Z. New Rules: Hospital Patient Status, Observation, Part B Billing for Denied Inpatient Admissions

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Patient Status: Longstanding Confusion

- Patient Status = Inpatient or Outpatient
- Affects:
  - Payment Methodology (DRG vs. APC)
  - Beneficiary Financial Responsibility
  - SNF Coverage (3-day inpatient stay)
- Patient Status Criteria ≠ Coverage Criteria
- Observation is a type of outpatient service
OIG Concerns about Patient Status

- OIG Report: *Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040 (July 29, 2013)

- “Observation Stays,” “Long Outpatient Stays” and “Short Inpatient Stays”
  - Similar reasons for encounters, but
  - Generally higher reimbursement for inpatient stays
  - Adverse impact on beneficiary liability
  - Adverse impact of observation and long outpatient stays on SNF coverage (lack of 3-day inpatient stay)

Observation Services
(Outpatient)
Observation Services

- “[A] well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

- Observation services DO NOT include:
  - Provided for convenience of patient/family/physician
  - Provided when inpatient admission was appropriate
  - In preparation for, or monitoring related to, other services
  - Post-op monitoring during standard recovery period

- Now: Observation services should not extend into a second midnight.

New Conditions of Payment for Hospital Inpatient Services
Revised Inpatient Admission Requirements

[A]n individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital.

42 CFR § 412.3(a) (emphasis added).

New § 412.3 Conditions of Payment

- (a) “This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.”

- (b) “The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient’s hospital course, medical plan of care, and current condition.”
New § 412.3 Conditions of Payment

- (c) Physician order also constitutes a **required component** of physician certification of the medical necessity of hospital inpatient services under subpart B of Part 424

- (d) “Physician order must be furnished at or before the time of the inpatient admission.”

- (e) Physician Certification, including Admitting Order, **authenticated prior to discharge**

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Practical Problems Related to Orders

- Orders written by emergency department physicians who do not have admitting privileges.

- Verbal (*i.e.*, oral) orders must be authenticated prior to patient discharge.

- Care transitions create authentication/signing issues.
Physician Certification Requirements

- Physician must certify/recertify:
  - Services are provided in accordance with § 412.3;
  - Reasons for inpatient admission (need for care spanning 2-midnights, or inpatient only list procedure);
  - Estimated time patient needs to remain in the hospital;
  - Plans for posthospital care, if appropriate.
  - For CAH, 96 hour expectation

- Must be completed, signed, documented in the medical record prior to discharge.

- 42 CFR § 424.13, see also §§ 424.11, 424.14-.15

Administrative Certification Requirements

- Must be signed and in the medical record prior to discharge
- Must be signed by a physician who is responsible for the case or has knowledge of the case and has authority to sign
- Must be supported by the clinical documentation in the medical record
Two-Midnights Benchmark & Presumption

2-Midnights Benchmark (§ 412.3(e))

- Physician should admit to Inpatient when:
  - Inpatient Only List procedure, or
  - THE PHYSICIAN EXPECTS the patient to require a stay that crosses at least two midnights.
    - “consider all time after the initiation of care at the hospital in applying the benchmark.”
    - “in the hospital receiving medically necessary services” e.g., outpatient observation services
      - one midnight in OBS can be considered towards the new (2-midnights) benchmark
      - Triage and waiting time is not considered “treatment”
Documentation of Physician’s Expectation

• “The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event.”

• “The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.”

2-Midnights Presumption (§ 412.3(e))

• Based on time as an inpatient (not all time)

• “inpatient hospital claims with lengths of stay greater than 2 midnights after the formal admission following the order will be presumed generally appropriate for Part A payment”

• Stays of 1 midnight or less after the formal admission not presumed “reasonable and necessary,” but auditors are to “evaluate the claim pursuant to the 2 midnight benchmark”
Critical Determinants

- “It has been longstanding Medicare policy to require physicians to admit . . . as a hospital inpatient based on their expected length of stay”
  - Based on “…information available to the admitting practitioner at the time of the admission.”
- “The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care.”

No Presumption Regarding Medical Necessity

- “No presumptive weight shall be assigned to the physician’s order under § 412.3 or the physician’s certification . . . in determining the medical necessity of inpatient hospital services.”
- “A physician’s order or certification will be evaluated in the context of the evidence in the medical record.”
- 42 CFR § 412.46(b) (medical review requirements)
Two-Midnights Presumption is Rebuttable

- “If a hospital is found to be abusing the 2-midnight presumption for nonmedically necessary inpatient hospital admissions and payment (in other words, the hospital is systematically prolonging the provision of care to surpass the 2-midnight timeframe), CMS review contractors would disregard the 2-midnight presumption when conducting review of that hospital.”
- 78 Fed. Reg. at 50908 (emphasis added).
Exceptions When Physician Does Not Expect

- There may be rare and unusual cases where the physician did not expect a stay lasting 2 or more midnights but nonetheless believes inpatient admission was appropriate and documents such circumstance. The MACs are being instructed to deny these claims and to submit these records to CMS Central Office for further review. If CMS believes that such a stay warrants an inpatient admission, CMS will provide additional subregulatory instruction . . . (CMS FAQ)

What about Occurrence Code 72?

- National Uniform Billing Committee (NUBC) has refined Occurrence Span Code 72 to allow hospitals to indicate outpatient time considered in meeting 2-Midnight Benchmark for an admission.
  - “contiguous outpatient hospital services that preceded the inpatient admission”
- Such claims will remain subject to review and outside the 2-Midnights Presumption.
- Occurrence Code 72 is not mandatory, but might help clarify the basis for admissions that might otherwise appear suspect based on data review.
What about Widely-Used Screening Tools?

- Medicare Conditions of Participation mandate UR screening of admissions. 42 CFR § 482.30.
- Program Integrity Manual § 5.6.1 still mandates use of a screening tool.
  - Screening tools focus on intensity of services for inpatient admissions. Hospital staff need training on the limitations of screening criteria and the need for secondary analysis.
- Proprietary screening criteria were never Medicare-specific; the new Medicare rules are.

Handling Patient Status Errors:
Part B Billing for Inpatient Services
Handling Patient Status Errors

- Status errors can be corrected before discharge (may require Condition Code 44)
- Post-discharge determinations (or Final Rule)
  - CMS Ruling 1455–R or
  - 42 CFR § 414.5 (admissions on/after 10-1-2013)
    - Expanded Part B billing for inpatient services
    - 1-year re-billing deadline
- Strong incentive for:
  - Concurrent case management
  - Prompt post-discharge internal utilization review

Condition Code 44 Criteria (Not Changed)

- UR Committee decides inpatient criteria are not satisfied
- Change before discharge and before hospital billing
- Physician’s concurrence is documented in medical record

- Observation time starts when the physician orders observation and nursing begins to implement it.
  - Not retroactive; time on inpatient status does not count toward OPPS observation service claim
- “Reporting of individual HCPCS codes on an outpatient claim must be consistent with all instructions and CMS guidance, including . . . direct supervision required for hospital outpatient therapeutic services.”
Final Rule Replacing CMS Ruling 1455–R

- If Medicare Part A inpatient claim is **denied** as not “reasonable and necessary” **or**
- Hospital **UR discovers after discharge** that admit was not “reasonable and necessary”
  - Payment may be made under Part B for:
    - Any inpatient services **that would have been reasonable and necessary** if the beneficiary **had been treated as a hospital outpatient**
      - Excluding services required outpatient status (with certain exceptions (e.g., outpatient therapy services))
    - Any services furnished in the 3-day payment window


Requirements for Part B Billing (Final Rule)

- Beneficiary was enrolled in Part B
- Part A claim is withdrawn
- Part A appeal rights are waived
- Part A coinsurance/deductible must be refunded.
  - Beneficiaries are liable for Part B copayments
- Part B claims billed (**i.e., re-billed**) within the 1-year **claim filing deadline**, see 42 CFR § 424.44(a)
  - Part B payment will not be available for denials issued too late for timely rebilling
Ongoing Applicability CMS Ruling 1455–R

- Applies to Admissions prior to 10-1-2013 regardless of discharge date
- Rebilling deadline is 180 days from withdrawal, dismissal or determination/decision, PROVIDED:
  - The Ruling applied to the Part A claim denial or
  - The date of admission was before 10-1-2013, and is denied after 9-30-2013 on the grounds that “although the medical care was reasonable and necessary, the inpatient admission was not.”

To Rebill Part B or Fight Part A Recoupments?

- RAC/auditing activity increasingly problematic
- CMS moratorium on assignment of cases to ALJs due to enormous backlog (79 Fed. Reg. 393 (1-3-2014))
- Prepayment review/resolution process could have devastating economic consequences
- Can’t effectively correct errors - Gotta “get it right”
- Self-auditing critical
- You do the math
Practical Implications and Recommendations

Practical Implications of the Rules Changes

- CMS review will focus on technical order and certification requirements.
  - Content and authentication
  - Technical denials
- Medical necessity review will shift from need for hospital services to need for hospital services for specified period of time.
  - When could the patient be discharged?
Practical Patient Relations Implications

- Publicity surrounding the issues has led to patients demanding to be treated as inpatients.
  - Hospital staff must focus on patient education regarding the patient status analysis.

Attachments

- CMS Guidance: "Hospital Inpatient Admission Order and Certification" (September 5, 2013)
- CMS Guidance: “Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013” (Updated 11/27/2013)
- CMS FAQs: “2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013” (Updated 12/23/2013)
- Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013 (Updated 11/04/2013)