

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.

Moderator: Natalie Highsmith
February 4, 2014
1:00 p.m. ET

Operator: Good afternoon. My name is (Candice) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Final Rule CMS 1599 Discussion of the Hospital Inpatient Admission Order and Certification Second Midnight Benchmark for Inpatient Hospital Admission Special Order – Special Open Door Forum.

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

Ms. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Candice). And welcome to everyone and thank you for joining us for today's special open door forum. This is a follow up to allow hospitals and practitioners and other interested parties like yourself to ask questions on the physician order and the physician certification, inpatient hospital admissions, and medical review criteria that were released back in August of 2013 in the inpatient perspective payment system hospital final rule which is CMS 1599F as in Frank.

I would now go ahead and turn the call over for a quick administrative announcement regarding the extension of the probe and educate process to Melanie Combs-Dyer who is the Acting Director of the Provider Compliance Group in our office of financial management. Melanie?

Melanie Combs-Dyer: Thank you. This is Melanie. And I just want to make sure that everyone has seen the announcement that is posted to our Web site, the regular Web site where you go see the information about our Inpatient Hospital Pre-payment Review Program.

The announcement extends the probe and educate period for an additional six months. That is through September 30th, 2014. And what that means is that our Medicare Administrative Contractors, the MAC, will continue to select claims for review if there are dates of admission between March the 31st, 2014 through September 30th, 2014. You may recall prior to this extension, we were going to stop the probe and educate program on April the 1st.

So we're extending it through September the 30th. And MAC will continue to do their reviews. It will be the same number of reviews that we had previously described. They'll just now have more time to finish those reviews. Any reviews that they conduct if they find claims that are not in compliance with the two midnight rule, they will be denying those claims just like we had previously explained. And the MAC will continue to hold educational sessions. Again, our original goal is to try to finish those in April. Now, they will have through the summer to complete those educational sessions.

And generally speaking, our recovery auditors and our Medicare review contractors will not conduct post-payment patients status reviews of inpatient hospital claims with date of service – I'm sorry, dates of admission on or after October 1, 2013 through October 1, 2014. Should I take questions on that now or continue through the agenda – operator can you open it up and see if there are already questions that people may have on this piece before we go on to other agenda items.

Operator: And as a reminder to ask a question press star one. And the first question in queue from – comes from (Janine Engel). Your line is now open.

(Janine Engel): My question is not about this. Can I ...

Melanie Combs-Dyer: OK.

(Janie Engel)): ... (inaudible) – will I stay in the front of the queue for a question about certification?

Melanie Combs-Dyer: Operator, can you put (Janine) back in the queue?

Operator: Absolutely. She'll be back in queue.

Melanie Combs-Dyer: Great. And Operator can you remind people how to take themselves out of the queue if they want to get out of the queue.

Operator: Absolutely. To remove yourself from the queue you can press the pound key.

Melanie Combs-Dyer: And so we'll try one more time. Does anybody have question about the extension of the probe and educate period?

Operator: And the next question in queue is from (Ronald Hirsch). His line is now open.

Melanie Combs-Dyer: (Ronald) is your question about the extension of the probe and educate process?

(Ronald Hirsch): No, it isn't. But I had to call in two hours early to get in the queue. So this pound key you can ask questions related to each topic individually.

Melanie Combs-Dyer: That's OK. I will ask the Operator to please put Ronald back in the queue and I will at this point hold – ask you guys to hold your questions if you have any questions about the extension of the probe and educate period until the end. And at this point I will turn it over to Dan Schroeder.

Dan Schroeder: Hi, Dan Schroeder of Division of Acute Care Hospital and Ambulatory Policy Group. One announcement, I know a lot of people have already seen it but we've released a revision or a clarification of the September 5th guidance to the hospital inpatient admission order and certification document. It was on the Web site on Friday. It was on the 31st. It's dated January 30th but I think all the links are working as of Monday.

I hope a lot of you have got the chance to read through it. I'll go through some of the major key points but I won't go through the entire document. I'm telling people it will probably be easier for you to assess it if you print out this

document and the September 5th guidance. And you can probably more easily see where we expanded a little bit and gave it some additional clarifications.

One of the major questions that we received in response to the September 5th guidance was questions about non-physician practitioners, physician assistants, residents who don't have admitting privileges in various hospitals where they typically would write admission orders even though they don't have specific admission privileges at that hospital. We understand it's somewhat common practice. And we offered some guidance to remedy situations where an order may be later countersigned by someone who does have that admission privilege.

So in essence we're saying that in certain circumstances where a practitioner is otherwise able to write such an order and has state privileges and is qualified to write that order they can write the order on behalf of a – of someone who does have admitting privileges assuming that order is later countersigned and verified by that physician or the practitioner.

Some other major key points, we added some details in the content section of the physician certification section mainly to give contractors and also hospitals the knowledge of what are some examples that could qualify to meet some of the certification requirements. In particular, we got a lot questions about our language that there's an estimated time criteria in the certification. And we've received a lot of questions saying that it's often not feasible or possible for a physician making an order or making certification that they can estimate when the length of stay are.

We revised that a little bit or we clarified somewhat to say that the certification can be made either at admission or at discharge. And if it is made at discharge then it would be acceptable to cite areas in the medical record in which qualify that there was a acceptable length of stay that was either actual or estimated supported by the medical record in the progress note, et cetera. We also made a little – some additional clarifications to the authentication and of the practitioner order.

There's a lot in there. It was really helpful if it's just too kind of compare drafts. And hopefully, the goal of this was to make a little clearer on – and perhaps resolve some of the concerns that people in the industry were having about whether or not there were some new requirements instituted in regards to the certification and admission order in response to the two midnight. And in many cases there were not new requirements but our initial guidance may have caused some confusion. But hopefully this will resolve some of that. And this call maybe can resolve some more of that.

I'll turn into questions at that point. Anyone else want to chime in?

Melanie Combs-Dyer: Operator, can you open it up to questions now from anybody on the line on either my probe and educate extension or the issues that Dan just talked about.

Operator: And again if you would like to ask a question, please press star one. We have a question from (Aileen Sullivan). Your line is now open.

(Aileen Sullivan): Yes, the first speaker, you said generally speaking RACs will stay away from this time period. Can you clarify what generally speaking means? And then, to the second speaker will an E.R. physician count as similar – like a resident, can we have our E.R. physician admit patients that meet the inpatient criteria there and then do the certification?

Melanie Combs-Dyer: This is Melanie and I'll go first. The generally was really sort of modifying the other Medicare review contractors not conducting post payment review. There could be an exception for example with our CERT contractor. The Comprehensive Error Rate Testing Contractor pulls a random sample of claims. They're not doing targeted reviews. They are just randomly choosing claims and it's possible that some of those claims could be selected.

I can't think of a situation where a recovery auditor would be doing patient status reviews on a post payment basis. So I don't think you have anything to worry about there. And I'll turn it over to Dan to talk about this second part of your question about the E.R. physician.

(Aileen Sullivan): OK.

Dan Schroeder: Yes. I'm just getting a note that, I mean it is acceptable under certain circumstances that any ED physician, E.R. physician could have admission privileges, but we are aware that in many cases they do not. We address that somewhat in the guidance – in the new guidance – revised guidance (B) (2) (a) where we're referring to residents and non-physician practitioners authorized to make an initial – we're kind of using a term initial admission decisions.

If you read through that section the last paragraph we said that this is last type – I'm so sorry, that this process may also be used by physicians such as E.D. Physicians who do not have admitting privileges but are authorized by the hospital to issue temporary or bridge admission orders. In those cases we would consider the inpatient stay as beginning with that order assuming that it is countersigned appropriately and timely by someone who does have admitting privileges.

(Aileen Sullivan): So the E.R. physician can do the certification? He can fill that portion out in our electronics medical record.

(Dan Schroeder): If they meet those – yes. If they meet those requirement that they are just reading here or the – the order of practitioner may allow this individuals to write inpatient orders on his or her behalf, if the order of practitioner proves and accept responsibility for the admission decision by countersignature, the order of prior for discharge.

(Aileen Sullivan): We have our EMR built as the E.R. physicians dropped down in his – he selects his name, he selects the attending physician who his speaking to on the phone at 2:00 in the morning. And then, he puts in the certification to E.R. physician. Now that's not good enough even though there's documentation in the record that the E.R. doc and the attending concur on inpatient status. The E.R. doc puts in the certification. I now have to make sure that the attending physician countersigns this before discharge?

Dan Schroeder: The – I mean the certification, the E.D. doc would be – it could be acceptable to sign the certification document, but we still have this requirement of an

admission order. And the admission order must be made by someone with admitting privileges and if the E.R. doctor is not having ...

(Aileen Sullivan): He has bridged – ours have bridge orders, so.

Dan Schroeder: Yes, we're considering a bridge order to be somewhat what we're discussing here as an initial order. It'd be the same as a resident who does not have admitting privileges can make this – I don't want to use the word temporary, but orders that would later be countersigned by someone who does have the authority to make those orders.

(Aileen Sullivan): And so the – but the bottom line is my case managers have to search the doctors before the patients are discharged to get it certified, to get it countersigned, which is going to get ...

Dan Schroeder: The admission order – yes.

(Aileen Sullivan): Yes. So that's going to increase the length of stay and leave the patient here because – I don't know how we're going to get the physicians back here into the hospital to countersign before discharge, I mean they can do it, you know, in medical records like they do other countersign other orders. But, it's just going to leave the patients in the hospital longer if it means we're possibly not going to be paid.

Natalie Highsmith: I'm sorry, (Aileen), we do have to move on to our next person in the queue. Thank you for your questions and your comments.

Operator: And your next question comes from the Dr. (Steven Mierson). Your line is not open.

(Steven Mierson): Yes. Thank you. I think you're going to hear during the course of today's call that this clarification has caused more confusion than it has clarified things. I'm sorry to say.

One of the issues that comes up and it's very fundamental that we're having trouble getting a clear answer on is when an admission begins and when an admission ends. The regulation that was just released and indeed beyond the

previous regulations say that a patient is admitted pursuant to an admission order and they talk about formal admission pursuant to an admission order. And it sounds like that the admission is not actually started by the admission order but rather is pursuant to or following the admission order and seems to be actually from when I'm close reading of this document that the admission would start when the patient is actually either registered in the hospital or receiving hospital care.

Hospitals have been using the admission order as the date and time of admission. That seems to be contradicted by using the term pursuant to. I'm talking about patients, as I mentioned even of a patient being formally admitted prior to the admission order, and that – so that would not count because it's not pursuant to or following the order. And the second question is when the patient is discharged and mentioned qualified discharge orders like discharge after supper is mentioned, as if when the patient takes their last bite of dessert, they're magically discharged where patient may spend more time in the hospital (inaudible).

Dan Schroeder: I...

(Steven Mierson): That's – There's a noise on the line. But we need more clarification of when does admission start and when does it end.

Dan Schroeder: This is Dan again. I mean, I don't think any of us presume that this is the end (inaudible) all of our clarifications that we're ever going to have to give out of CMS. But as far as the language concerned pursuant to, I believe we were trying to use language that would fit in multiple situations. And there are certain circumstances where admission order could be given well in advance of an actual admission, scheduled surgeries or there's some delay – some other delays.

So by using the word pursuant to we are acknowledging that in the majority of cases, there would be an admission or there would be an admission order and services would be rendered on the same day. In certain circumstances they would not be. So that's the only intent behind using pursuant to.

And then, as far as your second question on when discharge would be, I think again, we're giving some leeway in that. It is not necessarily discharged when a piece of paper is signed that additional orders could be subsequent to the discharge like, you know, discharge after voids or discharge after meal or I think we could even consider discharge after seeing, you know, a therapist or something like that that we're giving somewhat of a leeway of thing that it is not a rigid timeframe of when things as to paper but a general practice by the hospital that could be understood in medical record.

(Steven Mierson): And this is follow up. One time, the admission date and time is critical for this. An admission order is written at 11 p.m. But the secretary and the E.D. doesn't get around to entering it into the computer until 12:05 a.m. Then that patient has missed the first midnight. And I think it's very important that the hospital know which one of those drives the date and time of admission. Is it registration or is it the admission order itself? And some clarity on that would be good. Either say it's the admission order or it's a registration, but right now, I mean I've been reading this regulation so I can't tell that – when the admission starts.

Natalie Highsmith: OK. Thank you for your comments and your questions. (Candice), can we move on the next questioner please?

Operator: And your next question comes from (Janine Engel), your line is now open.

(Janine Engel): (Inaudible)

Melanie Combs-Dyer: Hey, (Janine)?

Operator: (Janine Engel), your line is now open.

(Janine Engel): Sorry. So my question is about the certification statement. And in the document that was just released, there's statements that say that the information is in progress notes that the statements might need to be there written in the progress notes. And my question is, is there an expectation that if there is no certification – separate certification form, will there need to be specific statements within the progress notes indicating that the physician is certifying that a patient needs – the patient stays medically necessary or will

just the regular documentation that we're used to seeing in physicians progress notes be adequate.

Dan Schroeder: This is Dan again. Someone else might want to chime in after me. We didn't – We have been – pretty clear that there's no magical word that must appear (you're saying) I certify or I – it – there's a lot of formats that would be acceptable. I think the answer is better documentation is always the better option than less specific documentation. But overall, I don't believe, for most purposes of the certification we're looking for inherently new requirements when reviewing for the two midnight policy or any other policy. It essentially is status quo and in it for majority of sections that we referenced.

(Janine Engel): All right. So, I'm just – sorry to kind of be the dead horse here because there's – on page three of the document that you all released last week, they, you know, you all indicated you have previously that, you know, that specific or separate form is not required. But there are statements that say – and I'm quoting – if all the required informations included in progress notes, the physician statement could indicate that the individual medical record contains the information and the inpatient services are continued to be medically necessary.

And it's not physician – physicians don't document – I certify (this day) as medically necessary. They simply document the medical information. And it's concerning if there's an expectation that a separate sort certifying statement is required versus simply looking at the usual documentation of the care provided.

Jennifer Dupee: This is Jen Dupee. I think that you actually characterized exactly the guidance that we have given our review contractors which is that, what we're looking for the certification purposes is regular, good documentation in the medical record. So, we're looking at things like progress notes, the plan of care, things like that.

We're not looking for a magic – many magic words. We're not looking for certification statements and I certify that my patient needs to stay for two midnight, anything like that. And in fact that by itself is not adequate to meet

the certification or the medical necessity requirement. So what you just said is exactly what we are looking for. We're not looking to change, you know, the nature of medical practice or the practice of documents – of good documentation in the medical record. So we're hoping that will help providers be little bit more at ease that what we're actually looking for is something that – to that we were looking for before and what they already do everyday.

Operator: And your next question comes from (Ronald Hirsch). Your line is now open.

(Ronald Hirsch): Hi there. So number one, to follow up on that is, you're saying that doctor does not need to specify a number of days which they estimate the patient will require? We'll assume that's a yes because I don't want to use up on my questions.

Number two is the element of discharge planning must that be signed by the doctor itself – himself? What happens is a patient – the doctor is waiting for a test result, gets a call to him at the office, tells the nurse, "Test result's normally. Go ahead discharge the patient. See me in two weeks." That's a verbal order but not authenticated until after discharge. Would that need authenticate – would that meet certification requirements? That's question one. Or does he have to sign the order before the patient can leave the hospital?

Dan Schroeder: I – This is Dan. I think this is somewhat addressed by, you know, essentially what we've said in discharge to void or discharge after void, or discharge after meal. And that there is some leeway that the discharge order could be written in advance of a subsequent action or procedure or something like that. I might have missed some ...

(Ronald Hirsch): Yes.

Dan Schroeder: ... article ...

(Ronald Hirsch): So OK. This patient has a stress test scheduled. The doctor writes his note in the morning and says, "Call me with stress test results." And the nurse calls the result was negative and the doctor wants to discharge the patient. So he gives the discharge order as a verbal order. Does he need to authenticate that

order before the patient leaves the hospital to meet the certification requirement for discharge planning?

Dan Schroeder: (Report) it ...

Jennifer Dupee: I'm going to put you on mute for just a second, Dr. (Hirsch).

(Ronald Hirsch): Sure.

Female: (Inaudible)

Dan Schroeder: Hi. We're discussing this a little bit. There might be some disconnect here between what is the certification requirement of discharge planning and what is the requirement of a discharge order. I think we might want to discuss this a little bit more so there's might be something to send by e-mail and we could have a little bit more of a conversation.

(Ronald Hirsch): I've sent it five times.

Dan Schroeder: OK. We'll pull that ...

(Ronald Hirsch): So my second question – the first one my one recommendation is all of you guys spend a week in a hospital with the case manager and the doctors to understand what really goes on? But my next question is in this document, you specified that if a patient is formally admitted with an admission order from a physician who's authorized to admit patients to the hospital and another physician who's then responsible for the care decides that that admission order was not proper as they're allowed to not authenticate the order and that invalidates the admission.

That is absolutely contrary to the code of federal regulations 42.30C. It also violates beneficiary rights because they've been informed that they're an inpatient and have received the important message from Medicare. So how can you now violate code of federal regulations allowing doctors to ignore order despite not authenticating it?

Don Thompson: We're actually not in the habit of issuing clarifications that violate our regulations. So I may have a difference of opinion here with respect to whether the clarification that we issued. Those in fact violated the code of federal regulation. I think the issue, if I understand it correctly, that you're discussing is kind of when that clock would start and what we said in terms of when the clock might start with respect to two midnight for when exactly the inpatient order is authenticated. And all we've said is that basically someone with admitting privileges needs to authenticate the order.

I'm not sure how our physician and someone who has admitting privileges needs to authenticate the order, translate into a violation of code of federal regulation. But this can be a lengthier conversation so perhaps again I know you have sent this one to the mailbox. But I just I think we have a difference of opinion about whether this particular policy and clarification violate federal regulations.

Natalie Highsmith: OK. Thank you very much. (Candice), my next question.

Operator: Your next question comes from (Pam Heckley). Your line is now open.

(Pam Heckley): Yes. Thank you. We have a question related to the signature of the inpatient order. Here's the case example. A patient comes in and is expected to stay two midnights, has a verbal order from the nurse, from the physician, and then dies unexpectedly before the physician has the chance to authenticate that order. Would that still be billed as Part A inpatient?

Dan Schroeder: Yes, but I don't know if this situation is directly addressed in any of the guidance that we've given, but, essentially we say that the inpatient order must be authenticated timely and before discharge. In a circumstance where there's unexpected death or even emergency transfer or something like that, I think the definition of discharge could be somewhat loose in saying that the order could still be (inaudible) or authorized in an appropriate amount of time.

(Pam Heckeley): Thank you.

Operator: And the next question comes from the (Dawn Sinkel). Your line is now open.

(Dawn Sinkel): Yes. My question is regarding process. We sent in our charts and then they were denied because the contractor said they didn't receive them. However, we have certified mail that's signed with the – who received it. Is our best option just to do an appeal with that documentation that supports that the contractor did receive our charts, and then will those cases be overturned?

Melanie Combs-Dyer: No. I don't think that the best thing to do is to appeal. I think in these cases, would you mind actually contacting us. Don't send us any PHI, but just write us an e-mail in the IPPS admissions mailbox and we can follow up with the MAC about this.

(Jennifer Philips): This is Jennifer Philips. I do just want to clarify that these are cases that you believe are requested under the probe and educate period?

(Dawn Sinkel): OK. I did call the contractor and they advised me to do an appeal, but I will send the e-mail to you as well.

(Jennifer Philips): That would be good. Thank you.

Melanie Combs-Dyer: And (Jen), do you need them to include their NPI number in the e-mail or will you be able to tell just from the name of the e-mail.

(Jennifer Philips): Why don't you just indicate that you are the one who asked this question on the call and we'll follow up with you directly?

(Dawn Sinkel): OK. Thank you.

(Jennifer Philips): Thanks.

Operator: And your next question comes from (Andrea Doss). Your line is now open.

(Andrea Doss): Hi. With – to Occurrence Span Code 72, the MAC is putting all the claims out into T status saying that it's not a valid occurrence code for that bill type and I was wondering if you have any insight into why that is. All the claims I've used to Occurrence Span Code 72 on have gone into T Status.

Melanie Combs-Dyer: This is Melanie. Have gone into what status?

(Andrea Doss): T Status with a written code that it's not a valid occurrence code for bill type 111. The type is not a valid Occurrence Span Code.

(Jennifer Philips): Hi. This is (Jennifer Philips). And I do know that at one point, this was identified as an issue that was hitting up against edits. Our counterpart in our Atlanta office was working on this issue and issuing a change request to address it. So if this is still occurring, just go ahead and e-mail IPPS admissions mailbox. You can also follow up with your MAC directly and they might be able to provide additional information.

(Andrea Doss): I did and they didn't know what I was talking about when I told them about the Occurrence Span Code.

(Jennifer Philips): OK. If you would, then just go ahead and send me an e-mail to the IPPS admissions mailbox with a few additional details. In that way, I can make sure both to get your sure results and make sure that the MAC representative is aware of this new code.

(Andrea Doss): OK. And your name is, again?

(Jennifer Philips): It's the IPPS admissions A-D-M-I-S-S-I-O-N-S at cms.hhs.gov. And I'm (Jennifer Philips) and I do monitor that inbox and with ...

(Andrea Doss): OK.

(Jennifer Philips): ... Jennifer Dupee. Thank you.

(Andrea Doss): Thank you.

Operator: And your next question comes from the (Lori Schafer). Your line is now open.

(Lori Schafer): Hi. Yes. This is related to the MAC requesting. We have 50 plus charts now that they've requested. And we were under the impression that 10 to 25 would be the max for the probe and educate. Can you confirm that?

Melanie Combs-Dyer: This is for one NPI number? Or do you have multiple?

(Lori Schafer): One NPI, yes.

Melanie Combs-Dyer: You don't have multiple NPI numbers?

(Lori Schafer): No, this is all one hospital.

Melanie Combs-Dyer: And are these all patient status reviews or are some of them different types of reviews?

(Lori Schafer): No. These all specifically say regarding this rule for the two midnights.

(Jennifer Philips): Hi. This is (Jennifer Philips). And we have been notified that at times the MAC may inadvertently request, you know, items that are excluded from the probe and educate period such as inpatient only procedures. Those are particularly difficult to exclude on the front-end. And it's for many reasons than often require the MAC to look at the record and manually confirm that it is indeed an inpatient only procedure.

So some – that may be the issue. I would suggest ...

(Lori Schafer): Oh, it's not the issue because I've looked at all 30 some plus charts and only a couple of them have procedures on them not even inpatient only. So – And they're telling us they don't know what to do. Do we send the extra records? They're – They have no guidance for us.

(Jennifer Philips): If you would follow up with details for this as well to the IPPS admissions mailbox. That way we can look into this in a little bit more detail offline.

(Lori Schafer): OK. Great. Thank you.

(Jennifer Philips): Thank you.

Operator: And your next question comes from (Connie Jacobson). Your line is now open.

(Connie Jacobson): Hi. Yes. I also had a question about the educate and probe. And since they've decreased – or I'm sorry – increased the length of time that they're able to review them, should we assume they're going to pull more records. We were under the understanding as well that it was 10 to 25 based on hospital

size but we've already received 16. And does that mean that they're going to have until October to give us some feedback? And that may call the problem correcting our process if there's anything wrong.

Melanie Combs-Dyer: This is Melanie. And we did not ask our MACs to double the number of reviews. It's the same number of reviews. Though based on what (Jennifer Philips) just said, sometimes the edits are having trouble firing correctly. So you may need to contact your MAC or write to the IPPS mailbox if you think that you will need to ...

(Connie Jacobson): I did. I contacted our MAC and they basically said that it's a random pull. And in a recent conference in town here, they gave us some guidance and said that they have to – they're required to pull a certain percentage of every top of record. And so, they'll continue to pull them until they find them. And my problem with that is that these are prepayment audit. And since – I mean there maybe a back lag which you point, so many – how long is it going to take until the issues are resolved on them.

Melanie Combs-Dyer: I think in this case we're going to have to get some more details from you. So if you wouldn't mind just e-mailing us that would be great.

(Connie Jacobson): Will do. Thank you.

Melanie Combs-Dyer: OK. Thank you.

Operator: And your next question comes from (Amy Maverick). Your line is now open.

(Amy Maverick): I just wanted to clarify; we have many (inaudible) practitioners working nights for us. And they're allowed to do so by their state boards and also that the hospital to do admission. They do – And then they work with the physician the following day. So they do not need to actually make a phone call to the physician at night to OK that admission – inpatient admission. That can all take place the following day.

Dan Schroeder: This is not the verbal order so this would be ...

(Amy Maverick): Nurse practitioner functioning independently in the hospital as part of our team at night. And their state board allows them to do that as well as the hospital also allows them that privilege but they don't technically have admitting privileges. They're allowed to do those initial inpatient visit work ups at night.

Dan Schroeder: I believe, yes, that that is what our guidance is saying. I'm – The role of nurse practitioner isn't quite clicking in my head because we haven't had that question specifically, but if it's – they're writing orders in which they are – have – they write under state board and possible policy. They can order necessary treatments, essentially begin the inpatient order on behalf of someone who does have admitting privileges. And we're saying if that is signed promptly, probably the next day if that's what you're saying is happening ...

(Amy Maverick): Yes.

Dan Schroeder: ... that would be an appropriate inpatient today. And we would also begin the inpatient clock essentially when that order began.

(Amy Maverick): OK. Thank you.

Operator: And your next question comes from (Sheryl Gilbert), your line is now open.

(Sheryl Gilbert): Hi. If the physician does not sign the admission order until after discharge, can we submit a bill for anything?

Dan Schroeder: This is Dan again. If there is no admission order that is in the medical record ...

(Sheryl Gilbert): Well, there is one. It would be a verbal.

Dan Schroeder: ... it's a verbal order that is not countersigned promptly, it is generally it is our policy that's in the regulations that there needs to be a valid admission order in order for there to be a valid admission. And that was really as far as of guidance that we can state. I think we are well aware that they're going to several situations where things are laid or admitted and we do get MAC some

discretion in including orders, but as far as whether the law of what's required to submit a bill to part A, there is a requirement for a valid admission order.

(Sheryl Gilbert): Well, would we be allowed to submit an inpatient part B bill?

Dan Schroeder: Yes. Outpatient, correct, I mean if there is no valid admission order, the assumption would be that these were outpatient services.

(Sheryl Gilbert): So we would not have to go through the self-audit protocol. We could just submit an inpatient part bill if we don't have a valid signed order?

Dan Schroeder: Outpatient – are you saying inpatient part B or outpatient part B? If there was no order – if there was no valid order, then you can bill it under the outpatient if there never was a valid order.

(Sheryl Gilbert): OK. Thank you.

Operator: And your next question comes from (Lillian Forga), your line is now open.

(Lillian Forga): Thank you. I have two questions. We were under the impression that when the MACs were conducting round one of their probe and educate audits that we would receive results finding letters. But now, we understand that CMS has, I guess put a hold on that. And then my second question to you is, when this was originally designed we were told there would be RAC round one – I mean MAC round one and MAC round two audits. And then, depending upon our performance if it was not favorable, we could be opened up to 100 to 250 sample audit. Is that going to change now that you've extended the implementation time frame?

Melanie Combs-Dyer: On the first part of your question about the hold, we did ask our MACs to hold up on some of their denials and some of their educational calls until this new order and certification guidance came out. And now that that has come out, we will be lifting the hold and the MACs will be continuing to do their reviews and their educational calls.

And on the second part of your question about have we changed the volumes in round one, round two, and opened up to 100 to 250, no, those volumes stay

exactly the same. The only thing that changes is the date. They don't have to get through all three of those by April. Now, they need to get through, however, many rounds they need to get to – get through by September the 30th.

(Lillian Forga): I'm hearing from peer institutions that they're not receiving a results finding letter. Instead, they have to go into FISS to see, you know, how the MAC has determined this probe and educate audits. Well, can we now that you've listed the hold on it, can we now expect to see a summary letter for – in my institution that 10 charts that were requested?

(Jennifer Philips): Hi. This is (Jennifer Philips) and that's correct. And some of the MACs do operate instead for the individual claim results and then they'll send one probe letter for all 10 or 25 claims whichever the case may be. So we still anticipate that those will be received at each facility. If you do not – If you have not received that you should be receiving it yet.

(Lillian Forga): OK. Thank you.

(Jennifer Philips): You're welcome.

Operator: And your next question comes from (Mary Mazalic). Your line is now open.

(Mary Mazalic): Thank you. I do have a question about the change in the timeframe. This was – I was trying to ask the question at the beginning of the call. And could you just, for the record, state that the rule is in effect now-- that the only change is the change in the timing for direct reviews? We're hearing from lots of different parties that CMS has canceled this rule, that CMS has delayed the implementation of the rule. And I can tell from your comments; that's not true, but, could we just have a kind of clear short statement to that.

Melanie Combs-Dyer: CMS has not canceled these new rules. CMS has not delayed the implementation of the rule. CMS has extended the probe and education period for this rule. Is that helpful?

(Mary Mazalic): Very helpful. Thank you so much.

Operator: And your next question comes from (Jen Langdon). Your line is now open.

Male: Thank you. I'm with (Jen). But my question is that similar to what Dr. (Engel) had asked at the beginning of the call but are simply different spin on it. So on page three, it says if all the required information is included in the progress notes of the physician statement could indicate that the individual's medical record contains the information required and then inpatients services are – or considered to be medically necessary.

What if you do have an attending certified physician sign a statement to that effect and they reference the pieces in the progress notes but those pieces in the progress notes are written by say residence or P.A.s. Do those individual pieces that are in their progress notes have to then be written by or countersigned by the certifying physicians or is the statement by the certifying physician that the information is in the medical record enough to certify that information?

Dan Schroeder: Hi. This is Dan. No. We're not saying that every element that is used to justify or the certification needs to be countersigned with – by a physician. The physician is essentially reviewing the entire case or plan of care or progress notes and at some point are certifying that everything was with medical necessity and had lengths of stay that met the requirements of an inpatient episode. We're not saying in any way that they have – would have to go through in line by line to certify each and every part of medical record.

Male: OK. Thank you very much.

Dan Schroeder: Yes.

Operator: And your next question comes from (Sarah Easterlin). Your line is now open.

(Sarah Easterlin): Yes. My question is related to the inpatient only procedures and the review for medical necessity of status versus medical necessity of services performed. I've sent in this question as far as clarification for contractors as well as to ensure providers are not getting denied inappropriately for inpatient only procedures upfront. What's being done about that on the front-end to try to prevent that?

Jennifer Dupee: As we indicated, this is Jen Dupee, in one of our earlier statements, sometimes inpatient only procedures are a little bit difficult for the MACs to identify in the front-end. So when they do receive the claims and verify the procedures that were done, those claims are excluded from the patient status reviews because of course inpatient only procedures are an exception to the two midnight rule.

However, MACs do have the discretion, if they have the resource to do so, to conduct a medical necessity review on the inpatient only procedure itself. That's the different type of review than the patient status reviews.

(Sarah Easterlin): Correct.

Jennifer Dupee: Correct. So – And we have – how we've been dealing with any cases where there potentially isn't any question of claim being denied and the question of whether it was denied under the probe and educate was not excluded of whether was actually a denial because of the case I just described that it was actually a review of the procedure itself. We've been asking providers to let us know of those and we've been following up with the MACs. So if you do have any specific instances of those, we would like for you to contact us.

(Sarah Easterlin): OK. The reason I'm posting this question is that I know a good number of the accounts that will be in the probe and audits educate will be procedures, and a number of those accounts will be on the inpatient only list, and a number of those accounts possibly do have medical necessity requirement that are for justifying why you needed that particular procedure.

So I can see a potential increase in inpatient only procedures being denied. That could possibly be inappropriate. So I'm trying to make sure that we're putting things in effect to make sure that providers don't have to fight this unnecessarily.

Jennifer Dupee: One thing that we have told providers previously is that if you do have a claim that is selected that you believe that there's an inpatient only procedure that has been performed, you can go ahead and make a note, a cover sheet on that file to indicate that to the MAC and they just help expedite that review for the

(inaudible) inpatient procedure and the exclusion of that claim from the probe and educate. But again, that does not mean that necessarily the MAC couldn't do a medical necessity review on that inpatient only procedure.

(Sarah Easterlin): Thank you.

Operator: And your next question comes from Dr. (Novick). Your line is now open.

(Novick): Thank you very much. My question is on transfers in from another hospital. We're tertiary center doing (inaudible) on high risk patients. For instance they – patient has a (non-STEMI) in another institution they come over to us after three days or sometimes four days. Do I keep them as an inpatient based on the two midnight rule or do I do them all as outpatient?

Jennifer Dupee: Dr. (Novick), as you may be aware; we have not come out with the additional guidelines on transfers. And this is something that will be coming out very shortly. However, it's something that we haven't discussed. And we didn't believe that we are at a final conclusion on how these should be treated. In the mean time, these are being excluded from the probe and educate reviews. So we're just indicating that hospitals should interpret the policy as best they can when dealing those claims. But beyond the lookout that should be coming out very shortly.

(Novick): Thank you very much.

Operator: And your next question comes from (Kim Brownfield) your line is now open.

(Kim Brownfield): Yes thank you. One question I have is on section B or B number four. And in that aspect, if you had a surgery patient that you had an admission order set that included the (inaudible) certification and the inpatient order and maybe that's written a week ahead of the actual admission, do you then require a separate inpatient admission order to be written again and signed by the attending physician or can that order count?

Dan Schroeder: I believe we're saying that order would satisfy the requirements for admission order. I mean there are medical record requirements the document subsequent orders and we would hope that there something in the medical record that the

patient is here now and they're about to have something done to them. But for strictly speaking that we need a valid admission order that could be for about completed well and advanced and it would take effect when the patient begins to receive services.

(Kim Brownfield): Thank you.

Operator: And your next question comes from (Deb Mossier) your line is now open.

(Deb Mossier): Thank you. I have just a question regarding the staffing for utilization review. We were in a conference call and we said it pretty much it's not required. And we have to do with (partners) on call (a lot times). We are elective procedure, only procedure place so we know what our patients are coming in doing something unique arrangements for E.R. nurse review call it all time.

Female: I'm sorry. We're going to put you on mute for just one second.

Female: Thanks. Sorry about that.

(David Eddinger): This is (David Eddinger) from (Survey and Cert). You got to be careful to segregate the activity that might need to be done for payment purposes from the COP. The COPs have no requirement that you have a utilization nurse there 24/7. It actually has requirements dealing with what the hospital has to do as well as what sort of physician activities and utilizations review committee have to do. But there is no specification there about having nurses there 24/7 to take care of reviews.

(Deb Mossier): OK. Thank you.

Natalie Highsmith: OK. (Candice), we have time for one final question.

Operator: And your last question comes from (John Guller). Your line is now open.

(John Guller): Yes. My question is about the recent change in the language from authentication of orders to countersigning of orders regarding residents. And I was just wondering, is that purposeful language that we specifically have to have the attending countersigned the order versus authenticated?

Dan Schroeder: This is Dan. I would have to say, probably at this point, it may not be very significant or different so but when we put together regulations like that sometimes for documents like this, we view certain language to meet certain things. And I'm racking my brain right now just to try to figure out why we changed countersign from authenticate. It might be the idea that you – if physician would authenticate their order but they could countersign an order made on their behalf. I believe that might be what we were thinking in using the language but it may very well just be a difference without the significant difference.

(John Guller): And in a prior guidance you said authenticated parenthetical sign dated in time, and then the new guidance, you say authenticated countersign.

Dan Schroeder: I'm not sure if there's any significantly different intent between parenthetical signed dated in time and parenthetical countersign.

(John Guller): OK. Let me ask you this then. You know, one of the solutions that we had was the resident writes the order and then the attending comes in the next day, and in their progress note, authenticates that order versus going into a separate program and cosigning the original order. Do you have a preference between the two or are both acceptable?

Melanie Combs-Dyer: We're going to put you on mute for just a second.

(John Guller): OK.

Female: Our check list.

Melanie Combs-Dyer: So we're having some extensive back and forth here obviously. We apologize for the silence there. We're going to continue talking about this. Would you mind actually submitting that question and we're going to forward that to the appropriate people that we need to get an answer.

(John Guller): Sure. I'll send that in. Thanks.

Female: OK perfect thanks.

Natalie Highsmith: OK. Well, we have reached our 2:00 hour and I want to thank our staff in the room for joining us today and thank you on who's joined us on the phone lines. And please stay tuned if there's another follow up open door forum on this topic. Please stay tuned to the LISTSERV. And everyone, thank you and stay warm and see you all later.

Operator: And thank you for participating in today's special open door forum conference call. This call will be available for replay beginning at 4:00 p.m. Eastern Time, today, Tuesday, February 4, 2014 through midnight on February 7th, 2014. The conference I.D. number for the replay is 4773-65-19. And the number to call for replay is 855-859-2056.

And this concludes conference call, you may now disconnect.

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