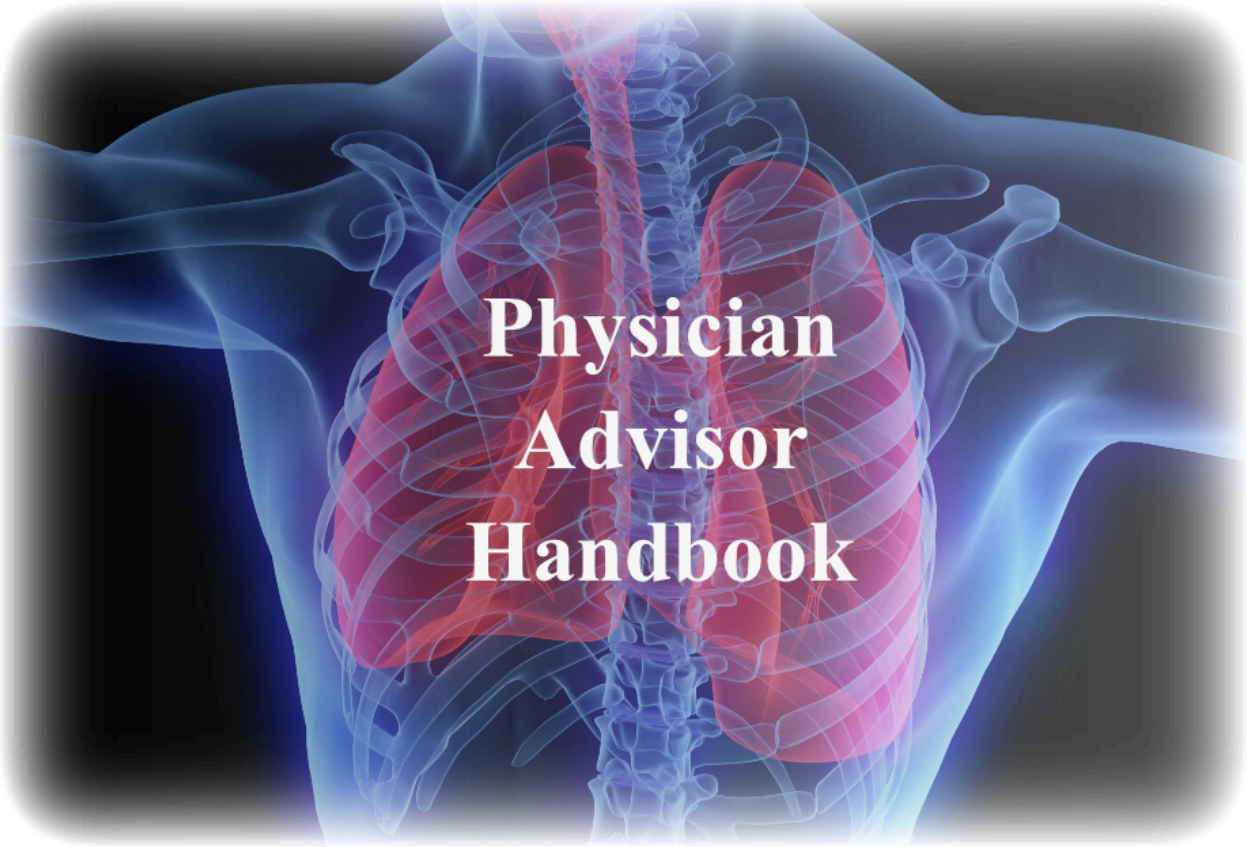


Produced by:
John Zelem, M.D.
President/Owner
Streamline Solutions Consulting, Inc.
john@streamlinesolutionsconsulting.com
www.streamlinesolutionsconsulting.com

Table of Contents

Physician Advisor Handbook

Disclaimer

It is the intent of this manual to recognize that there are basically two groups of payers:

1. Medicare FFS
2. Commercial

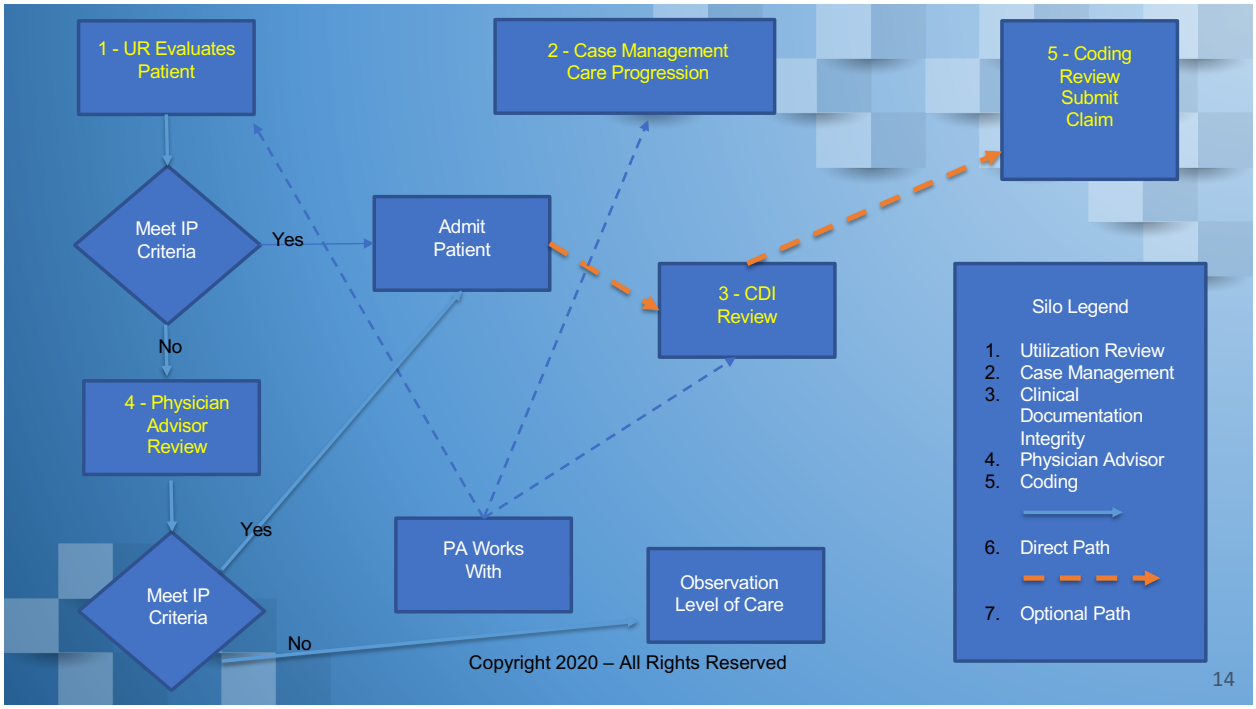
Medicare FFS is consistent as it is regulatory driven. Although it is a well-known fact that the regulations may be challenging to understand and operationalize, they are consistent across the country. There can be many interpretations from providers to auditors to government regulatory reviewers such as the Office of the Inspector General (OIG), Medicare Administrative Contractors (MAC), Department of Justice (DOJ), and many others but the regulations are the regulations.

The Commercial segment includes Medicare Advantage, Medicaid Advantage, and the commercial payers. What distinguishes this from FFS is that is it all contract driven and there are a plethora of contracts that exist in the healthcare system.

All that is discussed for this manual is using Medicare FFS as the process benchmark, realizing that the commercial payers may claim to follow Medicare rules but seldom do.

References will be provided when possible.

Clinical Revenue Cycle Components and Process



Importance of UR and Who Can Admit a Patient

Importance of Utilization Review

UM Committee is one of the only committee required by Medicare in the Conditions of Participation

Medicare does not say ALL cases have to be reviewed, but Medicare does say **ALL billing claims have to be accurate**

The best way to ensure claims are accurate is by using a **compliant and consistent UR process** that ensures appropriate review and documentation to support the claim

Streamline Solutions Consulting, Inc

15

Only A Doctor Can Legally Admit Patients To A Hospital

- **42 CFR 482.12(c)(2)**
  - "Patients are admitted to the hospital *only on a recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.*"
- **Medicare State Operations Manual**
  - "In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate."

Hence, the need for the UR Process!!!

Streamline Solutions Consulting, Inc

18
27

Medicare Conditions of Participation (CoP)
https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs

As a physician Advisor it is important to have an appreciation for the CoP, therefore the reference is above but the section on Utilization Review is most important.

---

§ 482.30 - Condition of participation: Utilization review.
The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

(a) *Applicability.* The provisions of this section apply except in either of the following circumstances:

(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.

(2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§ 456.50 through 456.245 of this chapter.

(b) *Standard: Composition of utilization review committee.* A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in § 482.12(c)(1).

(1) Except as specified in paragraphs (b) (2) and (3) of this section, the UR committee must be one of the following:

(i) A staff committee of the institution;

(ii) A group outside the institution -

(A) Established by the local medical society and some or all of the hospitals in the locality; or

(B) Established in a manner approved by CMS.

(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.

(3) The committee's or group's reviews may not be conducted by any individual who -

(i) Has a direct financial interest (for example, an ownership interest) in that hospital; or

(ii) Was professionally involved in the care of the patient whose case is being reviewed.

(c) *Standard: Scope and frequency of review.* (1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of -

(i) Admissions to the institution;

(ii) The duration of stays; and

(iii) Professional services furnished, including drugs and biologicals.

(2) Review of admissions may be performed before, at, or after hospital admission.

(3) Except as specified in paragraph (e) of this section, reviews may be conducted on a sample basis.

(4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in part 412 of this chapter must conduct review of duration of stays and review of professional services as follows:

(i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in § 412.80(a)(1)(i) of this chapter; and

(ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in § 412.80(a)(1)(ii) of this chapter.

(d) *Standard: Determination regarding admissions or continued stays.* (1) The determination that an admission or continued stay is not medically necessary -

(i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and

(ii) Must be made by at least two members of the UR committee in all other cases.

(2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.

(3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);

(e) *Standard: Extended stay review.* (1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, of each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may -

(i) Be the same for all cases; or

(ii) Differ for different classes of cases.

(2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the

extended length of stay exceeds the threshold criteria for the diagnosis, as described in § 412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.

(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.

(f) *Standard: Review of professional services.* The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.

Medicare Benefit Policy Manual

Chapter 1 – Inpatient
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/bp102c01.pdf

All PA's should be aware of the contents of this entire chapter, but the most important content is presented here:

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services *(see §10.2 below)*. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient
- The medical predictability of something adverse happening to the patient
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

  Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

  Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during **review** of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

Chapter 6 – Outpatient
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf

All PA's should be aware of the contents of this entire chapter, but the most important content is presented here:

20.2 - Outpatient Defined

(Rev. 82; Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital or CAH. Where a tissue sample, blood sample, or specimen is taken by personnel that are neither employed nor arranged for by the hospital and is sent to the hospital for performance of tests, the tests are not outpatient hospital services since the patient does not directly receive services from the hospital. See section 70.5 for coverage of laboratory services furnished to nonhospital patients by a hospital laboratory unless the patient is also a registered hospital outpatient receiving outpatient services from the hospital on the same day and the hospital is not a CAH or Maryland waiver hospital. Similarly, supplies provided by a hospital supply room for use by physicians in the treatment of private patients are not covered as an outpatient service since the patients receiving the supplies are not outpatients of the hospital. (See the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 1,"Inpatient Hospital Services," section 10, for the definition of "inpatient.")

Where the hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is considered an outpatient. For information on outpatient observation status, refer to section 20.6 of this chapter and to the Medicare Claims Processing Manual, Pub.100-04, chapter 4, section 290, "Outpatient Observation Services." For information on conditions when an inpatient admission may be changed to outpatient status, refer to the Medicare Claims Processing Manual, Pub.100-04, Chapter 1, "General Billing Requirements," section 50.3.

1. Outpatient hospital services furnished in the emergency room to a patient classified as "dead on arrival" are covered until pronouncement of death, if the hospital considers such

   patients as outpatients for record-keeping purposes and follows its usual outpatient billing practice for such services to all patients, both Medicare and non-Medicare. This coverage does not apply if the patient was pronounced dead prior to arrival at the hospital.

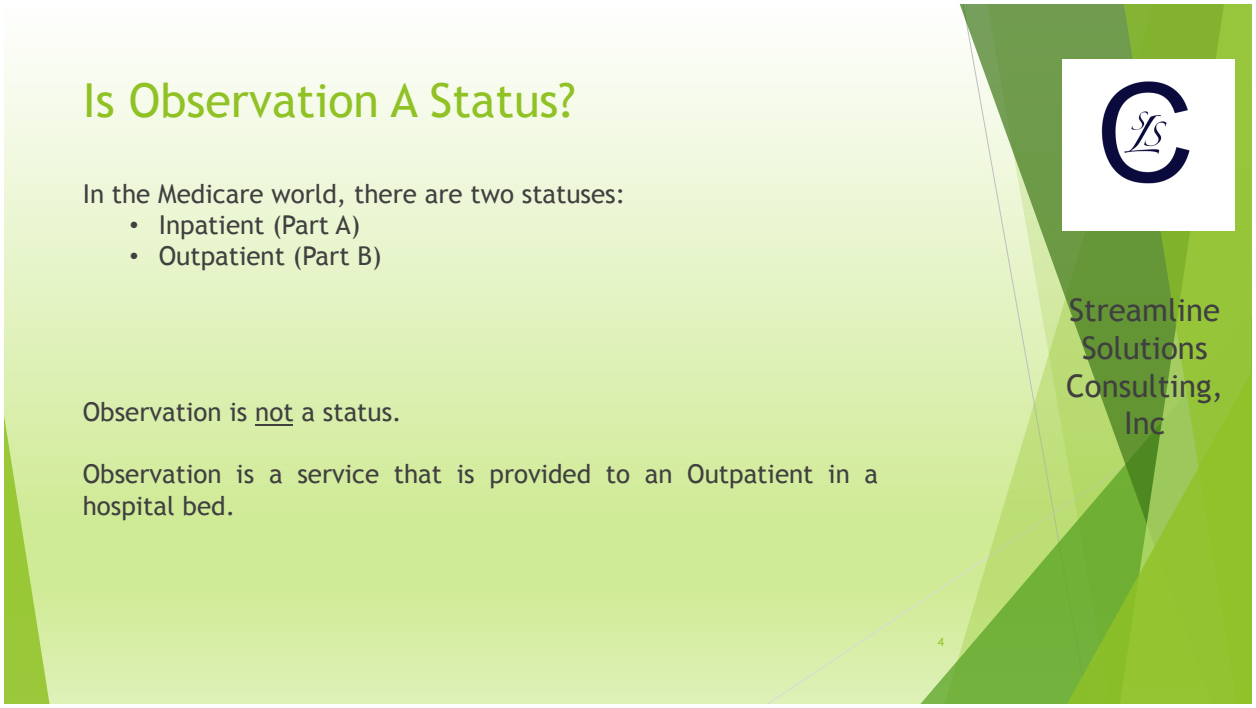
20.3 - Encounter Defined

(Rev. 101, Issued: 01-16-09, Effective: 01-01-09, Implementation: 01-05-09) Source: 42 CFR 410.2 and 482.12

A hospital outpatient "encounter" is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

The conditions of participation for hospitals under 42 CFR 482.12(c)(1)(i) through (c)(1)(vi) require that every Medicare patient is under the care of a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, a chiropractor, or a clinical psychologist; each practicing within the extent of the Act, the Code of Federal Regulations, and State law. Further, 42 CFR 482.12(c)(4) requires that a doctor of medicine or osteopathy must be responsible for the care of each Medicare patient with respect to any medical or psychiatric condition that is present on admission or develops during hospitalization and is not specifically within the scope of practice of one of the other practitioners listed in 42 CFR 482.12(c)(1)(i) through (c)(1)(vi).

Difference between IP and OP (OBS)



Definition of Observation

"Observation care is 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 are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. "

Medicare Benefit Policy Manual, Chap 6
20.6 - Outpatient Observation Services
(Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)

Streamline Solutions Consulting, Inc

5

Defining Observation Services

Coverage of Outpatient Observation Services

"When a physician orders that a patient be placed under observation, the patient's status is that of an outpatient. **The purpose of observation is to determine the need for further treatment or for inpatient admission.** Thus, a patient in observation may improve and be released, or be admitted as an inpatient."

Medicare Benefit Policy Manual, Chapter 6: **20.6 - Outpatient Observation Services**
(Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)

Streamline Solutions Consulting, Inc

6

Definition of Observation

"Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours."

Medicare Benefit Policy Manual, Chap 6
20.6 - Outpatient Observation Services
(Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)

Streamline Solutions Consulting, Inc

7

Documentation Requirements for Observation

In addition to meeting the documentation requirements for history, examination and medical decision making, documentation in the medical record shall include:

- Time in Observation status, including beginning and end times and dates;
- Documentation identifying the billing physician was present and personally performed the services;
- A written order identifying the referral to Observation by MD/NP and timely signed;
- Documentation progress notes and discharge notes were written by the billing physician.

https://med.noridianmedicare.com/web/jeb/topics/observation
Last updated by Noridian (MAC) Dec 5, 2017

Streamline Solutions Consulting, Inc

8

Effects on the hospital, the beneficiary, and the physicians

Why Getting Patient Status Correct is Important

- Inpatient side
  - Compliant billing – False Claims Act
  - Risk of audit
  - Loss of Revenue from penalties and denials
- Outpatient/Observation side
  - Increased LOS – artificially elevated
  - Increased Mortality rates - artificially elevated
  - SNF qualification – must be 3 qualified IP days
  - Financial burden – see below

Part A Deductible and Coinsurance Amounts for Calendar Years 2020 and 2021 by Type of Cost Sharing

	2020	2021
Inpatient hospital deductible per **benefit period**	$1,408	$1,484
Daily coinsurance for 61st-90th Day	$352	$371
Daily coinsurance for lifetime reserve days	$704	$742
Skilled Nursing Facility coinsurance	$176.00	$185.50

What Is A Benefit Period?

In Medicare Part A, which is hospital insurance, a benefit period begins the day you go into a hospital or skilled nursing facility and ends when you have been out for 60 days in a row. If you go back into the hospital after 60 days, then a new benefit period starts, and the deductible happens again. You would be responsible for paying two deductibles in this case – one for each benefit period – even if you're in the hospital both times for the same health problem.

Medicare Part B Income-Related Monthly Adjustment Amounts

Since 2007, a beneficiary's Part B monthly premium is based on his or her income. These income-related monthly adjustment amounts affect roughly 7 percent of people with Medicare Part B. The 2021 Part B total premiums for high-income beneficiaries are shown in the following table:

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $88,000	Less than or equal to $176,000	$0.00	$148.50
Greater than $88,000 and less than or equal to $111,000	Greater than $176,000 and less than or equal to $222,000	59.40	207.90
Greater than $111,000 and less than or equal to $138,000	Greater than $222,000 and less than or equal to $276,000	148.50	297.00
Greater than $138,000 and less than or equal to $165,000	Greater than $276,000 and less than or equal to $330,000	237.60	386.10
Greater than $165,000 and less than $500,000	Greater than $330,000 and less than $750,000	326.70	475.20
Greater than or equal to $500,000	Greater than or equal to $750,000	356.40	504.90

– $198 annual deductible
– 20% copay for all covered services
– 100% for all non-covered services

Discussion and practice on how to review cases:

- What was the initial order
- 2 MN Rule will be explained the next day
- Did it meet IP criteria
    - Discussion of criteria
- Why is it being sent for a second level review
- Review H&P with labs and tests done thus far
- Progress notes if available
- Consider reaching out to attending physician for additional information
    - Under what situations
    - What will the conversation be like?
    - REMEMBER: the final decision is solely the responsibility of the attending physician, PA only makes recommendations, as does UR
- Must look for medical necessity
    - Suspects – what does the physician suspect is going on?
    - Concerns – does the physician have high or low levels of concern for what can go wrong?
    - Predictable risks – how predictable are these concerns?
    - Intent for treatment – what is the treatment?
    - Remember requirements from MBPM
    - Can these services be provided in a lesser setting?

Definition - Medicare, for example, defines medically necessary as: "Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice."

What is the Inpatient Prospective Payment System (IPPS)

Inpatient Prospective Payment System Rule

Medicare payment for acute care hospital inpatient stays is based on set rates under Medicare Part A. The system for payment, known as the Inpatient Prospective Payment System (IPPS), categorizes cases into diagnoses-related groups (DRGs) that are then weighted based on resources used to treat Medicare beneficiaries in those groups. The Centers for Medicare & Medicaid Services (CMS) updates the IPPS regulations annually, with comment periods open prior to implementation of the final rule. Because a large percentage of surgical care takes place in the inpatient hospital environment, the American College of Surgeons (ACS) has a strong interest in CMS' IPPS and the hospital quality improvement efforts addressed in the IPPS rules.

What is the Outpatient Prospective Payment System (OPPS)

- Including the Inpatient Only List
- Knee and Hip Arthroplasties

Outpatient Prospective Payment System/Ambulatory Surgical Center Rule

Medicare payment for outpatient services provided in hospitals is based on set rates under Medicare Part B. The system for payment, known as the Outpatient Prospective Payment System (OPPS) is used when paying for services such as X rays, emergency department visits, and partial hospitalization services in hospital outpatient departments. Payment for ambulatory surgical center (ASC) services is also based on rates set under Medicare Part B. This system for payment is called the ASC Payment System and is used when paying for covered surgical procedures, including ASC facility services that are furnished in connection with the covered surgical procedure. CMS updates the OPPS/ASC regulations together in one rule annually, with comment periods open prior to implementation of the final rule. Because a significant amount of surgical care takes place in hospital outpatient departments and ASCs, ACS has a strong interest in CMS' OPPS and ASC Payment System and the quality improvement efforts addressed in the OPPS/ASC rule.

https://www.facs.org/advocacy/regulatory/medicare-payment/opps

Inpatient Only List

What is the Medicare Inpatient Only List?

In summary, the CMS inpatient-only list is a list of procedures that Medicare will pay for when care takes place in a hospital inpatient setting. Important to note is that the same safety and quality standards apply to both inpatient and outpatient services.

Most times, the rate at which Medicare pays for services in ambulatory surgical centers (ASCs) is lower than at hospital outpatient departments. The inpatient-only list is large, and many procedures have been added and removed over the years.

CMS Removes Inpatient Only List Starting in 2021

Recently, CMS announced the finalization of their rule to end the inpatient-only list. This transition will occur over a three-year period that they will begin by eliminating about 300 services, mostly musculoskeletal-related in nature (including joint replacements). The changes intend to give patients more freedom of choice in their health care options and save them money. They also allow Medicare to pay for inpatient and outpatient services in the case that each is relevant.

Eliminated procedures may be subject to review including the 2-midnight rule. This means the presumption of the need for Part A payment if an inpatient hospital stay lasts two or more midnights post-admission. Yet, CMS is exempting certain 2-minute rule reviews of newly removed procedures for two years.

Services Removed from the Inpatient Only List (IPO) for CY 2021

CMS has provided a table that includes services removed from the inpatient-only list for CY 2021. The list includes long descriptors and CPT/HCPCS codes and status indicators. You can find the list of removed services starting on page 709 of the CMS-1736 PDF.

https://www.medicarefaq.com/blog/inpatient-only-list/

OPPS proposed rule would eliminate 'inpatient only' list of procedures

OPPS proposed rule would eliminate 'inpatient only' list of procedures

- As outlined in the Outpatient Prospective Payment System proposed rule for CY21, a three-year elimination of the inpatient-only list would start in 2021 with 300 musculoskeletal services.
- Hospitals would receive a 2.6% OPPS payment increase for 2021.
- Medicare would increase the 340B payment cut from average sales price (ASP) minus 22.5% to ASP minus 28.7%.

Medicare has proposed to eliminate the list of procedures that providers are required to perform in inpatient hospital settings and instead allow those services to be performed on an outpatient basis.

Eliminating the "inpatient only" (IPO) list over three years, as outlined in the Outpatient Prospective Payment System (OPPS) proposed rule for CY21, will give clinicians the option to perform 1,700 more types of procedures in the hospital outpatient setting.

"Patients should have as many options as possible for lowering their costs while getting quality care," Seema Verma, administrator of CMS, said in a release. "These proposed changes, if finalized, would do exactly that, help put patients and doctors back in the driver's seat and in a position to make decisions about their own care."

The phased-in elimination would start in 2021, allowing outpatient procedures for about 300 musculoskeletal services, such as certain joint replacement procedures.

The American Hospital Association (AHA) expressed concern about eliminating the IPO list.

"Many of the services on the inpatient-only list are surgical procedures that may be complex, complicated, and require the care and coordinated services provided in the inpatient setting of a hospital," Tom Nickels, executive vice president of AHA, said in a written statement.

Chad Mulvany, director of healthcare finance policy, strategy and development, for HFMA, said the process for reviewing IPO items seemingly works well and is based on reasonable criteria.

"It's concerning that CMS is now electing to do away with this," Mulvany said.

The changes to the IPO list in 2021 alone would represent the largest onetime reduction. From 2017 through 2020, about 30 services were removed.

Although procedures removed from the IPO list would be subject to the two-midnight rule used to determine eligibility for admission, the OPPS proposed rule includes a two-year exemption for removed procedures from medical review activities relating to patient status, according to a CMS fact sheet.

After the two-year moratorium, Mulvany expects "increased administrative burdens from [quality improvement organization] reviews of site-of-service necessity" for the procedures.

"Also, it also feels like a back-door force for site-neutral payment, which if Congress wanted to do that, it would have done that," Mulvany said, referencing the administration's push to equalize payment for care delivered in different settings.

CMS would boost OPPS payment rates by 2.6% for 2021, representing a $7.5 billion increase.

42 CFR 412.3

Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination.

The physician's decision 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. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

Rule would expand ASC utilization

The proposed rule also would allow ambulatory surgical centers (ASCs) to perform 11 more procedures, including total hip arthroplasty, that previously were limited to hospital settings but weren't on the IPO list. Those would add to 28 procedures that Medicare has made ASC-eligible since 2018.

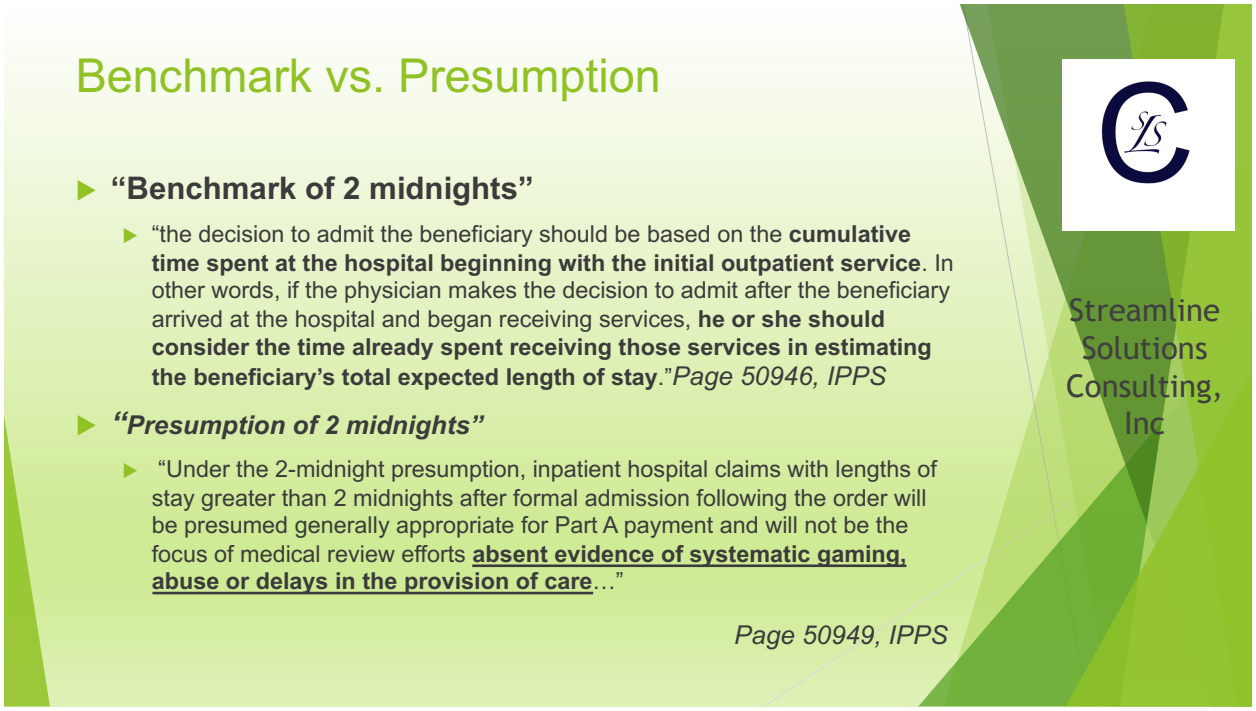
CMS would create a process for the public to suggest what additional services ASCs should be allowed to perform "based on certain quality and safety parameters."

The agency also may revise the criteria used to determine which procedures ASCs can perform, potentially adding 270 procedures that currently are limited to hospital outpatient departments.

https://www.hfma.org/topics/news/2020/08/opps-proposed-rule-would-eliminate--inpatient-only--list-of-proc.html

The Two-Midnight Rule

Background



In recent years, through the Recovery Audit program, CMS identified high rates of error for hospital services rendered in a medically-unnecessary setting (i.e., inpatient rather than outpatient).

CMS also observed a higher frequency of beneficiaries being treated as hospital outpatients and receiving extended "observation" services. Hospitals and other stakeholders expressed concern about this trend, especially since days spent as a hospital outpatient do not count towards the three-day inpatient hospital stay that is required before a beneficiary is eligible for Medicare coverage of skilled nursing facility services.

To address both of these issues, hospitals and other stakeholders requested additional clarity regarding when an inpatient admission is payable under Medicare Part A. In response, in 2012, CMS solicited feedback on possible criteria that could be used to determine when inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

The Two-Midnight Rule

To provide greater clarity to hospital and physician stakeholders, and to address the higher frequency of beneficiaries being treated as hospital outpatients for extended periods of time, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when

determining whether inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In general, the original Two-Midnight rule stated that:

- Inpatient admissions would generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation.
- Medicare Part A payment was generally not appropriate for hospital stays expected to last less than two midnights. Cases involving a procedure identified on the inpatient-only list or that were identified as "rare and unusual exception" to the Two-Midnight benchmark by CMS were exceptions to this general rule and were deemed to be appropriate for Medicare Part A payment.

The Two-Midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule did not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service.

Following the adoption of the Two-Midnight rule, CMS received extensive feedback from the stakeholder community, including concerns that the new policy was impacting physician and hospital practices.

Process for Developing Proposed Updates

Extensive Input

The proposed changes to the Two-Midnight rule reflected extensive stakeholder input, from hospitals, physicians, the Medicare Payment Advisory Commission (MedPAC), beneficiary advocates, Congress, and others.

CMS also received important information from the Probe and Educate process conducted by the Medicare Administrative Contractors (MACs), in which CMS contractors have worked with hospitals to clarify the parameters of Medicare payment policy with regard to inpatient and outpatient patient status.

Principles for Proposing to Update the Two Midnight Rule

As we considered changes to this rule, CMS sought to balance multiple goals, including: continuing to respect the judgment of physicians; supporting high quality care for Medicare beneficiaries; providing clear guidelines for hospitals and doctors; and providing incentives for efficient care to protect the Medicare trust funds.

CY 2016 OPPS Final Rule

In the CY 2016 OPPS final rule, CMS:

- Maintains the benchmark established by the original Two Midnight rule, but permits greater flexibility for determining when an admission that does not meet the benchmark should nonetheless be payable under Part A on a case-by-case basis.
- Discusses a shift in enforcement of the Two Midnight Rule from MACs to Quality Improvement Organizations (QIOs) (discussed in more detail below).

Changes in Review: Short Inpatient Hospital Stays

For stays expected to last less than two midnights – CMS is adopting the following policies:

- For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.
- CMS is reiterating the expectation that it would be unlikely for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight. CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.

No change for stays over the two-midnight benchmark:

- For hospital stays that are expected to be two midnights or longer, our policy is unchanged; that is, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports that expectation that the patient would stay at least two midnights. This includes stays in which the physician's expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice.

A More Collaborative Approach to Education and Enforcement

The final rule also includes a discussion of changes to CMS' approach to educating hospitals and our enforcement of the Two Midnight rule. Specifically, CMS began using Beneficiary and Family Centered Care (BFCC) QIOs, rather than MACs or Recovery Auditors, to conduct the initial medical reviews of providers who submit claims for short stay inpatient admissions on October 1, 2015. Beginning in 2016, BFCC-QIOs will begin reviewing inpatient cases under the revised Two Midnight Rule being announced today.

BFCC-QIO reviews of short inpatient hospital claims focus on educating doctors and hospitals about the Part A payment policy for inpatient admissions. BFCC-QIOs will refer providers to the Recovery Auditors based on patterns of practices, such as high rates of claims denial after

medical review or failure to improve after QIO assistance has been rendered. Accordingly, we do not expect substantial Recovery Auditor medical review activity for such claims for several months.

This change in medical review strategy compliments a number of changes CMS has already made to the Recovery Audit Program. CMS has either adopted or is in the process of working with the Recovery Auditors to implement the enhancements described below.

- To address hospitals' concerns that they do not have the opportunity to rebill for medically necessary Medicare Part B services by the time a Recovery Auditor has denied a Medicare Part A claim, CMS changed the Recovery Auditor "look-back period" for patient status reviews to 6 months (as opposed to 3 years) from the date of service in cases where a hospital submits the claim within 3 months of the date that it provides the service.
- CMS established incrementally applied Additional Documentation Request (ADR) limits for providers that are new to Recovery Auditor reviews and will establish limits on ADRs that are based on a hospital's compliance with Medicare rules and that are diversified across all claim types of a facility.
- CMS has also announced that it will establish a requirement that Recovery Auditors complete complex reviews within 30 days, and that failure to do so will result in the loss of the Recovery Auditor's contingency fee, even if an error is found.
- Finally, CMS will require Recovery Auditors to wait 30 days before sending a claim to the MAC for adjustment. This 30-day period allows the provider to submit a discussion period request before the MAC makes any payment adjustments

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

Condition Code 44, Condition Code W2, Occurrence Code Span 72

This section is informational for definitions in these three areas.

1. Condition Code 44 (CC44)

There are times where a physician may order a Medicare beneficiary to be admitted to an inpatient bed. When upon internal utilization review being performed before a claim is initially submitted, the hospital determines the services did not meet its inpatient criteria, Condition Code 44 is invoked. The National Uniform Billing Committee (NUBC) issued Condition Code 44, effective April 1, 2004, to identify cases when this occurs. The definition of Condition Code 44 is as follows:

- Condition Code 44 Inpatient admission changed to outpatient
    - A common misconception is that the change is to Observation. It is to outpatient as an order for Observation is required before this level of care can be instituted.
- For use on outpatient claims only,
- In cases where a beneficiary's status is changed from inpatient to outpatient after the UR determination that the inpatient admission does not meet the hospital's inpatient criteria, the hospital may submit an outpatient claim (Type of Bills 13x, 85x) to receive payment for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:
    - The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital.
    - The hospital has not submitted a claim to Medicare for the inpatient admission;
    - A physician concurs with the utilization review committee's decision; and
    - The physician's concurrence must be documented in the patient's medical record. **
- *Note that the attending physician **may not unilaterally change** a Medicare patient from IP to OP without invoking the UR process.*

There must be an order present to change the status to outpatient, which will generally include an order for observation if the physician plans to continue to treat the patient at the hospital. The order may be entered by the attending physician or may be a verbal order. For example, "I concur with Dr. Smith of the UR committee that the patient's status should be changed to outpatient. [Place the patient in observation.] Read back from Dr. Jones (attending physician), by …, RN."

In addition, according to *§ 482.30 - Condition of participation: Utilization review ;*

(d) Standard: Determination regarding admissions or continued stays. (1) The determination that an admission or continued stay is not medically necessary -

> *(i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of § 482.12(c), concur with the determination or fail to present their views when afforded the opportunity: and*

(ii) Must be made by at least two members of the UR committee in all other cases.

Once the condition code 44 process is complete, the entirety of the patient's stay becomes outpatient. If the condition code 44 process is done early in a medical stay and an order for observation is obtained, the hours of observation may contribute to payment for the stay. Eight or more hours of medically necessary observation following an emergency department or clinic visit triggers additional payment under the Comprehensive Observation APC.

2. Mechanisms for Billing with and without CC44**

Q5. How does a hospital bill using Condition Code 44?

A5. *When the hospital has determined that it may submit an outpatient claim according to the conditions applicable to the use of Condition Code 44, the hospital should report the entire episode of care as an outpatient encounter, as though the inpatient admission never occurred*

When a hospital submits a 13X or 85X type of bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report Condition Code 44 in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition Code 44 will be used by CMS and QIOs to track and monitor these occurrences.

Use of Condition Code 44 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. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

Q6. How should the hospital bill Medicare if the criteria for using Condition Code 44 are not met, but all requirements in the condition of participation in §482.30 have been complied with?

A6. *If the conditions for use of Condition Code 44 are not met, the hospital should submit a bill using Type of* ***Bill 12x*** *for covered Part B Only services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about Part B only services is located in the Medicare Benefit Policy Manual (Chapter 6, Section 10)***. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and other services. The Medicare Benefit Policy Manual includes a complete list of the payable Part B Only services.***

****MLN Matters Number: SE0622**

As stated many times, it is imperative to understand the consequences to the Medicare beneficiary with a downgrade. This is one of the reasons why a physician cannot unilaterally change a patient from an IP status to OP (OBS) without a proper utilization

review. There can be a significant financial burden to the beneficiary if placed in Observation but did qualify for IP. There are also significant financial effects on the hospital also which are addressed elsewhere in this report.

3. Condition Code 44 vs. Condition Code W2

As background, in the 2014 inpatient prospective payment system (IPPS) final rule, CMS gave hospitals the ability to self-deny an inappropriate inpatient admission under the *CoP* for UR and then rebill all eligible services provided during the hospital stay under inpatient Part B (Type of Bill (TOB) 12X), with a companion outpatient bill for the outpatient services prior to the order (TOB 13X) (CMS, IPPS final rule, 2014).

When a review of an admission determines that a Medicare patient didn't meet inpatient criteria and the patient has already gone home, negating the use of CC44, hospitals now have a way to be reimbursed for diagnostic and therapeutic services.

The Centers for Medicare & Medicaid Services' Inpatient Prospective Payment System (IPPS) final rule for fiscal year 2014 did allow hospitals to file a provider liable claim using **Condition Code W2** if the hospital performs a self-audit and makes a post-discharge determination that a patient stay wasn't medically necessary. Similar to condition code 44 (already described), in order to apply condition code W2, the process first begins with a determination by a physician representative of the utilization review committee. This may be facilitated by a utilization review nurse or case manager. The determination should be documented either in the UR committee's records or in the medical record of the patient.

Keep in mind, with Condition Code W2, that **the patient's status remains inpatient**, even though the care is billed for Part B payment.

The difference in timing requirements makes the condition code W2 process less resource-intensive than the condition code 44 process. To consistently meet the requirements for using condition code 44, hospitals need to coordinate with the UR physician and the attending physician, then **provide notice to the patient in a short period of time before the patient is discharged**—which can be quite resource intensive. With condition code W2, hospitals continue to do concurrent review, but can coordinate between the physicians and provide notice to the patient in an efficient and planned manner after the patient's discharge. Multiple determinations can be completed at weekly, biweekly, or monthly meetings in a short period of time. See Figure 1.1 for more information.

Figure 1.1 **Condition codes 44 and W2 timing requirements**

	Condition code 44	Condition code W2
UR determination	Before discharge	After discharge
Notice	Before discharge	Within two days of determination
Patient status	Outpatient (Type of Bill (TOB) 13X)	Inpatient (TOB 12X)
Attending physician consultation	Concurrence required	Offer opportunity, if no concurrence, two UR reps override
Payable	All covered services	All covered services (except infusions, injections, transfusions, nebulizer treatments for some hospitals – more later)

Source: "Condition Codes W2 and 44: Strategies to Reduce Burden and Increase Efficiency," HCPro, 2015.

4. Occurrence Span Code 72

The 2-Midnight Rule allows hospitals to account for total hospital time (including outpatient time directly preceding the inpatient admission) when determining if an inpatient admission order should be written based on the expectation that the beneficiary will stay in the hospital for 2 or more midnights receiving medically necessary care. Because currently the inpatient claim only permits CMS to accurately track inpatient time after formal inpatient order and admission (i.e., utilization days/midnights), CMS would also like to use Occurrence Span Code 72 to track the total, contiguous outpatient care prior to inpatient admission in the hospital. This will enable CMS to identify claims in which the beneficiary received care as an outpatient for 1 or more midnights and was subsequently admitted as an inpatient based on the expectation that the beneficiary would require 2 or more midnights of hospital care. ****

****** MLN Matters® Number: MM8586**

10.3 - Hospital Inpatient Services Paid Only Under Part B
(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

The services listed in Chapter 15, §250 of this manual, "Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities," when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and are not covered under Part A.

In all hospitals, all other services provided to a hospital inpatient must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any

nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

However, note that in order to have any Medicare coverage at all (Part A or Part B), any nonphysician service rendered to a hospital inpatient must be provided directly or arranged for by the hospital.

LOS Management

	Length of Stay Management (LOS)	
Group	**Task**	**Drill Down**
Need Executive support		
	Initial Meeting with execs to set priorities	
	Get Department representation of those involved	
	Set up Monthly/Quarterly update mtgs	
	What is the depth of knowledge of the problems	
	Warn CFO and CEO of likely physician complaints	How will they be handled?
Identify baseline data		
	ALOS data	Overall
	Breakdown by:	Physician
		Diagnosis
		Specialty
	Top Problem Docs, maybe start with top 3	May want to separate out by specialty
	Top Problem DRG's, start with top 3	
	Readmission rates by:	Overall
	Is there a correlation with LOS and readmission rates by	Physician
		Diagnosis
		Specialty
	Correlation by physician of actual LOS vs. DRG vs. average LOS benchmarks	Compare to resource utilization - average cost per stay
	Discharge based on DC status	
Daily/Weekly Rounds to Attend		
	CM Huddle Rounds	
	Multidisciplinary Round	
	Hospitals Rounds?Weekly meetings	
	LOS rounds if they exist	
Potential Process Solutions		

		Review the patients and status (LOC)
	Call the Problem Docs every day	
	Offer to round with them	Every day
		Three times a week
		Many times all they need is a "nudge"
	Work on their documentation of acuity	
		Get their documentation deficiencies
	Talk with CDI	
	Work on reducing readmissions	
	Weekly recognition of good performers	
Procedures		
	Are patients being admitted the day before	WHY?
	How are they being statused after an OP Procedure	Payer dependnt
		IP, OP, OBS
	LOS after the procedure	Is it appropriate?
	How do you handle the IP Only List?	
Other Areas		
	Look at cases boarded in the ED	
	Design a matix/dashboard for UR Committee	
	Discharge Planning	Must work 7 days a week
		Facilitate placement issues
	Identify and reduce	Unnecessary resource consumption
		Health Care costs
Other issues to address as time progresses		
	Delayed Testing	
	Delayed ER to bed time	
	Bed Turnover time	
	Registration Process	
	Time till first level reviews	Done in ED
		When done for direct admits
		Hours of CM coverage
	When does the 2nd level review get referred	Internal vs. remote
	Lack of DC Planning	
	Social issue delays	

What Can OSPA address immediately	
	Review all cases regardless of level of care that do not meet criteria Obtain GMLOS at the time of admission based on DRG/Dx Review all BS daily Review cases (OBS and IP) that have reached GMLOS and everyday thereafter Help teach better documentation of acuity
Metrics to follow	
	What specifically is your facility focusing in on now Calls to physician regarding DC Follow readmission data with decreasing LOS Cost/LOS/Dx/MD FFS Medicare CC44 Process Length of time it takes a consult to see a referral Timing of Discharge order Outcome of physician call/contact LOS in critical care beds before sent to floor Covering docs not willing to DC patients
	When did the DC occur after the call? How long does it take for the order change Docs cannot unilaterally change IP -> OBS w/o UR Review Once request entered Should be before noon, even 11 AM How long to DC, convert to IP, other Or change level of care

This Manual is not intended to be a complete education for Physician Advisors. There are many other areas that will need further education. If you are interested in personalized or group training or further questions or any education please reach out to:

John Zelem, M.D.
President/Owner
Streamline Solutions Consulting, Inc.
john@streamlinesolutionsconsulting.com
www.streamlinesolutionsconsulting.com