Centers for Medicare & Medicaid Services
Special Open Door Forum:

Final Rule CMS-1599-F: Discussion of the Hospital Inpatient Admission Order and Certification; 2 Midnight Benchmark for Inpatient Hospital Admissions.
Thursday, September 26, 2013
2:00pm – 3:00pm Eastern Time
Conference Call Only

CMS will host a second, follow-up Special Open Door Forum (ODF) call to allow hospitals, practitioners, and other interested parties to ask questions on the physician order and physician certification, inpatient hospital admission and medical review criteria that were released on August 2, 2013 in the FY 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH) final rule (CMS-1599-F).

CMS final rule 1599-F clarifies that for purposes of payment under Medicare Part A, a Medicare beneficiary is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner. The final rule provides instruction 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 the ordering practitioner 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 as an inpatient based on that expectation, it is generally appropriate that the hospital receive Medicare Part A payment. Also as a condition of Part A payment, the order must also be documented in the medical record in accordance with the regulations, and a physician must certify the medical necessity of hospital inpatient services. The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status, but permits the ordering practitioner 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.

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. CMS also recently released New Guidance on the Physician Order and Physician Certification for Hospital Inpatient Admissions.

Special Open Door Participation Instructions:

Dial: Participant Dial-In Number(s): 1-866-501-5502
Conference ID # 68257949

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

CENTERS FOR MEDICARE & MEDICAID SERVICES
Moderator: Melanie Combs-Dyer
September 26, 2013
2:00 p.m. ET

Operator: Good afternoon. My name is (Christi), and I'll be you're conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, Final Rule 1599, Discussion of the Hospital Inpatient Admission Order and Certification, Two Midnight Benchmark for Inpatient Hospital Admission Special Open Door Forum.

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

I would now like to turn the call over the Jill Darling; you may begin your conference.

Jill Darling: Thank you, (Christi). Hello everyone. My name is Jill Darling in the CMS Office of Communication. Thank you for joining this special open door forum.

Before we begin, I'd like to make an announcement of the Health Insurance Marketplace Enrollment. Starting October 1st, 2013, individuals can apply and enroll in health coverage through the health insurance marketplace at healthcare.gov.

Health coverage starts as early as January 1st, 2014 in the initial open enrollment period for the Health Insurance Marketplace and on March 31st, 2014. Through the marketplace, individuals can apply, compare all their options and find out if they can get lower cost on monthly premiums, or get free or low cost coverage.

Information for consumers including available plan information and the ability to enroll in a health insurance plan is available on healthcare.gov. CMS has developed many materials that providers may find useful when answering questions that their patients may ask including flyers, fact sheet, brochures, talking points, videos and training slides. All of these are available on marketplace.gov – I'm sorry – on marketplace.cms.gov.

Now, I will hand it over to Jon Blum, the Deputy Administrator and Director to the Center of Medicare – the Centers of Medicare and Medicaid Services.

Jon Blum: Well, thanks very much for the introduction and thanks to everyone who is joining us on the phone today. Thank you for your patience. I think we have more interest that we anticipated coming on to the phone lines. We have to add some more lines. So, thanks for your patience and we apologize for the delay getting started.

All I wanted to do really is to, one, set the contacts for this phone call, then kind of set up the discussion of, of course, the new guidance that CMS will be talking about, and provide help to hospitals as they work towards the new – that state policy.

And I think, one, stepping back for why CMS made the change, I wanted to set the context for that. We really were facing several pressures all together the last couple of years. And pressure number one from our analysis was tremendous beneficiary concern regarding the growth and the duration of care being provided to the observation of state, that's pressure number one.

Pressure number two, being a high error rate to our purposes here at CMS for states that were classified as the inpatient stay that should have – due to (auditor's) concerns be classified as outpatient.

Then pressure number three was a rapid increase in the number of RAC reviews and concern from hospitals that they weren't permitted to reveal those cases that were overturned by the RAC from the inpatient stays to an outpatient stays.

And what CMS really is trying to do this past year is really take all three pressures and really trying to dispel what's at the heart of all three pressures. So the heart being an urge by both the hospital communities and by the beneficiary communities that we'll need a greater clarity on which cases are outpatient stays versus inpatient stays.

We had a two-year very public conversation with the hospital communities, the beneficiary communities, willing to try to come to some consensus. And what we fully understand, there're pros and cons for any policy that we choose. We really felt that we needed to find a balance approach that really found a global solution to all three of these pressures, provide much better clarity for what they should be considering for (payment) versus purposes to be an inpatient stay versus an outpatient stay to give some more comfort to the beneficiary community at beneficiaries who are put in observation stay, would have some comfort that those stays wouldn't be extended beyond two midnight.

They wanted to give hospitals the opportunity really for the first time to reveal for services that were overturned and to draw analysis that would help. They really needed to find a global solution. We had a two-year public conversation drawing from those comments. We've tried our best to respond to the very thoughtful comments that came to us during the rule-making process. And felt that that our final policy again was the best balance to these three pressures that we're facing in the Medicare Program.

We understand there are concerns. We understand that some feel that we didn't get it quite right. I understand that there is a complicated process through system changes to put in place these policies. We also understand that this is a new regulatory framework that we've built, requires some flexibility to put it in place.

We have heard calls from some that we should delay the rules. We had heard calls that we should give more flexibility to how they're being put into place. And so, one of the real concerns that we've heard is that during this transition period, hospitals would face scrutiny as they are (learning) change with their systems by the recovery audit contractors.

We really felt that is – we feel today, it is important for us to go forward with the policy to respond to the three pressures. At the same time, to give some comfort to

hospitals, that they're not going to be in jeopardy while they put in place these changes, these system changes – staff-related changes during this next time period.

And so, I'm (expecting) that our staff will walk through some guidance that has been posted that tries to accomplish the goal of putting in place the policy but at the same time, giving some more comforts, giving some more kind of leeway during this transition period for the next three months.

During this three-month period, we are going to monitor, to understand, to continue the conversation with our hospital partners, to understand the impact, to make sure these changes continued to best served, Medicare patients best served the highest clinical standards. We will continue to monitor. We will continue to evaluate. We will continue to be open to further changes to provide more comfort during this transition period but that we'll soon talk – but that's the detail of this transition period. But I wanted to convey that very strong message to everyone on the phone, we will listen, we will monitor and we will consider possible longer periods to this transition period if the data (wants).

So, with that, I'll turn it over to our staff to walk through the changes. We're here to answer questions but really to try to overemphasize and understand this transition. We feel it's important to go forward with the policy change, but we also wanted to give comforts and to give a period of time that we're all learning together how to navigate those new frameworks.

So, with that, I'll turn it over to Melanie of the CMS team to walk through our most recent guidelines. So, Melanie, please take it away.

Melanie Combs-Dyer: Thank you, Jon. This is Melanie Combs-Dyer, I'm the Acting Director of the Provider Compliance Group here at CMS. And I want to tell you today a little bit about a new probe and educate program that we're going to be running as Medicare Administrative Contractors, the MAC.

In this program, we will have our MACs focus their review on claims that are less than two midnight after admission. That is claims that are marked as one inpatient midnight. Those are the only claims that the MACs will be able to pick during this time period for patient status review.

Now, the MACs will be able to continue with their coding reviews with other types of reviews maybe for looking to see if the coverage guidelines were met for a particular type of surgery. But for this inpatient, outpatient patient status review, the only type of review that will be occurring all between 10/01/13 and 12/31/13 are those reviews conducted by the MAC for claims marked as one inpatient midnight.

So we'll not be looking at two inpatient midnight claims and we'll not be looking at three inpatient midnight claims, only one inpatient midnight claim.

They will be taking sample of claims. 10 claims for most hospitals, 25 claims for a very large hospital. That is for admissions that start on or after 10/01/13, between 10/01/13 and 12/31/13.

Once the MAC has (pulled) that sample of claims and done (inaudible) 10 to 25 claim reviews, they will use the result of those reviews to provide education back to the provider to let the hospital know how they're doing in terms of complying with the new rule.

The recovery audit contractors will not be doing any reviews during this time period. They will not be doing any prepayment review with the exception of their therapy reviews, these would be for those claims in the RACs, prepayment demonstration state nor will they be doing any post-payment review.

When we get to the end of this three-month period of time for the probe and educate program at the Medicare Administrative Contractors, we will study the results. We'll find out what the MACs have found. We'll look at how well the hospitals are complying with the rules. We'll look at to what – more guidance or education we need to put out and decide how we go from there, where we go from there in terms of reviews.

At this point, I'd like to turn it over to Jennifer Phillips who's going to walk through a couple of the frequently asked question that had been coming through our mailbox in the last few weeks and give answers to those questions.

Jennifer?

Jennifer Phillips: Good afternoon, everyone. As Melanie mentioned, we appreciate the thoughtful feedback and inquiries we received today through the IPPS admissions at cms.hhs.gov mailbox. I would like to discuss some of the FAQs for today.

One of the questions we've been receiving is, can CMS clarify when the two midnight benchmark begins on how we incorporate outpatient times prior to admission and determining the general appropriateness of the inpatient admission?

So, the response is when determining whether the two midnight benchmark will be met and whether inpatient admission is generally appropriate, the physician ordering the admission should account for the time the beneficiary spent receiving outpatient services within the hospital. This will include services such as observation services, treatment in the emergency department, and procedures provided in an operating room or other treatment areas. From the medical review perspective, well, the time the beneficiary spent as an outpatient before the inpatient hospital admission order is written will not be considered inpatient time and maybe considered during the medical review process for purposes of determining whether the two midnight benchmark is met and therefore whether payment is generally appropriate under Part A.

For beneficiaries who arrived through the emergency room, the clock starts when the beneficiary starts receiving care. For beneficiaries who did not arrived to emergency room or are directly receiving inpatient services, for example, inpatient admission orders written – prior to admission for an elective admission or transferred from another facility, the starting point for medical review for purposes will be when the beneficiary starts receiving services following arrival at the hospital. We know that this instruction excludes wait times prior to the initiation of care and therefore triaging activities such as vital signs before the initiation of medically-necessary services, responsive to the beneficiary's clinical presentation must be excluded.

In other words, if the beneficiary is (inaudible) in an E.R. waiting room at midnight, this would not count as the first midnight. However, if the beneficiary is receiving services in the Emergency Department when the clock strikes midnight, this will turn as the first midnight.

Another question we've received is if the beneficiary remains in the hospital for two midnights or more but would have been discharged before the second midnight absent a delay in the provision of care, such as when a certain test or procedure, is not available on the weekend, may this be appropriately dealt as an inpatient under the two midnight benchmark.

Section 1862 (a)(1)(A) of the Social Security Act, statutorily limits Medicare payments to the provision of reasonable unnecessary medical treatment. As such, CMS' longstanding instruction has been and continues to be that care rendered for social purposes or reasons of convenience should be excluded from Medicare payment. Accordingly, CMS expects hospitals to exclude such delays in the provision of medically-necessary care from the two midnight benchmark assessment.

The physician should only admit to inpatient status those beneficiaries who reasonably expect to require (two) midnights of medically-necessary hospital treatment.

We've also been asked what factors should the physician be considering in making an admission decision that is generally appropriate for Part A payment. When a physician is deciding whether an inpatient admission is warranted, the physician must decide whether the beneficiary received hospital services, (inaudible) hospital services, and whether it is expected that the beneficiary will require a hospital stay surpassing two midnights.

The decision to treat the beneficiary at hospital setting is a complex medical decision made by the physician and will consider various factors including the beneficiary's age, disease processes, co-morbidities, and the potential impact of (sending) the beneficiary's (home). It is up to the physician to make the complex determination of whether the beneficiary's risk of morbidity or mortality dictates the needs to remain at the hospital or whether the beneficiary maybe discharged home.

If at the time of physician's evaluation of complex medical factors and risk, the beneficiary may be safely and appropriately discharged then hospital payment is not appropriate on either inpatient or outpatient basis.

If the beneficiary is expected to require medically-necessary hospital services for two midnights or more, then hospital payment is generally appropriate. Conversely, if the beneficiary's expected to acquire medically-necessary hospital services for less than two midnights, hospital payment under the Part A is generally inappropriate.

We've been asked about (what) standard medical review contractors use when they then follow up and assess the physician's expectations.

Medical reviewers show us that the physician's expectation using the same guidance that has been issued for hospitals and physician. The judgment of the physician and the physician's order for inpatient admission should be based on the expectation of care surpassing two midnights with both the expectation of time and the determination of the underlying needs for medical care at the hospital supported by complex medical factors such as history and comorbidities, the severity of the signs and symptoms, current medical needs, and the risk of an adverse event.

We also indicate that in accordance with current policy, factors that results in an inconvenience to the beneficiary or their families do not justify an inpatient hospital admission. The factors that lead a physician to admit a beneficiary must be clearly and completely documented in the medical record.

In making a determination of whether inpatient admission is appropriate, medical review contractors will evaluate the physician order for inpatient admission to the hospital along with the other required elements of this certification, the medical documentation supporting the order was based on an expectation of the need for care extending at least two midnights, and the medical documentation supporting a decision that it was reasonable and necessary to keep the patient at the hospital to receive such care.

We've also been asked that – whether under the two midnight criteria, how facilities should treat (and bill) beneficiaries who require a potentially short-term medical treatment in an intensive care setting.

Beneficiaries treated in an intensive care unit are not an exception to the standard, as our two midnight benchmark policy is not contingent on the placement of the beneficiary within the hospital. Hospitals are reminded that patients requiring

aggressive intensive treatment for a short period of time will have those individual interventions reported and paid on the outpatient claims. For this reason, these two midnight benchmark remains applicable.

Physicians should admit those beneficiaries to date best for prior medically-necessary treatment extending two midnight and continue to provide identical care as outpatient those beneficiaries who they expect to require medically-necessary care for less two midnights.

Another question we've been asked regarding the decision to admit a beneficiary is whether the beneficiary's hospital stay needs to meet inpatient (level) utilization review screening criteria in order to be considered reasonable and unnecessary.

If the beneficiary requires medically-necessary hospital care that is expected to (transcend) two midnights, then inpatient admission is generally appropriate. If the physician expect the beneficiary's medically-necessary treatment in less than two midnights, it is appropriate to continue the treatment of the beneficiary in outpatient setting.

If the physician, at the time the beneficiary presents, is unable to determine how long the beneficiary require in the hospital receiving medically-necessary care then the physician may order observation services and delay the order to inpatient admission until the following day if and when it becomes clear that medically necessary care will be required beyond the second midnight.

While utilization review continues – committees may continue to use commercial screening tools to help at the admission decision, these tools are not (binding) on the hospitals, CMS or its review contractors. The reasonableness of the physician's decision and expectation of care will be assessed based on the medical factors that's previously discussed such as (inaudible) comorbidities, the severity of the signs and symptoms, current medical needs, and the risk of an adverse event which all must be clearly documented.

We've also been asked several questions about (inaudible) of a minor surgical procedure, particularly whether if a beneficiary is admitted for minor a surgical procedure would then require hospital care beyond the usual anticipated recovery time, whether it would appropriate for the physician to utilize outpatient

observation or whether it would be appropriate for the physician to admit the beneficiary for (inpatient) hospital services.

If the beneficiary requires medically-necessary hospital care beyond the usual anticipated recovery time, the physician should look to the expected length of stay. If the physician is not necessarily aware of whether the beneficiary's prognosis and treatment will require an expected length of stay beyond two midnights, the physician should continue to treat the beneficiary as an outpatient. If additional information is gained during the outpatient stay, suggests that the beneficiary will require a stay surpassing two midnights, the physician should admit the beneficiary as an inpatient.

(Inaudible) just some of the questions we have received, we have several others that we'd like to share with you before opening up the FAQ – I'm sorry, your questions today. And I'd like to pass it over to Jennifer Dupee.

Jennifer Phillips: It would probably best to just break this up a little bit, little different voice for you all to hear. We're almost getting there at the end. We've thought it would be important for us to try to go through these so that hopefully some of your burning questions that you're hoping to address during this call, you don't have to wait for the Q&A session.

The next question is what documentation does CMS expect physicians to provide to support a two midnight expectation? In other words, (must-see) written explicitly.

We believe that the expectation – that expectations for physician documentation are already well-rooted in good medical practice. Expectation of the time and the determination of the underlying need for medical care of the hospital are supported by the complex medical factors such history and comorbidities, severity of signs and symptoms, medical needs and the risk of an adverse event, which we would expect to be documented in the physician assessment and plan of care.

And then explicitly state in the final rules that while we acknowledge that unforeseen circumstances might result in a shorter beneficiary stay than the original expectation of a two midnight stay. This must also be clearly documented and supported by the documentation in the medical record.

The next question is whether there are any scenarios outside the beneficiary transfer, death, departure against medical advice, or received of a Medicare inpatient-only procedure that would permit a beneficiary to be appropriately admitted as an inpatient for a stay of less than two midnights. And the answer to that is yes.

The regulation specifies that a decision to admit is based on the physician's expect – reasonable expectation of the length of stay, lasting at least two midnights taken into account the complex medical factors that are documented in the medical record. Because this is based on an expectation as opposed to a retroactive determination based on actual length of stay, in circumstances that result in a shorter stay than the physician's reasonable expectation, may still result in a hospitalization that is appropriately considered inpatient.

As enumerated in the final rule, we anticipate that most of the situations will arise in the context of death, transfer, departure against medical advice. However, we do recognize that rare occurrences, there may be situations in which the beneficiary improved much more rapidly than the physician's reasonable expectation. Such instances, in addition to the other instances that we described, must also be clearly documented and the initial expectation must be reasonable for these circumstances to be acceptable as well.

We anticipate that these circumstances would be relatively infrequent. The more usual situation would be where the physicians are -- (inaudible) initial expectation of the beneficiary's length of stay was uncertain and that is the physician was uncertain whether the beneficiary to be discharged after one night midnight in a hospital or whether they would require second midnight of care. In that case, we would expect that the initial day should be spent in observation until it is clearly expected that a second midnight will be required.

Now we're getting to a little, shorter answers here. Thank you for bearing with us again.

The next question is, if a physician writes an inpatient order based on the expectation that the beneficiary will require care across two midnights but prior to the passage of the two midnights, the beneficiary refuses any additional medical treatment and is discharged, would it be considered unforeseen circumstance?

And again, this relates to our last answer that if the beneficiary does refuse any additional care and is subsequently discharged, this is similar to departures against medical advice and could be considered an appropriate inpatient admission. (Inaudible) – so long as the original expectation was reasonable and at the time the inpatient order was written and that is documented within medical record.

The next question is, the two midnight benchmark accounts for all of the time in the hospital receiving medically-necessary care. Is there way for CMS to similarly identify those hospital claims that represents hospital stays greater than two midnight although the actual inpatient admission may have been less than two midnights due to initial outpatient care for medical review purposes? So, again, these would be the instances in which the beneficiary would spend one night as an outpatient and then be admitted the next day when it was clear that a second night in the hospital would be required.

We have received stakeholder input on this particular issue and we have been receiving that into our IPPS admissions mailbox. Such suggestions have included changes as claim date instructions, the creation of new condition codes, remittance codes or occurrence span codes and provider input into remarks field. We're evaluating potential changes in claim submission, but remind providers that claims less than two midnights after the formal inpatient admission may under – may still be subject to complex medical review and do not fall within the two midnight after admission presumption of appropriate inpatient status.

The next question is, under the new guidance, will all inpatient stays of less than two midnights be automatically denied? No, that is not the case.

Under the new guidelines, we expected the majority of short or less than two midnight hospital stays will be provided (inaudible) outpatient services. However, because this is based on the physician's expectation as opposed to the after the fact determinations that's based on actual length of stay, we expect to see payable services (in a) number of instances for short inpatient stay.

First – and I think we've kind of covered most of these. First, if the physician has a reasonable expectation of the two midnight stay but there was an unforeseen circumstance that resulted in a shorter stay, and as (inaudible) in the final rule, we

would expect that mostly be beneficiary, death, transfer, or departure against medical advice.

A second situation would be when the beneficiary received the service on the inpatient-only list but was be able to be discharged before two midnights have passed.

A third situation would be inpatient stays less than two midnights will be evaluated in accordance with the two midnight benchmark during review, and payment will (be) appropriate if one midnight was spent as a hospital outpatient prior to the inpatient order being written.

And finally, inpatient claims for patients who unexpectedly improved and were discharged in less than two midnights would also be payable so long as the medical record clearly demonstrates the admitting physician has a reasonable expectation of a two midnight stay and the improvements that allowed an earlier discharge was clearly unexpected.

We encourage hospitals to focus their attention on (inaudible) a short stays without the death, transfer, or discharge (AMA) or a proceeding outpatient stay over midnight to ensure that the physician clearly expected a longer stay, the discharge was unexpected, and that the claims represent an appropriate payable inpatient service.

We're almost there.

Next question. Will CMS's review contractors limit their medical reviews only to those services or events prior to the order for inpatient admission?

CMS will continue to instruct its contractors to review the reasonableness of the physician's admission decision based on the information known at the time of admission. However, the entirety of the medical record must still support that this expectation was reasonable that the beneficiary would require a stay (inaudible) two midnights.

Last question, how does CMS intend to identify facilities conducting systematic (gaming) abuse or delays in the provision of care in an attempt to qualify for the two midnight presumption-- and that is inpatient hospital admission for medically-

necessary treatment was not provided on a continuous basis through the hospital stay and services could have been furnished in a shorter timeframe?

We will be doing this by reviewing stays spanning at least two midnights after admission for purpose of monitoring and responding to patterns of incorrect (DRG) assignments, inappropriate or systematic delays and lack of medical necessity for the stay in the hospital, but not for the purpose of routinely denying payment for such inpatient admissions on the basis of the services should have been provided on an outpatient basis.

We expect to shift our attention to the (smaller) anticipated volume of zero and one day short inpatient stays as Melanie went over previously. And then if the facility has correctly applied the proposed benchmark, away from short stays to other areas with persistently high improper payment rate.

We'll be using such information to identify these trends as a comprehensive error rate testing (inaudible) result, our first look analysis for hospital outlier monitoring reports or problem reports and the Program for Evaluating Payment Patterns Electronic Reports or known as PEPPER report.

Then, and I think I'm going to turn it back over to Melanie.

Melanie Combs-Dyer: I just want to say very quickly, thank you, Jennifer. And Jennifer, this is Melanie.

For those of you who are on the phone, I'm about to give you a website where you will be able to go later today and see some questions, some answered questions and answers that we have received. And probably sometime tomorrow the questions and the answers that – and Jennifer just read to us will be posted to this website.

The URL is www.cms.gov/medical-review . It's singular, medical-review. Again, www.cms.gov/medical-review .

And at this point, we'll turn it over to the operator who can give instructions on how we can take our first call.

Operator: As a reminder ladies and gentlemen, if you'd like to ask a question, please press star then the number one on your telephone keypad. And if you would like to withdraw

your question, press the pound key. Please limit your question 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 1 again to rejoin the queue.

And now, the first question comes from the line of (Kria Bastia) from American Hospital Association. Your line is open.

(Kria Bastia): OK. Hi, everyone. Thanks so much for providing kind of walking (those) questions and answers that will appear on the website tomorrow. The guidance that we received in AHA earlier today stated that during the implementation period of October 1, 2013 until December 31st, 2013, CMS will instruct the MAC and recovery auditors not to review claims in more than two midnight after admission for appropriateness of patient status. And so, generally, we're reading that those claims won't be reviewed. But does that mean that after January 1st of 2014 RACs to comeback and still review claims from that period, the 90-day period (inaudible)? Can you clarify if they were to do that, which standard would apply?

Melanie Combs-Dyer: This is Melanie, and no. There will be no routine (inaudible) review for admissions after – or and after 10/01/13 through 12/31/2013 with a couple of exceptions of that being our (CERT) contractor, the error rate contractors can always pick claims for review.

But the Zone Program Integrity Contractors (inaudible) contractors can always pick claims for review. And the OIG and other folks like that could always pick claims for review. But for admissions on or after 10/01/13 through 12/31/2013, there would not be any post-payment review by the MAC, by the recovery auditors, or by our supplemental medical review contractors.

Jennifer, did I leave anything out or is that a complete answer?

Jennifer Phillips: I think further information will be coming in the coming weeks and with what the strategy will be after January 1st.

Melanie Combs-Dyer: Yes, that's absolutely correct. After – at the end of 12/31 we will need to hear back from the MAC what has happened during those reviews, where is more education needed. And at that point, we will then figure out what our review

strategy is going forward. So far, we've only (inaudible) what our review strategy is for that time period. Was that (inaudible)?

(Kria Bastia): (Inaudible). So essentially, this 90-day period is protected except for the these kind of trial education, 10 to 25 claims that a MAC may reveal?

Melanie Combs-Dyer: That is correct. I will – if anytime, any of our contractors see (gaming) that would always be subjects to review.

Jennifer, can you explain a little bit about what kinds of things we might be able to (inaudible) in terms of (gaming) of the system during this time period?

Jennifer Dupee: Sure. So, we would be using the type of data that we went over during that last question, such as the – any search results or using the PEPPER report.

One other thing to keep in mind is, during this time and for the most part, these are probably the reviews you're referring to which is we call patient status reviews, which are focused on the inpatient versus outpatient determination of whether it was an appropriate admission. However, we can still continue reviews for other purposes such as the medical necessity of an underlying surgery, our example sometimes is like total hip replacement or something like that, correct coding reviews, things of that nature, but these patient status reviews, which had been the main focus of these shorter stays and that we're trying to eliminate most of the problems that we've had with these – with this rule, those will be under this revised strategy for the last quarter of the year.

Melanie Combs-Dyer: Thank you, Jennifer. Operator, let's take our second question.

Operator: Your next question comes from the line of Joanna Kim from American Hospital Association. Your line is open.

Joanna Kim: Hi, thanks. I have actually one follow up on (Kria's) question if you don't mind, are – is that clarification you mentioned that the 90 days is relatively protected. If it's possible for you all to present in writing, we would very much appreciate that. I think that the way it's written in the guidance is (inaudible) confusing and some folks have thought that after January 1, the RAC could come back and review those claims on a post-payment basis. So clarification there might help some.

My actual question is, on the second page of the Frequently Asked Questions, it says auditors will not review any claims related to (CAHs), we were curious that it wasn't explicit whether that's kind of a indefinite statement that the auditors won't review them or whether that's only during the October to December 31st period?

Melanie Combs-Dyer: OK. This is Melanie. I'll take the first question. And I'll turn the second question to Jennifer.

The first question had to do with can we clarify or (inaudible) up some sort of statement of the RAC not doing post-payment review during this time period, and thank you for that suggestion. We will go back and look at that and see we can put something else on our website about that. We are in the process of issuing a contractor instruction but we can certainly look to try to put something else on our website about that.

So, stay tuned over the next couple of days and we'll see if we can get something off about that. Regarding critical access hospitals, Jennifer?

Jennifer Phillips: Yes. So, in this document we are referring to the October to December timeframes but we would be happy to also release information about that when we update the website (inaudible).

Joanna Kim: OK, we'd really appreciate that. Thank you very much.

Melanie Combs-Dyer: Operator, can you get us the next question?

Operator: Our next question comes from the line of David Smith from Pocono Medical Center, your line is open.

David Smith: All right. This is David Smith from Pocono Medical Center. My question regards observation of patients. If we have an observation patient, let's say, up for two days and does not meet admission criteria but the same token doesn't need discharge criteria either, should we be admitting them and then doing a condition (inaudible)?

Melanie Combs-Dyer: I'm going to ask Dr. Duvall to answer that one.

Dan Duvall: OK. If you look at our instructions, we talk about the need to receive care at the hospital. So, this is an acute care hospital and the patient needs to stay there. If the

patient needs to stay there for longer, then the two midnight, our expectation is that that patient should be admitted.

On the other hand, if you're actually saying that the patient does not need to stay at the hospital, then you should not be admitting those patients, if you're keeping at the hospital and – again, they really didn't need to stay at the hospital. So, the important distinction is whether the patient needs to stay at the hospital to receive care at the hospital for longer than two midnights.

Melanie Combs-Dyer: David, did that answer your question?

David Smith: Not really because the patient may not need discharge criteria. Let's say they had a minor CVA or something and they're having difficulty walking home alone and they live 20 miles away. We can't, on good conscience, send those people out through – our door, but by the same token, they may not need admission criteria.

Mark Hartstein: Yes. This is Mark Hartstein, I'm the Director of the Hospital and Ambulatory Policy Group. And there maybe (changes) why the patient no longer needs hospital care but they can't be discharged. But even if they do not need hospital care, they can't be discharged, and then they should not be admitted.

David Smith: So, we should keep them as an observation, is that correct Mark?

Mark Hartstein: Well, observation is a set of services that's used to determine whether the patient can be admitted or discharged from the hospital. But patient like that is an outpatient status. Sometimes, these patients have been referred to as social patients or patients who may be in need of care outside of the hospital but that care is unavailable to them. So, for instance, a common a scenario and maybe that the patient needs a nursing home bed but there's not a nursing home bed that's available for that patient but the patient does not need care in the hospital.

We recognize and understand that those are very difficult situations for the hospital because the hospital really is not in a position to admit that patient because the patient does not need hospital care but they also can't be released from the hospital because there's not a place for that patient to go.

Melanie Combs-Dyer: And am I correct that it is longstanding Medicare policy that patients who are being kept for social reasons or convenience reasons should not be billed to Medicare that's not something that Medicare can pay for?

Mark Hartstein: Yes, that will be correct.

If the patient needs any medically-reasonable and necessary Part B service while they're in the hospital, then those can certainly be provided and billed to Medicare. But if a patient does not need hospital care, then there's really no hospital services that Medicare can be billed for for a patient like that.

Melanie Combs-Dyer: Thank you, Mark. This is Melanie and I just want to let folks know that the website has gone live and has the first set of questions, not the one that Jennifer read today but some additional questions relating to patient status review.

Again, that website is www.cms.gov/medical-review , and once you get to that page, if you look at the left hand side, you'll see a link for inpatient hospital reviews, you can go there and get some information particularly in that download section. And if you continue to check that over the next few days, you'll see more information there.

Operator, I think we're ready for our next question.

Operator: Our next question comes from the line of (Emery Kardichi) from (Memphis) Medical Center. Your line is open.

(Emery Kardichi): Hi, thank you. I have a question about the attending physician's authentication of an inpatient admission order and certification for an academic medical center. And most of our admission orders are written by our health staff or physician assistant. Can the attending authenticate those orders and the health staff certification in his own note? In other words, (inaudible) am in agreement with admit to inpatient status or do they have to absolutely co-sign the order?

Daniel Schroeder: (Inaudible) the Division of Acute Care. (Inaudible) answer but we're working a lot of guidance on questions about certification and admission orders and that should be forthcoming very shortly.

(Emery Kardichi): OK. I'm looking forward to it.

Melanie Combs-Dyer: OK. Operator, I think we're ready for the next question.

Operator: Our next question comes from the line of (Neri Schroeder) from Providence Alaska. Your line is open.

(Neri Schroeder): Hi, yes. Thank you very much for the (inaudible) that you've offered today. We still have some questions on the certification requirements and one of them during many vary iterations that we've had on the statement is do we need to specifically reference inpatient care will be provided at under according to Section 412-23 or is it sufficient to state that inpatient appropriate therapies will be provided as outlined in the (HNP) and ongoing progress note?

Marc Hartstein: So, I don't think we've indicated anything quite that explicit in the regulations as to what is – I mean, there are certain elements that are required in the certification and I think the inpatient admission order to be – I don't think we explicitly indicated what it needs to include although to the extent that the inpatient admission order is clear that the patient has been admitted for – to receive inpatient services. I think it's going to be in the hospital's interest as well as anybody who's doing medical review on a case to see an inpatient admission order that's very clear that the patient was admitted as an inpatient receiving inpatient services.

We've gotten this question in the past and it really has nothing to do with these the regulations about where the – there may – non-specific type of inpatient admission order like admit to Tower 7 or Unit 3.

To me as a layperson, if I were doing a medical review, that doesn't sound particularly clear to me that the patient was – that there was an inpatient admission order because that may not have – Unit 3 or Tower 7 may not have any particular meaning to me like it does to the person who wrote that order.

So, I think, our advice, and guidance, and suggestions have always been, even before this rule, that it would be really in the hospital's interest to make that inpatient admission order as clear as possible.

This patient is admitted to receive inpatient services. And I think the same would be true with the certification of particular elements that the certification needs to include that are included in the regulations. And this is actually a statutory

requirement. That is really not something that CMS has control over since – (explicit) in Section 1814 of Social Security Act.

And I think we've listed what those requirements are for the certification in the regulations. And again, to the extent that you clearly include the information that's required on the certification, I don't think we're going to specify exactly how it needs to be written.

(Neri Schroeder): OK. Thank you very much.

Melanie Combs-Dyer: Operator, we're ready for our next question.

Operator: Our next question comes from the line of Denise Williams from Angleton Danbury. Your line is open.

Denise Williams: Hey, thank you. My question, I actually have several but I'm just going to ask one right now. And it is dealing with the E.R. physicians writing the admission – admitting order from inpatient stay.

We have E.R. physicians that are credentialed through their company, especially, they're actually contracted. So, they don't have admitting privileges but they talk with our hospitals, talk with the physician, talk about the care, the other physicians tell him what to do, then the E.R. physicians write the admission orders. Do those orders then need to be co-signed by the admitting physician or is it – are they good to where they are or do we need to put in our bylaws and say that the E.R. physicians can admit?

Melanie Combs-Dyer: We'll have Dr. Duvall answer you this one.

Denise Williams: All right. Thank you.

Dan Duvall: OK. All right. Well, in a sense, you just answered your question. And that, yes, the E.R. physicians can admit because you said, they didn't have admitting privileges. And so that's part of being able to admit.

However, that doesn't mean that they can be writing the admission order. The assumption is that, and speaking as an E.R. doc, that E.R. docs are communicating and discussing the patients with the physician that actually is the – going to be

taking care of the patient in the hospital, the person who does have the admitting privileges.

And so, if that person in the discussion makes the decision that, yes, the patient can be admitted, the E.R. physicians then documents that, he needs to indicate that the person that they were interacting with, and then that has to be validated by the physician who actually has the admitting privileges. And we're still working on details of exactly how we want to express that to you. But in essence, that's the outcome.

Denise Williams: OK. All right. Very good.

Melanie Combs-Dyer: Operator, we'll take our next question.

Operator: Our next question comes from the line of Linda Hogel from TriHealth. Your line is open.

Linda Hogel: Hi, thank you. I had a question about the timing of the admission order from the physician for inpatient. Does the inpatient time start when the physician signs the order or can that be a verbal or telephone order that initiates that inpatient stay?

Melanie Combs-Dyer: Dr. Duvall, can you answer that one?

Dan Duvall: OK. Our instructions say that a patient becomes an inpatient when formally admitted pursuing through a physician order. So it's the formal admission that takes – that actually starts the inpatient stay.

Now, the physician order needs to be documented and there are usual practices in hospitals for documenting that physician order. It can be written. If there are – the orders are verbal order or telephone order, then there are mechanisms for recording that and then having the physician authenticate that according to the normal hospital practices.

(Inaudible)

Linda Hogel: Well, if the physician – is it a verbal or telephone order, does the inpatient stay start once the physician authenticates it or as the order is entered?

Dan Duvall: The inpatient stay starts with the formal admission. The formal admission occurs after the physician writes the order. He can actually authenticate it after the admission started, after the formal admission process.

Melanie Combs-Dyer: So, this is Melanie. If a verbal order comes in and it is properly documented in the medical record that is the time of admission even if the physician does not co-sign it until several hours later, is that correct?

Dan Duvall: Close. The physician may write the order and let's say the physician writes the order at 10:00, the patient is formally admitted at 11:00 so the patient becomes an inpatient on 11:00 and then the following morning, the physician authenticates the order, that's fine. It's the formal admission following the documentation of the order.

Marc Hartstein: And I just want to add to your – the policy that Dr. Duvall just explained is not new policy; it is longstanding policy that goes back many, many years.

Linda Hogel: OK. Thank you.

Melanie Combs-Dyer: Operator, we're ready for our next question.

Operator: Our next question comes from the line of (Aileen Sullivan) from (Dale) Medical Center, your line is open.

(Aileen Sullivan): Hi. My first concern is that there may not be that much change. There are many patients. The reason that this was started was because there are many patients staying in observation for extended lengths of time. So, if we have a patient who comes in with G.I. pain on a Friday, they're doing the work up over the weekend. They're not sick enough to be admitted. They're – but on the second day they're still complaining of nausea. So, do we leave these patients in observations? There or many of them.

I have physician say to me all the time, I have a 90-year-old patient, she is now – she has a negative abdominal workup but she's complaining of nausea. I'm not sending her home. So, do we keep these patients in extended observation again and not – then nothing changes or do we admit them and submit a no-pay claim?

Male: Yes.

(Aileen Sullivan): So, this isn't going to go away. This is very, very common.

Marc Hartstein: Yes, so, I think the purpose of our rules is to try to provide more clarity around situations where – it's unclear whether or at least it was unclear where the patient should have been admitted or not admitted under the prior guidance. And I think what we're doing is overlaying on top of the inpatient medical necessity decision a time element where we – the patient – where we expect them to receive care in the hospital for more than two midnight. That patient would be presumed medically-necessarily inpatient.

So, that's…

(Aileen Sullivan): We don't know that.

Female: Yes.

(Aileen Sullivan): We don't know that.

Marc Hartstein: Yes. That's our general guidance. If you're asking about a specific clinical situation and I think it's very difficult for us to be able to address specific clinical situations on the telephone because we don't know what the order, the circumstances are surrounding that patient.

(Aileen Sullivan): But these are the common.

Male: OK. But when the patient – it's really based on the physician's expectation. I think, as we said before, if you have patient that comes to the hospital and the patient needs a hospital level of care, need hospital care, care in the hospital, regardless of whatever the clinical circumstance is, the patient – the physician can make a determination at that point. Well, do I expect that patient to need to stay in the hospital two midnights or more, if they do not, then they should not admit that patient? Then another day goes by.

If the hospital expects that patients need another night in the hospital, then I think our guidance indicates that that patient would be OK to admit – medically-necessary to be treated on inpatient basis because that patient still needs hospital care for an extra night.

The individual clinical circumstances could vary infinitely. I know these maybe common clinical situations but it's really difficult for us to address specific clinical situations in an in a national call.

(Aileen Sullivan): OK. And if someone could just address re-certification, how are we – how are hospitals supposed to track that we are getting close to and outlier day and need re-certification? If someone could just address how we're supposed to do that because we often don't know the (DRG) until after the patient is discharged. Thank you.

(Dan Schroeder): This is (Dan Schroeder) again. I'm sorry, we are working on another (set) of FAQs specifically about orders and re-certification and certification, we're not quite there yet.

(Aileen Sullivan): Thank you.

Melanie Combs-Dyer: Operator, I think we're ready for the next question.

Operator: Our next question comes from the line of Marti Arvin from University California. Your line is open.

Marti Arvin: Good afternoon and thank you very much. And as you would imagine, I'm sitting here both representing the University of California at Los Angeles and with my colleagues from the (four) Academic Medical Centers in the U.C. System.

So, we're going to anxiously await your guidance that provides further clarity around residents writing orders and how that will be processed.

The question I have is specific to a circumstance where a patient maybe admitted to a psychiatric hospital where the rule is not applicable but they then get – had at discharge because they need some form of medical care in an acute care hospital. And so, they're discharge from the separately-licensed psychiatric hospital, admitted to the acute care hospital for the medical services that they need, and then they'd be discharged from there and readmitted back to the psychiatric hospital, all of which wouldn't stay in the acute care hospital may be less than two midnights but would still warrant inpatient care. Can you describe how that – on what the approach would be for that circumstance?

Melanie Combs-Dyer: Marti, we are running short on time and that was a very long example. So, I'm going to ask that you e-mail in that scenario to our e-mail box and I think we'll have a better time following what happen with this complex patient that you just described. The e-mail address is…

Jennifer Dupee: So, I'm glad Melanie brought this up because I also wanted to speak about the e-mail address. As you probably imagined, we've got hundreds of questions. We are reading every single one and making our way through them and I do apologize if you have not received the response yet. It's just because of, you know, the overwhelming response.

Again, as a reminder and this e-mail address is also on the announcement for this open door forum. But it's IPPSAdmission@cms.hhs.gov and IPPS Admission is one word.

Melanie Combs-Dyer: Thank you, Jennifer. And sorry about that Marti.

Male: Yes, just also on the issue of residents involved in making an inpatient admission decision, I also encourage you to go to the (inaudible) because there is some information that's out on that previously that you can use it as guidance. (And if you) continue to have questions, you can send them to the e-mail address box that you just received.

Female: And we have one follow-up.

Melanie Combs-Dyer: Go ahead, Marti. It looks like Marti got cutoff. Operator, I think we're ready for our next call.

Operator: Our next question comes from the line of (Stacey Clent) from JFK Hospital. Your line is open.

(Stacey Clent): Hi, yes. I'm still trying to sort out how the conditions of participation as it related to requiring some kind of review of appropriateness of admission ties into this. Are we still thinking that we need to have our case managers or utilization review specialist look at Medicare admissions and apply some type or criteria around medical necessity? Is that still even required at all? Do they now use the two midnight rule

as the criteria? I'm still struggling with what the hospital should do in terms of that appropriateness of admission review.

Dan Duvall: This is Dan Duvall. We actually have not made any changes, there may have been no changes in the conditions of participation on the hospital utilization review programs, therefore, don't have any changes in what applies to them.

Now, in terms of how they will be – or reviewing cases internally as the hospitals start incorporating the new guidance, there are going to be some changes where were those types of question are going to be coming up. And this is one of those areas where we'll have to be providing additional detail as we work with the – not only the U.R. programs but the (QIOs) then (inaudible) the whole (U.R.) process. So, you'll have to stay tuned on that one.

(Stacey Clent): OK.

Melanie Combs-Dyer: Operator, we wouldn't – I'm sorry, was there a follow up question there? It sounds like there is none.

Operator, this is Melanie and we'd like to take one final question before we bring this call to a close.

Operator: And your last question comes from the line from Gail Sheehan from OSF. Your line is open.

Gail Sheehan: Thank you for the information. We have a question about critical access hospitals because in the additional guidance that was published on September 5th, there was mentioned that one element of certification was the physician attestation that the patient was expected to remain in the hospital no longer than 96 hours but the conditions of participation of that is an average requirement, not applicable to each and every patient necessarily and we're having difficulty reconciling those two.

Melanie Combs-Dyer: Yes, I think that's (inaudible) answer to the question.

Gail Sheehan: (Inaudible) asking then.

Female: (Inaudible) in the Division of Acute Care. Thank you for your question.

So, the existing regulations, which are (42415A) and the statutory language at (1814A8). This language uses the terms may reasonably be expected when explaining the 96-hour certification requirement. So, therefore, if a physician, in good faith, provides certification that they accept that the individual will be transferred or discharged within 96 hours, but something unexpected occurs causing the individual to not be transferred or discharged within 96 hours. As long as the (inaudible) adhere to that 96-hour annual average length of stay, there is no concern.

Gail Sheehan: And what if the physician does not to remain under 96 hours but in very few limited circumstances would expect the stay to go longer. Is that permissible?

Female: Well, if they don't – if they expect that the individual will need more than 96 hours, then that individual should be transferred to another facility.

Gail Sheehan: So, those cases, may a critical access hospital providing patient care for a patient requiring greater than 96 hours of hospital care.

Female: They believe that 96 hours will be sufficient but then something occurred, which requires them to keep that individual for more than 96 hours, you know, they have that annual average length of stay requirement.

Gail Sheehan: So, you're making the average annual applicable to each and every patient?

Male: Yes, so – I think where (Renata) is going is – critical access hospitals for inpatient stays, their average length of stay should be 96 hours or less. For an individual patient, it's – there maybe circumstances where the critical access hospital has a patient that stays more than 96 hours.

However, if that's the expectation when the patient is admitted that the patient will need a longer length of stay, then that patient should be transferred. So, if the expectation is that it's 96 hours or less but the patient stays more than 96 hours. That would be fine. But if the expectation is that the patient is going to need more than 96 hours to stay, so longer than a three-day length of stay in the critical access hospital would be appropriate to transfer that patient because critical access hospitals are really intended for statutory purpose – public policy purposes (of them) is that they're supposed to provide short-term care so the patient – until the

patient can be – who need – who needs longer length of stay can be transferred to another hospital.

Gail Sheehan: (Inaudible).

Male: Or just stabilize the patient and transfer them.

Gail Sheehan: We agree that that's the average requirement but we didn't understand that could be the universal requirement.

Male: Correct. It's an average requirement but there could be circumstances where the patient – so there could be circumstances where the patient stays more than 96 hours and there could be circumstances where the patients stays less than 96 hours.

I think that the indication I think – and again, we're (afraid) that are concerns about the September 5th guidance in relation to the regulations that (inaudbile) and perhaps we need to put out more clarity on them.

But I think the answer for today remains the same and that is if you expect the patient stay longer than 96 hours, that's not the kind of patient that you would expect that we can treat on an inpatient basis in the critical access hospital, when that patient can be stabilized, the patient should be moved.

Melanie Combs-Dyer: So, I'd like to thank everyone for participating today. You guys had some really tough questions for us but we really appreciate them. And again, we will be updating our website with more of Q&As. I'm sure we'll be holding future open door forum calls.

And at this time, I'd like to turn it back over to the moderator to bring the call to a close.

Operator: Ladies and gentlemen, this does conclude today's conference call. Again, thank you for your participation. You may now disconnect.

End