2015 Inpatient Prospective Payment Services (IPPS) and Insights on Best Practices

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Agenda

• 2014/2015 IPPS Final Rule
• 2015 proposed OPPS
• Transmittal 534/540/541
• Appeals Settlement offer
• Rebilling
• Understand best practices for operating under 2015 IPPS

Final IPPS 2015
AKA CMS 1607-F (Published in Federal Register on August 22, 2014)

• **Calculation of payments.** The rule includes a 2.9 percent market basket update, offset by a negative 0.5 percent productivity adjustment and a negative 0.2 percent market basket cut as mandated by the Patient Protection and Affordable Care Act, and a negative 0.8 percent decrease in accordance with the American Taxpayer Relief Act of 2012.

• **Hospital readmission reduction program.** CMS has increased the maximum penalty from 2 percent to 3 percent.

• **Hospital-acquired condition reduction program.** Hospitals in the lowest quartile, will have their Medicare pay decreased by 1 percent.

• **Price transparency.** Under the final rule, hospitals are required to make public a list of their standard charges or provide their policies for allowing the public to view a list of those charges in response to an inquiry.

• **Hospital value-based purchasing program.** For 2015, CMS is increasing
the applicable percent reduction, the portion of Medicare payments available to fund the value-based incentive payments under the program, to 1.5 percent of Medicare reimbursements, resulting in about $1.4 billion in value-based incentives.

- **Medicare disproportionate share hospitals payments.** As part of the PPACA, Medicare DSH payments will be reduced 75 percent by 2019, or $49.9 billion. The final rule cuts overall Medicare DSH payments by 1.3 percent in fiscal year 2015, compared with fiscal year 2014.

**Final IPPS 2015**

**Two Midnight rule remains intact**

Little to no changes
Pages 50146 – 50148 pertain to the 2 midnight rule
Several comments regarding defining short or low cost inpatient hospital stays
No additional clinical exceptions added. However, still taking feedback: email to:
SuggestedExceptions@cms.hhs.gov

Although the FY 2015 IPPS/LTCH PPS proposed rule did not include any proposed regulatory changes relating to the 2-midnight benchmark, we nonetheless received a number of public comments regarding the current regulation.
CAH: finalize a policy that a CAH is required to complete all physician certification requirements no later than 1 day before the date on which the claim for the inpatient service is submitted (pg. 50165)
The 2015 Outpatient Prospective Payment System (OPPS) Final Rule was released on November 10, 2014 Comments found on www.regulations.gov

Highlights include:
• Refinements to Comprehensive APC Policy
• Significant Packaging of Ancillary Services
• Changes to Inpatient Certification Requirements

The Final Rule and Elements of Certification
Documentation is Key:
• There is an expectation that the elements of certification (i.e. the reason for hospitalization, the estimated time the patient will need to remain in the hospital, and the plan of post-hospital care), generally can be satisfied by elements routinely found in a patient’s medical record, such as progress notes (CMS-1613-P at 41057).

• “[I]n most cases, the admission order, medical record, and progress notes will contain sufficient information to support the medical necessity of an inpatient admission without a separate requirement of an additional, formal, physician certification” (CMS-1613-P at 41057).

• “[W]e believe that evidence of additional review and documentation by a treating physician beyond the admission order is necessary to substantiate the
continued medical necessity of long or costly inpatient stays” (CMS-1613-P at 41057).

Changes to Physician Certification Requirements

• A separately signed Physician Certification statement would no longer be required to be submitted with each and every Inpatient Hospital claim.
  – Only required for long-stay (20 days or more) and outlier cases

• The Inpatient Admission Order will continue to be required as a condition of payment, but is no longer considered an element of certification.

Changes to Physician Certification Requirements

REMINDER, the 2015 OPPS Proposed Rules if finalized as written, would not take effect, until the implementation date of January 1, 2015.

Until that time, providers should continue to adhere to current guidelines and regulations pertaining to the Two-Midnight Rule and Physician Certification Requirements

“Doc Fix” – HR 4302 Extension of the Probe & Educate
CMS has extended the Inpatient Hospital Prepayment Review “Probe & Educate” review process through March 2015. This means that:

- Medicare Administrative Contractors (MACs) will continue to select claims for review and deny claims found not in compliance with CMS-1599-F (commonly known as the “2-Midnight Rule”).

- MACs will continue to hold educational sessions with hospitals as described below in “Selecting Hospitals for Review” through March, 2015.

- Generally, Recovery Auditors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after October 1, 2013 through March 2015.

**Probe & Educate Process**

**Probe & Educate Status Update**

As of February 7, 2014:

As of February 24, 2014:

- CMS is requesting that the Medicare Administrative Contractors (MACs) re-review all claim denials under the Probe & Educate process to ensure the claim decision and subsequent
education is consistent with the most recent clarifications.

Examples
• Example 3 - **Short stays for medical conditions**: The beneficiary presented to the ED with recent onset of dizziness and denied any additional complaints. The beneficiary reported a recent adjustment to his blood pressure medication. The physician’s notes stated that the beneficiary was stable and that his blood pressure medication was to be held and dosage adjusted. The notes also indicated that the physician intended to observe the beneficiary overnight. The beneficiary was discharged the next day. The hospital submitted a claim for a 1-day inpatient stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a 2-midnight stay.

Examples
• Example 4 - **Physician attestation statements without supporting medical record documentation**: The physician’s order contained a checkbox with
pre-printed text stating “The beneficiary is expected to require 2 or more midnights of hospital care.” The physician’s plan of care, however, stated that the beneficiary was to have diagnostics performed post-operatively, with a plan to discharge in the morning if stable. The beneficiary was discharged the following day as planned, after a 1-midnight stay. Upon review of the claim, the MAC denied Medicare Part A payment because the medical record failed to support an expectation of a 2-midnight stay when the order was written.

• CMS reminds providers that attestation statements indicating the beneficiary’s hospital stay is “expected to span 2 or more midnights” are not required under the inpatient admissions policy, nor are they adequate by themselves to support the expectation of a 2-midnight stay. Rather, the expectation must be supported by the entirety of the medical record.

Transmittal 541, CR 8802

• Earlier versions of Transmittal 541 have previously been introduced as Transmittals 505, 534 and 540; however those versions were rescinded.
• Issued on September 12, 2014, but Implemented and Effective on September 8, 2014 (date of service)
• Provided the MAC, Recovery Auditor, and ZPIC the discretion to deny other related claims submitted before or after the claim in question.
• The Recovery Auditors will be allowed to also auto
deny if approved by the New Issues Review Board.

- **CHANGE FROM Transmittal 534** - Allowed as one approved example: now **only a surgeon’s claim** could be automatically denied, but **NOT recoded** to an appropriate outpatient evaluation and management service following the denial of a hospital’s inpatient admission.

- **CHANGE FROM Transmittal 540** – Paragraph in Policy section was changed to be consistent with paragraph in Manual, with respect to the surgeon’s claim as outlined above.


### The CMS Administrative Agreement

#### Appeals Backlog

- The average processing time for appeals decided in fiscal year 2014 is **398.1 days**.
- For comparison, the average processing time for a case in 2009 was 94.9 days.
- There are currently 480,000 appeals awaiting assignment to an ALJ.
- In early 2014, OMHA received 15,000 appeal requests per week, up from 1250 appeals per week 2 years ago.
- OMHA received a total of 320,000 claims in FY 2012, and over 600,000 claims in FY 2013.
- OMHA is currently anticipating the backlog to grow to 1,000,000 appeals by end of FY 2014.
- OMHA projects that its FY 2015 caseload will increase
to approximately 850,000 total claims.

**Processing Backlogs**

- **15 weeks** from receipt to open mail (though mail is stamped received as of the date it was physically received, not the date it is opened)
- **20-24 weeks** from the date mail is received until it is entered into OMHA’s database (this is the point at which the case becomes searchable in response to inquiries)
- Up to **28 months** from receipt until case is assigned to a judge
- **6 months** for a hearing date after a case is assigned to a judge

Source:
http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html

**OMHA Statistical Sampling**

**In July, 2014, OMHA announced pilot programs to address the high-volume backlog at the Administrative Law Judge level of appeal.**
What is OMHA Statistical Sampling?:

• A statistical expert develops an appropriate sampling methodology in accordance with Medicare guidelines

• Sample units are then randomly selected from a universe of claims based on that methodology

• An Administrative Law Judge then reviews the sample units and makes findings and a decision on those sample
units in a single appeal

• The results of the sample are then extrapolated to the entire universe


OMHA Statistical Sampling
To be eligible for OMHA statistical sampling:

• A request for hearing must appeal a Medicare Qualified Independent Contractor (QIC) reconsideration decision.
• The appellant must be a single Medicare provider or supplier.
• All jurisdictional requirements for a hearing before an Administrative Law Judge must be met for the request
for hearing and all appealed claims.
• The claims must be currently assigned to one or more Administrative Law Judges or have been filed during the time period currently being assigned by OMHA Central Operations – at this time, that includes appeals that were filed between April 1, 2013, and June 30, 2013.

**To be eligible for OMHA statistical sampling:**

• No hearing on the claim has been scheduled or conducted
• There must be a minimum of 250 claims and all claims must fall into only one of the following categories:
  – Pre-payment claim denials;
  – Post-payment (overpayment) non-Recovery Audit Contractor (RAC) claim denials; or
  – Post-payment (overpayment) RAC claim denials from one RAC.


**Administrative Agreement**

• CMS is offering an Administrative Agreement (Settlement) to:
  – Any acute care hospital
    • Those paid via Prospective Payment System (PPS), Periodic Interim Payments (PIP), and
Maryland waiver
– Critical access hospital (CAH)
– Willing to resolve their pending appeals (or waive their right to request an appeal)
– In exchange for timely partial payment (68% of the net payable amount).

Source:

Eligible Claims
Claims meeting all of the criteria are eligible and ALL eligible claims must be included in the request for Administrative Agreement.

Cannot Pick & Choose Claims

Eligible claims must be included in a spreadsheet that the hospital is required to complete and submitted along with the Administrative Agreement request.

Eligible Claims (con’t)

• The claim was denied by any entity that
conducted a review on behalf of CMS;

- The claim was not for items or services furnished to a Medicare Part C enrollee;

- The claim was denied based upon a Patient Status Determination - The claim was denied based on an inappropriate setting determination, that is, on the basis that the service might have been reasonable and necessary, but treatment on an inpatient basis was not;

- The first day of the admission was before October 1, 2013;

**Eligible Claims (con’t)**

- The Hospital timely appealed the denial;

- As of the date of an executed Agreement submitted to CMS by the Hospital:
  - The appeal decision was still pending at the MAC, QIC, ALJ, or DAB levels of review, or
  - The Hospital had not yet exhausted its appeal rights at the MAC, QIC, ALJ, or DAB level; and

- The Hospital did not receive payment for the service as a Part B claim (re-bill).
Payment by CMS

CMS agrees to pay the Hospital sixty-eight (68) percent ("the percentage") of the net paid amount of each denied inpatient claim.

- "Net paid amount" means the payment on the original inpatient claim net paid amount;
  - Net Paid amount excludes the out-of-pocket obligations that are included in the "gross" or "allowable" amounts.

- This payment will be made in one payment per hospital provider number, or per owner or operator of multiple settling hospitals.

- CMS will refund to the Hospital all
interest on any claim included in any appeal covered by the Agreement that CMS has collected from the Hospital as of the effective date of the Agreement

- If CMS fails to make payment within the allotted sixty (60) days, CMS will pay interest to the Hospital for the period beginning on day sixty-one (61) through the date of payment.
- The interest rate shall be the Current Value of Funds Rate ("CVFR") as promulgated by the United States Department of the Treasury.

Source:

Miscellaneous Provisions

• If the Hospital has not fully repaid the originally denied amount on a claim included in an appeal
listed on the spreadsheet of eligible claims, the Hospital will receive for that claim payment the percentage value applied less the outstanding overpayment balance.

• If the Hospital has not yet repaid any of the originally denied amounts on a claim included in an appeal, or where the amount retained by the
Hospital exceeds sixty-eight (68) percent of the net paid amount, the Hospital will owe CMS a refund for that claim.

–CMS will calculate the refund amount as the difference between the retained amount and sixty-eight (68) percent of the net paid amount.

–Any refund owed CMS
will be subtracted from the total payment due under this Agreement or from future Medicare payments to the Hospital.

Source:

Miscellaneous Provisions

- The Hospital agrees it will not commence any further
appeals or actions of any kind challenging the Medicare contractor’s determination(s) regarding the claims included in the appeals
– The Hospital will not attempt to rebill any of those services under Part B.
• CMS retains the right to recoup any duplicate or incorrect payments made for claims that were, but should not have been, included under this Agreement
  – Payments that may have been made in the appeals process or secondary to Part B billing inadvertently included among the payment made under this Agreement.
• The Agreement does not include a release of liability of any claims the United States may have under the False Claims Act, (31 U.S.C. section 3729 et seq.), the Civil Monetary Penalties Law, (42 U.S.C. section 1320a-7a), or the common law theories of payment by mistake, unjust enrichment, or fraud.

Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/MedicalReview/Downloads/AdministrativeAgreement.pdf

CMS Settlement Process
Basic Settlement Process:
• Decision must be made and process started Oct 31, 2014
• Provider submits eligible claims spreadsheet
• CMS reviews and provides feedback allowing provider time to abandon/proceed with settlement
• Medicare signs initial Administrative Agreement and
pays provider for those claims agreed upon

- A repeat of the process occurs with respect to any discrepancies concerning the eligibility of claims
- CMS employs a final reconciliation process and makes additional adjustments as warranted
- Continue to check the CMS website for updates…

Patient Deductible Responsibilities
The providers refund responsibility is as follows:

- If the Beneficiary co-insurance has been collected at the time the INITIAL administrative agreement is signed by the provider, no refund is required.
- If the Beneficiary co-insurance has not been collected at the time the INITIAL Administrative Agreement is signed by the provider, the provider must cease collections.
- If a Beneficiary repayment plan has been executed at the time the INITIAL Administrative Agreement is signed by the provider, the provider may continue to collect the co-insurance in accordance with the repayment plan.
Key Considerations
Every Hospital Should be Asking These Questions...

• Is my hospital an eligible facility?
• How do I determine which claims are eligible?
• How many eligible claims do I have?
• What is the total value of the eligible claims?
• What is the value of those claims if I rebill under Part B?
• What is the administrative burden to engage in the settlement?
• How long have my appeals been in the appeals process?
• What has been my appeals success rate?

Key Considerations
Every Hospital Should be Asking These Questions...

• What is my hospital’s financial situation with respect to the settlement?
• How much reserve did we assign to denied claims (i.e.,
was it more or less than 68%)

• What is the impact of denied days on the calculation of GME, IME, and DSH payments?
• What percent, if any, of the patient deductible has been paid?

Finally

• No right answer for every hospital
• Every hospital should evaluate the offer
• Expect some facilities will accept the offer and others will reject the offer

Rebilling

• If a case has a physician inpatient order, yet fails “expectation 2 midnight stay” or medical necessity:
  – If patient is still in the hospital, hospital may use Condition Code 44 to reclassify patient as in the past
  – If patient has been discharged, hospital may use Self Audit/Rebilling if within timely filing requirements
• Rebilling:
  – Submit provider-liable Part A claim
  – Submit an inpatient claim for payment under Part B and outpatient claim for Part B appropriate services
  – Status does not change – remains IP
– Beneficiary responsible for Part B copayments

**Rebilling Evolution**

**Does Rebilling Make Cents?**

- Where are you most likely to miss revenue in the UR process?

- Without *concurrent* reviews hospitals risk losing dollars *on observation/outpatient cases!*

- Consider:

  - **INPT DRG**
    - > CC44 with 8 hours obs (APC)
    - > CC 44 with less than 8 hours of obs (No APC)
      - > Post discharge rebill 12x
        » > Claimed denied after 1 year

**Best Practices to Comply With Current IPPS**

**Conditions of Participations Have Not Changed**

**Conditions of Participations (CoPs) must be followed**

- “We did not propose and are not finalizing a policy that would allow hospitals to bill Part B following an inpatient reasonable and necessary self-audit determination that does not conform to the requirements for utilization review under the CoPs.”
• 482.30 (c)(1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of:
  – Admissions to the institution
  – Duration of stays
  – Professional services furnished, including drugs and biologicals

Concurrent UM Still Matters

• “Use of Condition Code 44 or Part B inpatient billing pursuant to hospital self-audit is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital’s existing policies and admission protocols.”

Components Required for an IP Claim

• Expectation/completion of a 2-midnight stay
  - UR review must ensure expectation of 2 midnights is “reasonable”
• Medical Necessity
  - UR review must establish hospital level of care is needed to care for the patient
• Physician certification/documentation signed by the physician prior to DC
  - Order, reason for inpatient services, expectation
and plan for post-hospital care

What is Medical Necessity?
• Is the physician's expectation of 2 midnights reasonable?
  – Achieved with criteria? PA evidence based determination? Other?
• Is hospital level of care needed to care for the patient?
  – Ensure no care for convenience, no delays in treatment/testing or custodial

Admission Review – Key Considerations
Initial review for expectation of Length of Stay (LOS)
• Physician documentation of an expectation of 2-midnight stay generally falls into three categories:
  – Supports expectation of 2-midnight stay
    • “I expect this patient to remain in the hospital for longer than…”
    • Expected LOS > 2 midnights (in document signed by physician)
  – No documentation/conflicting documentation
  – Clearly conflicts with or fails to support expectation of 2-midnight stay
    • Order – “Discharge in am” (when care has not already crossed at least one midnight)
    • Progress note – “anticipate d/c in am” (when care
has not already crossed at least one midnight)

Recommended Hospital Work Flow

Considerations Regarding the Time of UR Review

• Review at admission:
  – IP
    • 2+ midnight expectation AND medical necessity established AND physician certification complete
  – Observation/Outpatient
    • Expectation of <2 midnight stay and medical necessity established
  – NOTA
    • Review for documentation of care for convenience, a delay in treatment/testing or custodial care

• Review after 1+ midnight:
  – IP
    • 2+ midnights completed or expected AND medical necessity established AND physician certification complete
  – Observation status should be rare after 2 midnights
  – NOTA
    • Review for documentation of care for convenience, a delay in treatment/testing or custodial care

Summary

• “Get It Right” while the patient is in the hospital and as
early in the stay as possible
  - Implications for hospital, patient and physician

• Admission review – key considerations:
  - Order
  - Expectation
  - Medical Necessity
  - Documentation and Certification

• Rebill when appropriate
• While the time requirement has evolved, the science at the core of medical necessity remains the same

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2 Midnight Example 1