



## **Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013**

(Last Updated: 11/04/13)

On August 2, 2013 the Centers for Medicare & Medicaid Services (CMS) issued Final Rule CMS-1599-F, which modifies and clarifies CMS's longstanding policy on how Medicare contractors review inpatient hospital admissions for payment purposes.

CMS intends to issue guidance to Medicare Administrative Contractors (MACs) about how to select hospital claims for review during a "Probe and Educate" program for admissions that occur October 1, 2013 through March 31, 2014. This document contains a summary of the technical direction that CMS will issue to the MACs.

Throughout this document, the term "patient status reviews" will be used to refer to reviews conducted by MACs to determine a hospital's compliance with CMS-1599-F, which focuses on the appropriateness of an inpatient admission versus treatment on an outpatient basis.

CMS will instruct the MACs to apply CMS-1599-F to the "Probe and Educate" patient status reviews they conduct for claims submitted by acute care inpatient hospital facilities, Long Term Care Hospitals (LTCHs), and Inpatient Psychiatric Facilities (IPFs) for dates of admission on or after October 1, 2013 but before March 31, 2014. CMS-1599-F is also applicable to Critical Access Hospitals (CAHs), but CAHs are specifically excluded from patient status reviews during this 6-month timeframe. MACs will NOT apply these instructions to admissions at Inpatient Rehabilitation Facilities (IRFs). IRFs are specifically excluded from the 2-midnight inpatient admission and medical review guidelines per CMS-1599-F.

### **A. Claims for Hospital Admissions that Span 2 or More Midnights**

The 2-midnight **presumption** outlined in CMS-1599-F specifies that hospital stays spanning 2 or more midnights after the beneficiary is formally admitted as an inpatient pursuant to a physician order for such admission will be presumed to be reasonable and necessary for inpatient status as long as the stay at the hospital is medically necessary. CMS will direct MACs NOT to focus their medical review efforts on stays spanning at least 2 midnights after admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. However, MACs may review these claims as part of routine monitoring activity or as part of other targeted reviews.

### **B. Claims for Hospital Admissions that Span 0-1 Midnights**

Inpatient stays spanning 0-1 midnights after the beneficiary is formally admitted as an inpatient are not subject to the presumption and may be selected for review. However, if total time in the hospital receiving medically necessary care (including pre-admission outpatient time from the time care is initiated in the hospital) spans 2 or more midnights, the 2-midnight benchmark for inpatient admission will be met and payment supported upon medical review. Effective for



admissions on or after 10/1/2013, CMS will direct the MACs to conduct probe reviews and deny claims found to be out of compliance with CMS-1599-F. CMS will direct MACs to select a sample of 10 claims for prepayment review for most hospitals (25 claims will be selected for prepayment review for large hospitals). Based on the results of these initial reviews, MACs will conduct educational outreach efforts during the next 3 months. CMS will instruct MACs to deny each non-compliant claim and to outline the reasons for denial in a letter to the hospital. We will also instruct the MACs to offer individualized phone calls to those providers with either moderate/significant or major concerns. During such calls, the MAC will discuss the reasons for denials, provide pertinent education and reference materials, and answer questions.

In addition to these educational outreach efforts, for those providers that are identified as having moderate/significant concerns or major concerns, the MACs will conduct additional probe reviews on claims with dates of admission between January and March 2014. The size of these probe reviews will be 10 additional claims (25 for large hospitals). If continuing concerns are identified at the end of the 6-month review period, samples of 100 claims (250 for large hospitals) may be selected for additional review. CMS will also monitor provider billing trends for variances indicative of abuse, gaming, or systematic delays in the submission of claims, for the purpose of avoiding the MAC prepayment probe audits during this initial probe and educate period. The MACs will submit periodic reports to CMS for purposes of tracking the frequency and types of errors seen during these probe reviews.

## MAC Actions Following Patient Status Probe Reviews

	Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October – March 2014)		
	No or Minor Concerns	Moderate to Significant Concerns	Major Concerns
10 claim sample	0-1*	2-6*	7 or more*
25 claim sample	0-2*	3-13*	14 or more*
Action	<p>For each provider with no or minor concerns, CMS will direct the MAC to:</p> <ol style="list-style-type: none"> <li>1. Deny non-compliant claims</li> <li>2. Send summary letter to providers indicating: <ul style="list-style-type: none"> <li>• What claims were denied and the reason for the denials</li> <li>• That no more reviews will be conducted under the Probe &amp; Educate process.</li> <li>• That the provider will be subjected to the normal data analysis and review process</li> </ul> </li> <li>3. <b>Await further instruction from CMS</b></li> </ol>	<p>For each provider with moderate to significant concerns, CMS will direct the MAC to :</p> <ol style="list-style-type: none"> <li>1. Deny non-compliant claims</li> <li>2. Send detailed review results letters explaining each denial</li> <li>3. Send summary letter that: <ul style="list-style-type: none"> <li>• Offers the provider a <b>1:1 phone call</b> to discuss</li> <li>• Indicates the review contractor will REPEAT Probe &amp; Educate process with 10 or 25 claims</li> </ul> </li> <li>4. <b>Repeat Probe &amp; Educate of 10 or 25 claims with dates of admission January – March 2014</b></li> </ol>	<p>For each provider with major concerns, CMS will direct the MAC to :</p> <ol style="list-style-type: none"> <li>1. Deny non-compliant claims</li> <li>2. Send detailed review results letters explaining each denial</li> <li>3. Send summary letter that: <ul style="list-style-type: none"> <li>• Offers the provider a <b>1:1 phone call</b> to discuss</li> <li>• Indicates the review contractor will REPEAT Probe &amp; Educate process with 10 or 25 claims</li> </ul> </li> <li>4. <b>Repeat Probe &amp; Educate of 10 or 25 claims with dates of admission January – March 2014</b></li> <li>5. <b>If problem continues, Repeat Probe &amp; Educate with increased claim volume of 100 – 250 claims</b></li> </ol>

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