certifying physician needs to certify varying parts of, you know, the discharge planning and the inpatient order. We've gotten questions on whether it's necessary for that certifying physician to go and countersign every single aspect of the certification, and we've said no. As long as there's sufficient documentation that the certifying physician was aware of the patient care and the patient course and was involved in some aspect of the inpatient stay and creates an adequate certification, a statement or signature somewhere in the medical record, it's not necessary that they have to also countersign an otherwise proper inpatient order.

Sharon Maxwell: OK, yes, because in our hospital, we've developed a separate certification statement, so I just wanted to confirm that as long as that certification statement is all inclusive, they don't need to actually co-sign the nurse practitioner's order.

Daniel Schroder: That sounds good to me.

Jennifer Dupee: Thank you.

Operator: Your next question comes from the line of Jeanine Gerlach.

Aryeh Langer: Hello?

Jeanine Gerlach: Hello, this is Jeanine Gerlach, and I am from Regional Health. I have a question in regards to the NBC News misinformation on the observation/inpatient stay that's been put out there for the public, and what has or what will CMS do to educate the public and Medicare recipients to the actual regulations for Medicare inpatient stays?

Jennifer Dupee: Hi, this is Jen Dupee. We have seen that story, and we understand that there may be some misconceptions, and we are doing our best to actually educate the beneficiary community on this as well. So we are working on documents that discuss the 2-midnight rule and its impact on inpatient hospital stays, and are also conducting outreach with the major organizations that deal one-on-one with beneficiaries to give them the information as well. So if anyone does have any ideas for us on other ways we can reach out to beneficiaries, we're always open to hearing those suggestions.

Jeanine Gerlach: Thank you.

Operator: Your next question comes from the line of Robert Tipton.

Robert Tipton: Hi, guys. Great, great, great webinar. Very educational. I had a question regarding the educate part of the Probe and Educate reviews. Our facility has pretty much gone through the first level of probe reviews. We've gotten a number of claims returned, either approved or denied, and I'm sort of interested in whether or not the MACs are – I do see in the document that says “MAC Actions Following Inpatient Status Probe Reviews,” that a summary letter is supposed to be sent to the providers indicating the reasons for denials, whether there will be additional reviews or not, and I think it also states that it offers a one-to-one phone call.

Do you guys have any specifics on timeframes, who these letters might be going to, who these calls might be going to? I work for a major medical center in New York City and it's very large. We're trying to figure out, should we have received a letter already, where this call might come from, and all of that information.

Jennifer Dupee: Hi, this is Jen Dupee. I'm going to try to hit all of your questions. As far as who it would be going to, I believe it would generally be whoever normally receives the results of any kind of probe reviews that are conducted by the MAC. So if there's a question within your particular facility of who that would be, I would just encourage you to reach out to your MAC to find out that information.

Because we are conducting these re-reviews, it's our understanding that in most cases, the additional education and the final letters are actually just starting. So we would anticipate – we anticipate that the re-reviews will be completed sometime this spring, and that most people should be hearing their final results shortly thereafter, but it may be, you know, well, sooner than that. So it really could be any time.

If you do have a question about your particular facility and where they are in the process, we do just encourage you to reach out to your MAC, and they should be able to give you that information without a problem.

Robert Tipton: OK, Jen. And then the phone call as well, I assume once the letter is issued, the MAC would also then – that whatever educational phone call – it would also be inclusive of that process as well.

Jennifer Dupee: Yes, that's correct. It is kind of one packaged deal, so you'd get that – the letter, and then the education would shortly there follow.

Robert Tipton: Fantastic. Thanks so much for your time, guys.

Jennifer Dupee: Thanks.

Aryeh Langer: We have time for one more call, please.

Operator: Your final question comes from the line of Diane Fraley.

Aryeh Langer: Hello?

Operator: Diane Fraley, your line is open.

Diane Fraley: Hello? Can you hear me?

Aryeh Langer: Yes, ma'am, go ahead.

Diane Fraley: Hello? Yes.

Aryeh Langer: Hello?

Diane Fraley: I'm Diane from Pleasant Valley Hospital. Can you hear me? Hello?

Aryeh Langer: Yes, you can go ahead.

Diane Fraley: OK. We may have missed your complete answer on this question, so can you tell us, with a nurse practitioner with admitting privileges, can that nurse practitioner sign the physician certification form as the final signature, or does she still need the co-signing of the physician, even with admitting privileges?

Daniel Schroder: The answer is no. A nurse practitioner is not authorized to sign an inpatient – Medicare inpatient certification statement. I wouldn't even say that they require a co-signature; it's a physician or, in some cases, a dentist or podiatrist that are the only people who are authorized by statute to sign that certification statement. If a nurse practitioner makes ...

Diane Fraley: OK, so she should not even be signing them to get a co-signature then, is that correct?

Daniel Schroder: Yes. I wouldn't recommend – the certification statement is made by the physician. Again, there's no formal guidance on what a certification statement has to look like, where there's some flexibility in how you can construct or determine what a certification is. But essentially, it is that physician who has some knowledge of the

patient's course and some interaction with the patient that is allowed to sign that certification.

Diane Fraley: OK, all right, that answers the question. Thank you.

Additional Information

Aryeh Langer: And thank you very much. Unfortunately, that's all the time we have for questions today.

On slide 24 of today's presentation, you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience today.

Again, my name is Aryeh Langer. I'd like to thank our subject-matter experts and all of our participants who joined us for today's MLN Connects Call. Have a great day, folks.

Operator: This concludes today's call. Presenters, please hold.

-END-

