

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, December 19, 2013
1:00pm – 2:00pm Eastern Time
Conference Call Only

Operator: Good morning my name is...

Female 1: Hello, (Michelle)?

Operator: Good afternoon and evening. My name is (Michelle) and I will be your conference operator today. At this time, I would like to welcome everyone to the Final Rule CMS (1599-F) Discussion of Hospital Inpatient Admission Orders and Certifications; Two Midnight Benchmark For Inpatient Hospital Admissions.

After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

As of now, I would like to turn the call over to Ms. Jill Darling. Please go ahead.

Jill Darling: Thank you (Michelle), hello my name is Jill Darling in the CMS Office of Communications. Thank you for joining today's call. First I would like to make a health insurance marketplace enrollment announcement.

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 when the health insurance marketplace ends 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, factsheets, brochures, talking points videos and training slides. All of these are available on marketplace.cms.gov.

We wanted to share some consumer-friendly tips for individuals looking for quality, affordable health insurance in shop healthcare.gov during off-peak hours, mornings, nights and week-ends. Have your income tax information regarding when you log in. Comparison shop to get the best deal! And if you need to talk to someone, use the call center – 1-800-318-2596. Reps are available 24/7 in a 150 different languages.

You can also find in-person health in your area, at localhealth.healthcare.gov. I'll now hand the call over to Melanie Combs-Dyer, who is the Acting Director for the Provider Compliance Group.

Melanie Combs-Dyer: Thank you, Jill. The first thing that we would like to talk about today is our first rare and unusual case that we have posted to our website. You may recall that we have set on prior calls that it's not impossible to have a less than two midnight expectation for an inpatient stay. But, we would expect that those cases would be very rare and would have to be completely documented in the medical record.

And in previous calls, you have asked us to put some guidance with some examples on our website. And, we have found our first example. And I'd like to turn the call over to (Jen Philips) to describe that particular case and where folks can find it in the slides on the website.

Jen?

Jen Phillips: Good afternoon everyone. As Melanie mentioned, we've have identified our first rare and unusual circumstance. We have identified mechanical ventilation initiated during a present visit as the first circumstance in which a physician expectation of less than two midnights, may still support inpatient admission and payment.

We did note on our website that this would not include routine intubations that are associated with elective or minor surgical procedures and other treatments.

So, that is available at our inpatient hospital review website. We are also continuing to receive suggestions for exceptions to the two midnight rule to our IPPS admissions mailbox. We encourage you to submit any – any potential suggestions that you may have. They will undergo CMS review and if any additional rare and unusual circumstances are identified it will be posted in the same manner.

In addition, we have evaluated provider and stakeholder feedback about the ability of CMS to track the total time on an inpatient hospital claim. As you know, at the time the rule was released, CMS was only able to consistently and accurately track the number of inpatient midnights (on an) inpatient claim using the dates of service – meaning the number of (midnights) after the formal order and admission.

Industries notified CMS that they thought (it) would also be useful if we could track the total number of midnights the beneficiary may stay in the hospital receiving care.

So, we did work with the National Uniform Billing Committee to redefine occurrence span code 72 to allow the total time in the hospital to be recorded on an inpatient claim.

This redefinition did go in effect on December 1st 2013 and actual definition is continuous outpatient hospital services that preceded the inpatient

admission. You may also find this at (NUBCs) website and their implementation calendar.

Occurrence span code 72 is voluntary code, but we would like to share with the hospital providers – this may be used by the medical reviewers for the purposes of supporting the two midnight benchmarks. So, therefore, it can be taken into consideration. But the medical records must still support the medical necessity of the hospital stay.

With that, there were several other topics that we wanted to discuss that's specifically related to stakeholders feedback.

The first two topics, I will pass over to Dr. Handrigan, related to medical necessity and the start clock.

Michael Handrigan: Thank you, Jen. (Inaudible). So, we've received several questions about medical necessity and whether or not the concept of medical necessity has changed with the rule.

As you know, for Medicare to pay for any item or service, it must be medically reasonable and necessary for the care of the beneficiary. And that has not changed at all with the rule. In the past, there has been some confusion about how the test of medical necessity is applied. And, whether it applies to the setting of care, with respect to inpatient versus outpatient care – the intent of the rule is to clarify this.

We are instructing our contractors to apply the test of medical necessity to the actual services that are being provided to the beneficiary. The care and diagnostic services, that are being applied in-not to the setting of care. For example, if you are – the beneficiary requires telemetry monitoring; it's the telemetry monitoring that the test of medical necessity will be applied to. Not where or how that telemetry monitoring is applied.

And, now this is particularly important because the – the setting of care, whether you bring the patient into an observation unit or into an inpatient

service or into an intensive care unit – is (you) not relevant in determining medical necessity.

It's the underlying services that are being provided that must be medically necessary and documentation is to support that. We're hoping that this clarification will help resolve a lot of the issues that arose around the setting of care determinations about whether a patient should be inpatient or an outpatient.

And, that is a good point to start talking about where the clock starts with respect to the benchmark. The first determination the clinician needs to make when bringing the patient into the hospital is whether or not hospital care is required for the beneficiary.

But, that is to say – that – if the services being provided can only be provided in the hospital setting, in the – at the hospital level of care. And, I am specifically not saying inpatient level of care or outpatient level of care – but, determination is whether the beneficiary needs to remain at the hospital for that care.

And once that determination is made; then the next determination is for how long are those medically necessary services going to be required for the beneficiary. And, that gets to the benchmark and to the presumption.

If the physician or the clinician admitting the patient determines that those medically necessary services will be required for less than the duration of two midnights, then that should be appropriately billed as an outpatient service under part B.

If the clinician determines that the medically necessary services will be required for the duration of two or more midnights, then that should be appropriately billed as an inpatient under part A.

And, for the purposes of an inpatient admission, should it be unclear at the start of those services – whether the – it will be required for less than two

midnights or more than two midnights – it is appropriate to keep the patient at the hospital and subsequently make that determination.

Following the first midnight, if it becomes clear to the clinician, that care will be required beyond the second midnight, it would be appropriate to write an order for admission and keep the patient at the hospital and bill that patient under part A.

We have instructed our contractors to allow all of the outpatient time following simple triage to be incorporated into the benchmark time required for the two midnights.

For example, if – for an emergency department patient – if the emergency department patient arrives at the triage desk, and is triaged – after care that is responsive to the beneficiary's needs is established and begun, not including the simple triage time—but care that begins in response to the needs of the patient. From that time forward, all that time that is contiguous within the outpatient setting will be included in the time of the two midnights for the purposes of the benchmark.

I'll give you a specific example with times. If a patient arrives at 11 p.m. and is triaged, and at 11:15 p.m. the patient has an initial assessment – a care plan is begun. And the patient crosses the first midnight and is maintained in the hospital for 24 hours and it becomes clear that 11 o'clock the following night that the patient will be in the hospital following the second midnight – it will be appropriate at that point to write an admission order.

And, the time beginning from 11:15 when the initial evaluation began, the previous evening; prior to the first midnight – would establish that the start time for the benchmark.

And that patient would appropriately be billed as an inpatient under part A. And, we have instructed our contractors to include all of that outpatient time within the benchmark.

Jen I'll turn it back over to you and I'll take any questions at the end as they come in.

Jen Dupee: Thank you, Dr. Handrigan. This is Jen Dupee from CMS; I just wanted to briefly touch on the issue of transfers. We have them receiving a lot of questions about how hospitals are to bill in instances in which a beneficiary is transferred into the hospital from another acute care hospital.

We just wanted to let you know that we are still working on this – on this particular guidance, and it is one of our top priorities here in the next few weeks. So, you should be seeing something from us soon.

Just keep in mind that we are not looking at any transfer cases as part of the probe and educate. So, we're just encouraging hospitals to follow the rule and apply it in the way that they feel is most appropriate. And, we will be coming forth with that additional guidance here in the near future.

I also did – just want to – to touch on the fact – on the IPPS admissions mailbox while I have you on the line. I just wanted to let you know that we are continuing to accept questions and comments into that mailbox and we are monitoring it.

We understand; we haven't been able to get to issue a response to everybody yet. And, thank you for your patience on that. But, we are receiving all of your messages and we are monitoring that mailbox on a daily basis.

And, again, that e-mail box is (ippsadmissions) and that's one word – (@cms.hhs.gov). I'm now going to turn the line over to Melanie Combs-Dyer to speak a little bit about the probe and educate.

Melanie Combs-Dyer: Thank you Jen, this is Melanie Combs-Dyer, again from CMS. And I just wanted to give everyone an update on our instructions to the contractor about the probe and educate process. Our Medicare administrative contractors or MACs have begun sending out the documentation request letters.

It's sometimes called the additional documentation request or (ADRs). And so, you should begin to receive – if you have not already begun to receive them – you will be receiving them shortly.

I know a lot of people have been very anxious about when those were going to start and they either have started for you or they will start shortly.

Next, I'll turn it back over to Jen Dupee to talk about the upcoming training in January.

Jen Dupee: Thanks, Mel. So, we did want to give you all a heads-up that we will be hosting a Medicare Learning Network (Connects) National Provider Call on January 14th from 1:30 to 3 o'clock p.m. Eastern time.

During this call, we'll be giving an overview of the inpatient hospital admission and medical review criteria that we've been discussing on this call today. In particular, which we think will be really useful to you all – we will be using case scenarios to describe the application of the rules to sample medical records.

We already have those samples picked out – so, don't feel as if you need to – to provide anymore. Even though, of course – you can continue to write us in that mailbox as we have already described.

We're also going to be addressing frequently asked questions, received to date in answering questions from the public.

I do believe that you are able to submit your questions for this training ahead of time. So, please take advantage of that opportunity. The target audience of this call will include basically everyone that we have on this call – including hospitals, physicians, and other practitioners, case managers, medical and specialty societies and other healthcare professionals.

You can go, pardon me, to our website to – instead of me trying to spell out this particular URL, which is quite long – it'll just be easier to go to our website and then you can see the link there.

Our website is (go.cms.gov/InpatientHospitalReview) and that's all one word, inpatient hospital review and the first letters of those words are capitalized – or else, unfortunately it will not work. So, (go.cms.gov/InpatientHospitalReview), inpatient, hospital and review are capitalized.

And, with that, I'm going to turn things over to Dan Schroeder to talk about the order and certification requirements.

Dan Schroeder: A – just a quick notice to say that we are continuing to work on additional guidance regarding questions – we've received many questions in the IPPS mailbox regarding the requirements, the admission order and the certification – especially (in regards to) regulation changes that we've made over the two midnight policy.

Again, we continue to (inaudible) through the mailbox and we've received the questions, we haven't been able to respond to, many of them individually. But, we are working on updating or adding additional guidance particularly based off of what we've said on the September 5th guidance that hopefully will address a great number of these questions.

Particularly, who can – what roles and what types of physicians can either sign or authorize admission orders, when those orders must be authorized or countersigned. As well as components in the Medicare certification document that a – documentation that's required as part of an under statute.

Our hope is that we'll get this guidance out very quickly. So, it – we expect that there will be many more questions on these subjects but we hope the guidance will help to clarify that. Thank you.

Melanie Combs-Dyer: Thank you, and at this time, we would like to open it up for questions. So, I'll turn it over to the Operator to explain how that will work.

Operator, if you could help us how they can get into the queue to ask the question, we sure would appreciate it.

Operator: If you would like to ask a question please press star one on your telephone keypad. We do have a question from somebody who did not leave their information. If you have to ask a question, your line is open.

Ronald Hirsch: Hello?

Melanie Combs-Dyer: Yes, we can hear you; go ahead with your question.

Ronald Hirsch: Oh, OK, I didn't give my name; this is Ronald Hirsch with Accretive. We have a disagreement amongst us, the MACs about what to do with a patient who spends two midnights in the hospital under observation because the physician forgot to write the admission orders prior to the second midnight.

The patient is now on that third day or past the second midnight ready to go home. Two MACs instruct us it is proper to admit the patient and then discharge them since they did meet the benchmark. One other MAC says, no that is not proper that the patient must require another midnight or you could admit them. And I've submitted this question to you guys, probably four times to try and get clarification.

Marc Hartstein: So, this is Marc Hartstein, I'm the director of the Hospital and Ambulatory Policy Group. If the physician admits the patient then the patient – I mean – this patient has met the two midnight benchmark because the patient's been in the hospital more than two midnights.

The physician may write an order to admit and the patient could also be discharged that same day. However – (inaudible) – the patient would only be considered an inpatient for the time they spent from the time of the order until the time of discharge if that would be one inpatient day.

Ronald Hirsch: That's correct. Well, we would see that the zero inpatient, it would have them the occurrence code 72 – so, but we would get the (DRG) and the patient would be responsible for the inpatient's deductible. So...

Marc Hartstein: That's...

Ronald Hirsch: Great. Great answer! Thank you, I think you need to tell all your MACs. So, my second question, my follow-up is the clarity of what medical necessity really is. Now, we understand this (inaudible) level of care inpatient versus (obs). It's need to be in the hospital.

So, for example, a physician may decide that a patient with a UTI and a fever needs to be in the hospital starts with; an IV antibiotics; they stay two midnights, their admission. If a MAC or a RAC may come back and say, no we don't think that patient was sick enough to be in the hospital. They could've been treated with oral antibiotics and sent home.

How is that guidance going to be given to them to decide what's going to be done?

Michael Handrigan: Melanie, would you like to that or is...

Melanie Combs-Dyer: Dr. Handrigan, go ahead Dr. Handrigan.

Michael Handrigan: This is Dr. Handrigan. So, if the physician admitting the patient clearly establishes the need to keep the patient; at the hospital for those services – then, that will establish the medical necessity for the care being provided.

Of course, that will be open to review if there is – clearly, not a reason to establish medical necessity for the services if a physician says because I said so.

That's really not going to satisfy the requirement. But, if the physician in good faith documents a clear clinical rationale to keep the patient at the

hospital and why the services could not be provided outside of the hospital, then, that will establish medical necessity for those services.

Ronald Hirsch: Great, so, let's say a patient with a high risk TIA, very high risk, my calculation has a 10 percent risk of stroke in two days, the physicians decides that this patient needs to be monitored for two days in the hospital. That would be an inpatient admission. The second day, the patient would probably receive no care other than nursing checks and neurologic examinations. But, that would be appropriate for inpatient, correct?

Michael Handrigan: If the record establishes that the care could only be provided in the hospital, then that would be appropriate. Had we had – we're instructing our contractors in the same manner that we're instructing a community. So, the challenge in the past has been that there's been an argument about the setting of care.

For example, your TIA patient who was admitted to the hospital for a short stay to receive telemetry services, the argument in the past or the challenge in the past has been that those services could have been provided as an outpatient.

Our intent with the new rule is to clarify and avoid that argument entirely. Should, your beneficiary require services that can only be performed in the hospital then that establishes that they need to be in the hospital for those services. Then, the next question is for how long. And it's really the duration of time that is the discriminator now.

Ronald Hirsch: OK.

Michael Handrigan: So, long as the underlying services are medically necessary, if they remain necessary for more than two midnights, then, we've instructed our contractors that that should appropriately be billed as an inpatient service.

Ronald Hirsch: Excellent – the answers to all my questions, thank you very much.

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

Operator: OK, your next question comes from Masood Safaee from Mountain Health, your line is open.

Masood Safaee: I have a similar question to Dr. Hirsch's question, and I want to just – make sure that it is clearly for other physician advisors. Because I talked to many of the physician advisor across the country and they have the similar problem.

Regarding that medical necessity or (QA) who was mentioned about on question 7 – about the factors the physician should consider. You mentioned it is up to the physician to make the (inaudible) in medical determination of whether the beneficiary risk of morbidity or mortality dictate the need to remain at the hospital.

So, suppose that we have a elderly person (comes in with) pelvis fracture and need to stay at the hospital because at the risk of fall and other injuries. But, the (inaudible) obtained is not significant and we know this patient is (currently) the hospital for a few days.

Would you consider this a custodial care or you would say this patient should have gone – go to the (nursing home) or (inaudible) OK to consider that this patient is inpatient?

Michael Handrigan: With respect to this question, the rule does not change anything in the way that Medicare looks at this type of care. If it's determined for patient convenience or for social services, or any other reason that you're choosing to keep the patient at the hospital. Then, that would not fall within appropriate guidelines.

We've instructed our contractors to ensure that they are establishing medical necessity for the care that they're approving. So, in the case of – that you've outlined – if your patient is not receiving medically necessary care then that would not be appropriate to bill as an inpatient.

Masood Safaee: So, there's a differences between definition of medical necessity for the patient and this safe discharge. This patient receiving the physical (therapy) that can be (done) as the inpatient or outpatient receiving the pain medication that can be done as inpatient or outpatient. But, the patient is not safe to go home because at the risk of fall or further injuries. So, that is something that the physician would say, well this patient receiving services and there's a risk for the patient.

Michael Handrigan: Why I think you've answered your early question. And, again, this has not changed at all with the new rule. You know, if the services could be provided as an outpatient, then that would not be appropriate to bill as an inpatient.

Melanie Combs-Dyer: This is Melanie. I'll just add – if you're saying that the patient's not safe to go home, they really need to get to a skilled nursing facility – that's the place that you need to discharge them to. And if they're not – if there is no nursing home that's available to discharge the patient to, then you can certainly keep the patient in the hospital for social reasons or for convenience reasons. But, you should not bill Medicare for that time.

Masood Safaee: Thank you.

Operator: Your next question comes from Joseph Dawood from (Multicare Health), your line is open.

Joseph Dawood: Hello, so – I have a problem with medical necessity. Are we saying that regardless of the setting, if you feel that the patient has to be in the hospital – in one fashion or another, whether outpatient, inpatient – for the purpose of treatment – are you saying if you, (inaudible) – it needs one midnight, then it's an observation, if it needs two, it's an admission. Or do we still take severity of illness and intensity of service into, in the back of our minds when we decide what medical necessity means.

Melanie Combs-Dyer: This is Melanie, I'll address this one and Dr. Handrigan can jump in. Here is really the total number of midnights that the physician expects the patient to

spend receiving hospital level care. That's what really drives the decision about whether or not it is zero or one day that our contractors will be denying those inpatient part A claims. And if it's two or more midnights, the contractor will be approving those inpatient Part A claims.

Again, it's really very different than how it was looked up before with (Milliman) or (Interqual) or other sorts of severity of illness, kinds of indicators.

Now, we're looking at the total midnight spent receiving hospital level care or that the physician documents the patient needs to receive hospital level care, even if they expire or discharged against (medical advice) or transferred before that, that two midnight occurs.

Dr. Handrigan, did you want to add anything to my answer?

Michael Handrigan: I think that's exactly right and, with respect to your question, it's entirely the former. Our contractors will be generally agnostic to the intensity of the services. Hospital care is hospital care and should your patient require hospital care for less than two midnights, regardless of where you provide that care, then that should be an outpatient bill.

And, if they require care; for more than two midnights that should be appropriately billed, as an inpatient. And this is specifically why the rule states that just admission to the intensive care unit is not in and of itself justification for inpatient care.

It really is less than two midnights or more than two midnights.

Melanie Combs-Dyer: Would that...

Joseph Dawood: Yes, that's the best clarification I've ever heard of – that's very clear. And, I have a follow-up, if you don't mind.

Melanie Combs-Dyer: Sure, go ahead.

Joseph Dawood: You are going to look at the patients who perhaps come in and need hospital care and then on the second – after the first midnight, they decide they – I’m going to be on hospice. And they get to go home, maybe that second day, after that first midnight.

Did you have an exclusion for that yet or you’re still thinking about that?

Jen Dupee: (This is) Jen Dupee, so, in that instance we actually wouldn’t consider that to be an exclusion. That would fall within what we call one of our unforeseen circumstances. So, the admission decision is really based on an expectation of a two midnight stay.

So, if a beneficiary comes to the hospital and based on the condition and the physician’s assessment, he or she believes that the beneficiary will require two or more midnights of hospital care – and writes an inpatient order based on that expectation. And then, the next day, for example, the beneficiary decides to enroll in hospice and is actually discharged – that would be an unforeseen circumstance and we would still say that that’s an appropriate inpatient admission.

What’s important is that the original expectation and the order based on that expectation is reasonable and it’s well-documented in the medical record.

Melanie Combs-Dyer: And, Jen will we be revising our instructions that appear on our website or eventually in our program integrity manuals to add that situation to the list?

Jen Dupee: I think we have considered that because it’s the question has come up more than once. But, again, you know there are many circumstances that could come up that we couldn’t even possibly imagine. But, that, you know, that was a common question so, that is something we are considering.

Melanie Combs-Dyer: Thank you for question, I’d like to go back to an earlier question. This was the physician who was raising the issue about needing to get some of the patient home safely and needing to keep the patient in the hospital long

enough to find a – an appropriate nursing home and part of my answer was – it may be very appropriate to keep the patient in the hospital but don't bill Medicare.

And, I've been corrected, it's don't bill Medicare inpatient but it may be appropriate to bill outpatient, if they were outpatient services that were rendered. (Anne) did you want to add anything to that inquiry?

(Anne Marshall): Yes, this is (Anne Marshall), Division of Outpatient Care. I mean, I think we've gotten the question from several different angles. Are we saying that there's a requirement to admit beneficiaries based solely on the amount of time in the hospital.

And that is not the case. There's not an obligation to it admit. But, if for some reason, you don't believe that an inpatient level of care is necessary but the patient is receiving medically (inaudible) necessary part B services such as physical therapy, or nursing or monitoring or pain management, it certainly – certainly those services are reasonable and necessary. Part B outpatient services and it can be billed to the (OPPS).

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

Operator: Your next question comes from (Kin Tippin) from organization unknown, please go ahead.

(Dana Tippin): Yes, this is (Dana Tippin) (Center Towards) Rehabilitation Hospital. We're a free-standing rehab hospital and most of the inpatient PPS rules do not apply to rehabs. But, in the rule it did say that the physician certification was meant to include everyone.

And so, that begs the question, what is the expectation for rehabs – rehab hospitals – already have the requirement for a physician to sign off the pre-admission evaluation of the patient stating that they meet criteria. And then, within 24 hours do a post-admission physician assessment stating that the patient continues to meet criteria and estimate the length of stay.

So, is this rule actually asking for an additional document from the rehabilitation physician?

Dan Schroeder: Hi, this is Dan Schroeder admission of acute care. This is going to be one of the specific sections that we're going to address in the upcoming guidance that I spoke about. If you want to send an e-mail we could probably more directly respond to your question about how rehab certification has been affected by this. But, this will be addressed in the upcoming revisions – revised of the guidance – revision of the guidance.

(Dana Tippin): And, in the e-mail address sir?

Melanie Combs-Dyer: Jen could you please give the e-mail address?

Jen Dupee: Sure, it's (ippsadmissions) plural, and that's one word, at cms.hhs.gov.

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

Operator: OK, your next question comes from (Ina Banker), your line is open.

(Ina Banker): Hi, good afternoon. I'm just been trying to get a clarification about the application of two midnight rule for (MSP) claims? We're not getting (ADR) requests for a part of probe and the local (MAC) is pooling (MSP) claims as part of the (ADR) requests. Because the last time I asked that question, CMS indicated that they have not finalized the policy whether the two midnight rule applies to (MSP) claims.

(Jennifer Philips): Hi, good afternoon, this is (Jennifer Phillips) again. (This) was actually just brought to our attention today, so, if you wouldn't mind, following up with us after the call – we'll work with you and your (MAC) on this particular issue. And, you can also use the (IPPS) admissions mailbox and we may need to follow-up and, you know, get the (DCN) numbers and that sort of information from you offline.

(Ina Banker): So, is there somebody I can get in touch with offline? Because we already have these requests and we're supposed to be providing the charts as part of these (inaudible) requests. And, a number of those cases are in this (inaudible).

(Jennifer Philips): Yes, absolutely. But – so, the (IPPS) admissions mailbox, again (inaudible) I monitor, and we – we'll receive that e-mail if you send it. So, it's (ippsadmissions) one word at (CMS.hhs.gov).

(Ina Banker): OK, thank you.

(Jennifer Philips): Sure.

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

Operator: Your next question comes from (Harley Livi), your line is open.

(Harley Livi): Hi, this is (Harley Livi) and I've actually – I've actually got (Kimberly Young) here from Adventist healthcare; she's going to ask the question.

(Kimberly Young): My question is, we've been getting ADRs for TURPs, which are normally about a three day stay. It's not on the inpatient only list and that's why they're being denied. They're usually on continuous bladder irrigations for at least 48 hours, which are usually this – discontinued by the third day.

Would this two night midnight rule apply to them, even though they're not on the inpatient only list because your expectation is they will be here for at least two midnights and discharged on the third day.

Melanie Combs-Dyer: This is Melanie, (are) you cut out at one point and I want to make sure that I – I heard you. You said these were claims for two midnights?

(Kimberly Young): They are TURPs, trans-urethral resection prosectomy. And, they're in the hospital for a minimum of three days with two midnights crossing, with

continuous bladder irrigations usually 'til the third, morning of the third day. They are not on the inpatient only list and they're being presently.

Would this – would the two midnight rule apply to these?

Melanie Combs-Dyer: I'm trying to figure out and you said you got (ADR) – you got a documentation request letters for these?

(Kimberly Young): Yes, they are – we're being (audits).

Melanie Combs-Dyer: What would be...

(Kimberly Young): We're being (audits).

Melanie Combs-Dyer: I'm sorry, were they (admissioned) before October the 1st or are these admissions after October the 1st?

(Kimberly Young): These are admissions prior to October 1st but going on after October 1st - would the two midnight rule apply to them? Since they are an outpatient, considered outpatients since they're not on the inpatient only list.

Melanie Combs-Dyer: So, Jen...

Michael Handrigan: So, Mel this is Dr. Handrigan.

Melanie Combs-Dyer: Go ahead Dr. Handrigan.

Michael Handrigan: Let me, yes, let me take sort of a general approach to this question. The inpatient only list will be useful to the contractors in identifying exceptions to the two midnight rule. Whereas a beneficiary who's admitted for less than two midnights for a procedure – if it is on the two midnight list and that would be appropriately be billed as a DRG part A payment.

You're asking sort of the opposite question. And, whether, if it's clearly established that care will be required for greater than two midnights, even

though a procedure is not on the two midnight – I'm sorry – on the inpatient list, the answer to that question is yes.

The rule would apply and if the medical record clearly establishes the necessity for care continuous for more than the two midnights – that would appropriately be billed as an inpatient and that's what we are instructing our contractors, too.

(Kimberly Young): Wonderful.

(Jen Dupee): And, this is (Jen Dupee), just a follow-up as well, if these were for days (inaudible) admission before October 1st that would have fallen under the previous policy. So, it is possible that even though the review is occurring after October 1st – because there was a previous date of admission – it would still follow under the old rules.

So – so, the rules – the two midnight benchmark – is applicable to days of admission on or after October 1st.

Melanie Combs-Dyer: (Harley) and (Kimberly) was that responsive to your question?

Operator: She has dropped, the next question comes from (Ronald Atkins) from (Mental State Health), go ahead.

Mr. (Atkins)?

OK, your next question comes from (Meredin Harrison) from (Dimensions) Health, your line is open.

(Harold Weis): This is Dr. (Harold Weis) speaking for Miss (Harrison). On the (inaudible), this hospital in the (Cheverly), a little clarification on medical necessity guidelines. Since, a good number of our patients have commercial insurance, will we follow into (inaudible), is into (inaudible) but with other situations, other hospitals and (one other) criteria which sort of governs where the patient

should be placed within the hospital – recognizing that this applies primarily to those patients in the two midnight rule.

Are we saying that severity of illness guidelines are not considered in the Medicare population, but, only the services that are being provided? That the Medicare (inaudible) patient between an ICU admission versus a (inaudible) dislocation?

Melanie Combs-Dyer: Dr. Handrigan, would you like to start this one and then I'll chime in?

Michael Handrigan: Yes, great. So, the use of guidelines such as (Milliman), are very practical for the complex decision about whether the patient requires care at the hospital or not. So, you are free to use those as you always have, in determining whether the patient can safely be discharged and treated outside the hospital, or whether you need to maintain the patient at the hospital for care.

And, once you've made that determination, then you have to decide how long that care will be required and if, in your judgment, that will be required for more than two midnights – then, that would be appropriately billed as an inpatient service.

So, we're – we're not – I'm sorry, go ahead Mel.

Melanie Combs-Dyer: No, go ahead, finish your thought.

Michael Handrigan: Right, we're not stating in any way that you should abandon those guidelines in helping to (inaudible) to treat your patients. But, with respect to the last part of your question about where in the hospital are you providing the services? The two midnight rule is intended to be agnostic to where you provide those services or the intensity of those services.

Once you determine that medically necessary care is required in the hospital setting, and hospital care is required, if it's more than two midnights, that

should be billed as an inpatient and less than two midnights should be billed as an outpatient.

Melanie Combs-Dyer: And, this is Melanie Combs-Dyer again from CMS, I just want to add onto that. With respect to your general point about, you know, this is – it's hard sometimes for hospitals to deal with a – situations where the Medicare rules are different than the coverage and billing rules for a commercial payer. We recognize that but we know that that happens in all kinds of cases.

Maybe the commercial insurance has a prior authorization requirement and Medicare doesn't. Or maybe, Medicare one set of rules for particular situation that a commercial payer doesn't.

We recognize that it's – it's difficult to run a hospital but this is really no different than any other situation where our rules are perhaps different from other payer's rules.

Doctor (Weis) – was that, was that responsive to your question or did you have a follow-up?

(EG): This is (EG) to follow-up on that. We still are going to follow the observation guidelines for InterQual and (Milliaman)?

Michael Handrigan: So, as I said, you're free to follow guidelines that help you determine the proper services that you provide your patients. We're not trying to interrupt that in any way. What we are trying to clarify is once you've made the determination that care is required at the hospital, you then should determine how long that care will be required.

Now, and if it's in the determination of the admitting practitioner – that that care will be necessary for less than two midnights, that would be appropriately be billed as a part B payment as an outpatient. And, if it is determined by the admitting provider that that care will be required for more than two midnights, then that would be appropriately be billed under part A as a DRG. OK.

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

Operator: OK, your next question comes from Eileen Sullivan, from Bayonne Medical Center, your line is open.

Eileen Sullivan: Hi, can you speak to or clarify what the discharge plan requirement is by the physician for certification. Our physicians are really confused – do they have to include, I mean, very often, we don't know the discharge plan until – well into the hospitalization.

So, can you clearly specify what is required of the physician? Can the case manager document the discharge plan? Or does the physician actually have to say discharge plan, acute rehab. You know, one or two days into the admission.

Dan Schroeder: Hi, this is Dan Schroeder again. We – we will – there – we're adding a little bit of additional guidance to this based on what we've released in – on the September 5th guidance.

In short, the plans proposed for hospital care really relate to the already existing conditions of participation that hospitals agree to. There isn't really an additional requirement based on the two midnight policy or anything like that.

But, as part of the certification, there are requirements that the physician certifying plans for post-hospital care for appropriate as provided under 42 CFR 484.13. As far as, if the physician is required to specifically certify proposed hospital plan – I don't believe we've said that.

As part of the certification requirement, the physician is certifying the entire hospital stay. But, various different components can be developed some of like – a case manager. I believe that's appropriate.

Eileen Sullivan: So, we're OK. As long as the physician addresses what the discharge plan was in his discharge note.

Dan Schroeder: I believe that that about sounds fine to me.

Michael Handrigan: And, in general the certification is going to rely on information that's in the medical record as part of the new routine and normal medical documentation practices and then the physician signs the medical record.

Eileen Sullivan: OK, thank you.

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

Operator: OK, your next question comes from Janine Grooms from American Academy of Medicine, your line is open.

Janine Grooms: Hi, this is Janine, can you hear me OK?

Melanie Combs-Dyer: Yes, Janine, go ahead with your question.

Janine Grooms: So, yes – so, I received the question from one of our physician members. And he's – here's his question. He wants to know that reimbursements for (inaudible), is that not governed by the DRG bundle payment rule?

Marc Hartstein: No, it's not. So, DRG is (diagnosis) related groups refer this to the inpatient (inaudible) payment under the prospective payment system.

Janine Grooms: (Can you) repeat that again? I'm sorry, somebody was talking. I'm sorry to interrupt you. Can you repeat that?

Marc Hartstein: Yes, this is Marc Hartstein; I'm the director of the hospital in ambulatory policy group. If the patient has been admitted then payment is under the inpatient perspective payment system which is based on diagnosis related groups.

If the patient is treated as an outpatient then payment is under the outpatient prospective payment system and payment is based on APCs or ambulatory

patient classification. So, they're very different payment based on the whether the patient is treated as an outpatient or admitted as an inpatient.

Janine Grooms: OK, great. That's helpful. (Inaudible)

Melanie Combs-Dyer: Janine was that – was that helpful? OK, great. Operator we're ready for our next question.

Operator: Your next question comes from Linda Hogal, from organization unknown, please go ahead.

Linda Hogal: Hi, this is Linda from TriHealth in Cincinnati, can you hear me?

Melanie Combs-Dyer: Yes, Linda go ahead with your question.

Linda Hogal: OK, thank you. Does the two midnight rule also require that a physician write specifically the order to place in observation status and sign that order before the patient is discharged from observation?

(Ann Marshall): This is (Ann Marshall) in the division of outpatient care. Observation services are an outpatient service and do not require certification. And we're not that – we're not...

Linda Hogal: No, I know the...

(Ann Marshall): The two midnight rule – the certification requirements in the two midnight rule are not – they are not for outpatient services and payment.

Marc Hartstein: Yes, if I – I think; if I'm understanding your question, any service that the physician orders has to be documented. So, if the physician orders – in order for the hospital to bill for observation, what generally observation is packaged and not paid separately – but it is paid separately if it's over a certain amount of time.

But, observation like any other service in X-ray or getting other diagnostic or therapeutic service that's provided in the outpatient department, there would have to be a physician order for that service and documentation to support that the service was ordered by a physician or other medical practitioner responsible for the patient's care.

I think what we've really been focused on with the two midnight rule is whether the patient is treated inpatient or outpatient – in order to be treated inpatient as a condition, opinion there needs to be an order for inpatient admission.

(Linda Hogal): OK, but my question was not related to actually the certification, it was specific to the order and I think you answered that by saying – if the physician wants the patient placed in observation, he or she must state that in their order.

Marc Hartstein: Correct. So – so, observation is a set of services it's not a status.

(Linda Hogal): Yes.

Marc Hartstein: The patient, by default, when they come to the hospital is an outpatient until there's an inpatient admission order that's (inaudible) any services that are provided in the outpatient in order to support the provision and billing of those services – there needs to be an order for that service.

So, observation is a service. And then it needs to be in – a physician or other practitioner order to support that that service was performed pursuant to the directive of a practitioner like a physician.

(Linda Hogal): OK, but on the part A payment, the requirements state that the physician must authenticate their order before discharge for us to bill for part A. Is there a statement that says that we must get authentication of the observation order before we can bill for the observation services?

Marc Hartstein: No, it – and this is where we’re getting I think probably into – what some of the nomenclature means. There’s no requirement for a certification. But, any medical service that you provide...

(Linda Hogal): I know that.

Marc Hartstein: Yes, any medical service – and there’s no need for authentication. Whoever orders – and this has really has nothing to do with the two midnight rule or any of the issues that we undertook rule making on. It really has to do with if a service is furnished by a physician or by any other practitioner or a hospital – there needs to be documentation to support that the ordering of that service – observation would be no different.

(Linda Hogal): OK, what I was referring to was the actual written order for observation – is it required that that be authenticated before we send a bill.

Melanie Combs-Dyer: I think Linda at this point we’ll ask you to send any further questions that you have to our mailbox at (IPPS) – (ippsadmissions@cms.hhs.gov) and because of the lateness of the hour, let me ask the operator to give us one last question. This will be our last question of the day.

Operator: OK, for your next question will come from (David Vanderberg) from (St. Joe’s) Ann Arbor, your line is open.

(David Vanderberg): Hi, thank you very much for sneaking me in. I have a two-part question and I apologize if it’s already been asked or answered earlier, but I didn’t hear it. If a patient is admitted to the hospital and the admitting physician certifies that the patient should be – is inpatient and is expected to be here more than two midnights.

And the following day, the patients, upon re-evaluation, it appears that the patient is ready to go home.

I – my understanding is we have a choice of either submitting an inpatient bill for that patient or reconsidering and having the order change to observation

with agreement between attending physician and the utilization review physician. And then, submitting a condition 44.

Is that correct?

Melanie Combs-Dyer: Yes, it's correct, that's correct. You can use condition code 44 to change the patient status to outpatient under the usual CC 44, where prior to discharge, if you believe if that is the best medical course.

Michael Handrigan: However, it's not...

This is Dr. Handrigan – and let me – let me just jump in and add. The expectation of two midnights is based on a time that the patient is admitted. And if it's a reasonable expectation and the patient is admitted pursuant to a proper order, and should the patient improve on the second day and you determined that you can safely send that patient home. The expectation from admissions still stands.

And, you're free to bill that patient as an inpatient – yet our contractors will accept that as a DRG payment.

(Jen Dupee): This is Jen Dupee from CMS; I just want to jump in. I just want to emphasize that those instances that you're describing, we expect to be relatively infrequent. We believe in most of those cases, it would have been a situation where the physician wasn't sure whether the beneficiary would stay for one or two days.

In those instances, we do encourage to keep the beneficiary on observation or as an outpatient until it is clear whether the beneficiary will require a second midnight of hospital services.

At that time, an inpatient order can be written and the inpatient admissions will begin.

So, the physician, of course, can still take into account, the time that the beneficiary spent as an outpatient when determining whether the two midnight benchmark was met.

Melanie Combs-Dyer:(David), you said you had a two part question – (David) you want to go on with the second part of your question?

(David Vanderberg): Please, and that leads right into what was being – was being discussed. So if on the other hand was admitted into observation and stayed the first midnight. And, the second day, the patient – it was deemed that the patient required continued hospital care, and needed to stay a second midnight to complete that care. And the physician, based on that, writes an inpatient order, the patient is discharged the subsequent day. So, the patient was in the hospital for two days total but was an inpatient for one day. Would we expect that that case would be generally accepted for inpatient care? However, would it be – likely to be looked at by the contractors because it ultimately was a one day inpatient stay?

Melanie Combs-Dyer:Whether or not a claim is chosen for review by our contractors depends on the number of inpatient midnights that the patient spent in the hospital. If it is zero or one inpatient night – inpatient midnight in the hospital, then the contractor may select that claim for the patient's status review.

If the number of inpatient midnights the patient spends in the hospital is two or more then our contractors cannot select that claim for patient status review unless there's the situation of (gaming) or appearance of fraud or that sort of thing.

But, when it comes to actually reviewing a case and deciding whether or not to pay or deny, the contractor is looking at the total midnights of hospital level care. And, in that case, they are counting from the time that the patient arrives at the hospital after triage or any wait time that comes after triage – whatever care comes after that, including the care that would have been provided pursuant to the observation order – all of that time would be counted. And then, the situation you described, I believe you described two total midnights,

and so, in that case, the contractor would approve the inpatient Part A claim for payment.

Jen or Jen did you want to add anything to that or did I capture everything?

Jen Dupee: Yes, I was just going to add that this is exactly the type of situation that new (NUBC) code we talked about earlier does address. The occurrence span code 72 will now allow providers to voluntarily capture – if the total time at the hospitals for two or more midnights.

And so, that can be taken into account by our medical review contractors during review, but of course, would also need to be supported by the medical records.

Melanie Combs-Dyer: And that's to be our last question so, Jill I will turn it back over to you.

Jill Darling: All right, well thank you everyone who asked a question and everyone for joining the call today. If anyone, Melanie do you have any closing remarks?

Melanie Combs-Dyer: No, just to continue to watch our website and know that we are looking forward to the training for the inpatient hospitals that will begin on January the 14th, I believe the details – if they're not already on our website will be up soon.

And, we, again, look forward to talking to everyone at that time.

Jill Darling: Thank you everyone, have a wonderful day.

Operator: Thank you everyone, this concludes today's conference call, you may now disconnect.

END