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

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On August 2, 2013 the Centers for Medicare & Medicaid Services (CMS) issued Final Rule CMS-1599-F, which modifies and clarifies CMS's longstanding policy on how Medicare *review* contractors review inpatient hospital admissions for payment purposes. *On November 4, 2013, CMS released a six-month prepayment "Probe & Educate" medical review strategy for inpatient hospitals, aimed at:*

- *Identifying claims non-compliant with CMS-1599-F;*
- *Issuing denials for improper claims for payment; and*
- *Educating providers about CMS-1599-F.*

On January 31, 2014, CMS extended the "Probe & Educate" period, permitting Medicare Administrative Contractors (MACs) to review and provide education for claims with dates of service through September 30, 2014.

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

MACs *will* apply CMS-1599-F to the "Probe and Educate" patient status reviews they conduct for claims submitted by acute care inpatient hospital facilities, Long Term Care Hospitals (LTCHs), and Inpatient Psychiatric Facilities (IPFs) for dates of admission on or after October 1, 2013 but before *September 30*, 2014. MACs will NOT apply these instructions to admissions at *Critical Access Hospitals (CAHs) or* Inpatient Rehabilitation Facilities (IRFs). *CAHs are excluded from the probe and educate review process, while* IRFs are specifically excluded from the 2-midnight inpatient admission and medical review guidelines per CMS-1599-F.

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

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

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

Effective for admissions on or after October 1, 2013, CMS directed MACs to conduct probe reviews and deny claims found to be out of compliance with CMS-1599-F. CMS directed MACs to select a sample of 10 claims for prepayment review for most hospitals (25 claims for large hospitals). Inpatient stays spanning 0-1 midnights after the beneficiary is formally admitted as an inpatient are not subject to the presumption and may be selected for review. However, if total time in the hospital receiving medically necessary care (including pre-admission outpatient time in the hospital *following initial triaging vital signs and wait times)* spans 2 or more midnights, the 2-midnight benchmark for inpatient admission will be met and payment supported upon medical review. *MACs will review all other medical records to determine if the physician had a reasonable expectation that the beneficiary would require hospital care for 2 or more midnights, absent 2-midnight rule exception (i.e. an inpatient only procedure or rare & unusual circumstance) supporting the inpatient admission and Part A payment.*

Based on the results of these initial reviews, MACs will conduct educational outreach efforts *on a provider-specific basis.* CMS will instruct MACs to deny each non-compliant claim and to outline the reasons for denial in a letter to the hospital. MACs *will* offer individualized phone calls to those providers with either moderate/significant or major concerns. During such calls, the MAC will discuss the reasons for denials, provide pertinent education and reference materials, and answer questions.

In addition to these educational outreach efforts, for providers identified as having moderate/significant concerns or major concerns, the MACs will conduct additional probe reviews on claims with dates of admission *through September* 2014. The size of these probe reviews will be 10 additional claims (25 for large hospitals) for those providers identified as having moderate to significant concerns, and 100 (250 for large hospitals) for those providers identified as having major concerns. *Following the completion of a provider's probe and educate process, the MACs may conduct a limited number of additional reviews if provider billing trends or variances are indicative of abuse, gaming, or systematic delays in the submission of claims for the purpose of avoiding the MAC prepayment probe audits during the probe and educate period.* The MACs will submit periodic reports to CMS for purposes of tracking the frequency and types of errors seen during these probe reviews.

MAC Actions Following Patient Status Probe Reviews

	Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October *2013 – September* 2014)		
	No or Minor Concerns	**Moderate to Significant Concerns**	**Major Concerns**
10 claim sample	0-1*	2-6*	7 or more*
25 claim sample	0-2*	3-13*	14 or more*
Action	For each provider with no or minor concerns, CMS will direct the MAC to: 1. Deny non-compliant claims 2. Send summary letter to providers indicating: • What claims were denied and the reason for the denials • That no more reviews will be conducted under the Probe & Educate process. • That the provider will be subjected to the normal data analysis and review process 3. **Await further instruction from CMS**	For each provider with moderate to significant concerns, CMS will direct the MAC to : 1. Deny non-compliant claims 2. Send detailed review results letters explaining each denial 3. Send summary letter that: • Offers the provider a **1:1 phone call** to discuss • Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims 4. **Repeat Probe & Educate of 10 or 25 claims with dates of admission *October 2013 – September* 2014**	For each provider with major concerns, CMS will direct the MAC to : 1. Deny non-compliant claims 2. Send detailed review results letters explaining each denial 3. Send summary letter that: • Offers the provider a **1:1 phone call** to discuss • Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims 4. **Repeat Probe & Educate of 10 or 25 claims with dates of admission *October 2013 – September* 2014** 5. **If problem continues, Repeat Probe & Educate with increased claim volume of 100 – 250 claims**

* *Following the completion of a provider's probe and educate process, the MACs may conduct a limited number of additional reviews if provider billing trends or variances are indicative of abuse, gaming, or systematic delays in the submission of claims for the purpose of avoiding the MAC prepayment probe audits during the probe and educate period.*