2014 Internal Medicine Update
SC Chapter Scientific Meeting
The Two Midnight Rule: One Year Later
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Agenda
- Define “status” of hospital stay
- Why getting it “right” is important
- The “Two Midnight” discussion
- Cases for Clarification
- Transmittal 541 and your surgical colleagues (and maybe you...)

Big picture.....
- It all goes back to the correct documentation to allow the correct capture of the correct diagnosis
- It all goes back to efficiency and “correctness” of the clinical bill, so that denials will not happen and if they do, that in an appeal we win.
- It really all goes back to ..... MONEY!!!!!
What are we trying to get correct?
- Level of services
  - Inpatient
  - Observation
  - Procedure only
- The diagnoses
  - Diagnostic Related Groups (DRGs)
  - HCCs

Status determination
- Level of services
  - Inpatient
  - Observation
  - Procedure only
- The diagnoses
  - Diagnostic Related Groups (DRGs)
  - HCCs

Case Mix Index
- Severity of Illness
  - The extent of physiologic decomposition, organ system loss of function, and/or mortality
  - Refers to “how sick” and “how hard to manage” and “intensity of resources”
- Risk (of mortality)
  - Estimate of the likelihood of an in-hospital death of a patient
Knowledge: Inpatient or Observation

- We also need to get the status correct
  - IP care pays better than OBS (outpatient)
  - 1.5 - 2x better in some instances
  - IP coverage for Medicare Beneficiaries is better
  - Out of pocket is better if patient is IP (Part A) instead of OBS (Part B)
  - Co-pay, medication costs, etc.
  - 3 day (midnights) stay needed for SNF benefit

Knowledge: Inpatient or Observation

- If we bill IP and subsequent audit says OBS (3-5 years from now), then payment is in jeopardy
  - Keep, fight, pay interest if we lose
  - Give back, fight, they pay interest if we win
  - Give back, give up, lose all money now
  - CMS (Medicare) says “all one way is a red flag”, so no “all OBS and flip to IP” or vice versa
  - Also, beneficiaries deserve IP when appropriate
  - So, need to get it correct from the beginning

Why don’t we get it correct?

- We were never taught this in training
  - Physicians are unaware of the IP/OBS medical necessity determinations
  - Habits: you look too sick to go home, so IP
  - Medical necessity “yes”, documentation “no”
  - “Social” admissions and the pressures of family
  - Inappropriate site of care
  - OP services being done in IP setting
If we get it wrong, so what...?

- **Show me the money...**
  - Hospital reimbursements (inpatient)
    - DRG 190 (COPD w MCC) $7,691.60
    - DRG 191 (COPD w CC) $6,174.68
    - DRG 192 (COPD w/o MCC/CC) $4,586.43
  - Hospital reimbursements (observation)
    - Usually with medical DRGs is ~35% of the IP rate
    - Base observation payment rate starts after care of 8 hours is delivered to a patient (~$1200).
    - Does include ED care but does not include CT, MRI, etc.

If we get it wrong, so what...?

- **Show me the money...**
  - Physician reimbursement (inpatient)
    - 99221 admit w/ low MDM 1.92 RVU $ 97.35
    - 99222 admit w/ mod MDM 2.61 RVU $132.41
    - 99223 admit w/ high MDM 3.86 RVU $195.38
  - Physician reimbursement (observation)
    - 99218 admit w/ low MDM $ 95.69
    - 99219 admit w/ mod MDM $130.62
    - 99220 admit w/ high MDM* $178.64*

If we get it wrong, so what...?

- **Show me the money...**
  - Patient responsibility 2014
    - Premium inpatient - Part A
      - 99% do not pay premiums (>10 years in Medicare covered employment)
    - Up to $426/month for those <10 years, varies
    - Deductible inpatient - Part A
      - $1216.00 patient responsible and then "0" for <60d, $304/day for day 61-90, then $608/day for each day >90d
If we get it wrong, so what...?

- Show me the money....
  - Patient responsibility 2014
    - Premium outpatient – Part B (physician, OP care)
      - $104.90/month (<$85K single, <$170K couple)
      - Up to $335/month ($213K/$426K)
    - Deductible outpatient – Part B (physician, OP care)
      - $147 is initial patient responsibility and then 20% of
        everything else (hospital care, labs, radiology, procedures, etc.)

Inpatient criteria defined

- Medicare: “An inpatient is a person who has been admitted to a hospital bed or occupancy for purposes of receiving inpatient hospital services.”
- Ulmer: IP is when a condition is found that causes clinical (ex., hemodynamic) instability that under usual conditions is not expected to revert to normal quickly. Physicians cannot use a “retrospectoscope” and thus, at the bedside, determinations on a patient’s status are based on presenting signs and symptoms. The risk of deterioration given the global presentation, the comorbid conditions, and the expected time course to treat the condition all are to be considered. If these events cannot be treated safely in less than two midnights of care, then inpatient services are most likely required.
- And the American Physician has trouble understanding...?

Medicare further defines IP

- Complex medical judgment of a physician
- Patient’s history and current medical needs
- Severity of signs and symptoms exhibited by patient
- Medical predictability of something adverse to happen
- Need for outpatient diagnostic studies to assist in assessing whether the patient should be admitted
- The availability of diagnostic procedures where the patient presents
- There is an “inpatient only” surgery list
- Some surgeries not on the list often can qualify for IP due to the context they are done in
So, what is “observation”

- No hard coded definition
- And it has changed over time
  - Length of stay determination (24, 48 hour rule)
- Introduced in 1983, reinforced in 1996
- Designed to create lower level payment for hospitalized patients when
  - Certain “inpatient” criteria are not met
  - Diagnosis is unsure and more time needed to decide degree of illness

The observation status defined

- **Medicare**: Observation Services are those services furnished by a hospital on its premises, including the use of a bed, periodic monitoring by nursing and other staff, and any other services that are reasonable and necessary to evaluate a patient’s condition or to determine the need for a possible (inpatient) admission to the hospital.
- **Ulmer**: A period of time whereby physicians can evaluate a patient whose symptoms are not clear, or not severe enough to merit a high intensity of service or prolonged (< 2 MN) hospital stay. These patients are usually clinically stable.
- How is one to decide in a world of vagueness…?
- OBS rates increasing year to year

The criteria…the 80% rule

- Types of criteria – Medicare states it does not matter, just use something to screen and classify patients
- Big two
  - Milliman Care Guidelines (“MCG”)
    - Push “evidence based medicine” guidelines, >20,000 references to formulate decisions on IP and OBS
  - McKesson InterQual Criteria
    - Recent revision, rule-based, patient-specific decision support tool backed by “evidence based medicine” that align with CMS’s guidelines
  - Managed Care Appropriateness Protocol (MCAP) (SRHS former tool)
    - Focus on services rendered, not the intensity of the illness or the co-morbidities and risk
  - Commercial payers modify/alter/make-up
In summary of “criteria”....

- “Chest pain” (for example) is not always IP
- We need to know things about the patient
- We find this information out from the clinical record, the “story” of why they came in for care
- The dictated note is the ideal place to go
- BUT, we don’t document what we see at the bedside often clearly enough
- OR, we dictate that we are “going to observe” them in the step-down unit....and that 7 letter word sticks...
- Translating the medical record to “help make inpatient” if clinically indicated
- “helps the patient/hospital” if that is what the attending ordered
- “helps the patient/hospital” if the IP stay is justified and OBS was ordered
- “helps the patient/physician” as IP billing is financially better for MD/DO

World of Audit and Compliance per CMS

- Long overdue
- We (docs and healthcare entities) are not all good
- Ophthalmologist: billing Medicare $1M, but no privileges
- Medicare receives over 1.2 billion claims/year
- 4.6 million claims per work day
- 575,000 claims per hour
- 9,580 claims per minute (160 claims/second)
- 60 Minutes fraudster, “It was easy”
- Get bank account, buy some Medicare numbers on black market, obtain some provider numbers, submit claims and watch the money come in

It is not all “fraud”

- Most of the errors found are honest mistakes
- RAC demonstration project
  - Two appendectomies in one admission
  - Unit dose errors on medication administration
- But “honest mistakes” still translate into money for CMS
World of Audit and Compliance per CMS
- RAC's don't necessary recovery on fraud and abuse cases. They refer those to the Zone Program Integrity Contractor (ZPIC). Latest figures on ZPIC's are FY 2012, nationwide, not broken down by the zones.
  - $461 million- identified overpayments sent to MAC's for collection
  - $20 million- referred to law enforcement for investigation
  - $280 million in payments stopped with prepayment review
  - $15 million in payment stopped due to imposing payment suspension
  - Approximately $1.5 billion nationwide.
- FY 2012 Annual Report to Congress on the Medicare and Medicaid Integrity Program

Medical Necessity Denial #1
- Does not mean patient did not need services
- Could have been that the services were provided in the wrong setting
- Inpatient was ordered, but medical necessity audit made it seem care could have been delivered in an observation (outpatient) status
- 33 year old with CP, no family hx, no PMH, EKG and CE were negative. Hemodynamically stable, admitted IP to step down, routine orders.

How do we prevent this?
- Front line work with Case Management (CM)
  - RN CMs do the work
  - Criteria to validate the severity of illness (SOI) or intensity of service (IS)
  - If meets, RN can validate the admission level of service
  - If SOI or IS not met, the physician must do a "second level" review
    - This is a "Utilization Review Physician" as outlined in the Medicare Conditions of Participation = Physician Advisor
When we “get it wrong”

- Denials = money recoupment
- IP but denied (could be 3-5 YEARS later)
- Appeals are possible, but is costly and labor-intensive.
- If we are too conservative
  - “All OBS” for example
  - Less revenue for patient care
  - Patients have to bear more financial burden
    - Co-pay and deductible in play
    - Medication cost liability

So....what is Inpatient care?

- Defined:
  - Medicare: “An inpatient is a person who has been admitted to a hospital bed occupancy for purposes of receiving inpatient hospital services.”
  - Stems around “Physician Certification”
    - The “Two Midnight Rule” (10-2013)

Review of the “2 MN Rule”

- Physician Certification (six elements)
  1. “Admit to IP” clearly written
  2. Diagnosis that merits the inpatient care
  3. Reason for IP care in hospital
“Reason for IP care in hospital”

- Hemodynamic instability
- Co-morbid conditions deranged
- “Prior history”
  - Vent, CHF with ARF every time, Asthma failed OP, etc.
- Clinical criteria have been met in your opinion
- DOCUMENT WELL to show your concern and what you are thinking.

Review of the “2 MN Rule”

- Physician Certification
  1. “Admit to IP” clearly written
  2. Diagnosis that merits the inpatient care
  3. Reason for IP care in hospital
  4. Expected length of stay (LOS) (i.e., “2 MN”)

“LOS expected (“2 MN”)”

- This means time transcends “2 MN of care”.
- BUT, the care must meet medical necessity (see previous slide)
- The time treated in the ED before midnight is important as 2 MN is inclusive even if IP order not written yet
- Can use prior history, pay attention to how rapidly an elderly person will turn around.
Review of the “2 MN Rule”
- Physician Certification
  1. “Admit to IP” clearly written
  2. Diagnosis that merits the inpatient care
  3. Reason for IP care in hospital
  4. Expected length of stay (LOS) (i.e., “2 MN”)
  5. Discharge plans
  6. Sign off before discharge from hospital

Verbiage: cases to clarify
- This 77 yo with COPD exacerbation has failed OP treatment and with new hypoxia (sat 82% RA) and BS > 400 will require IP services and greater than two midnights of care.
- This 82 yo pt with CHF and a Cr of 2.3 has a repeated history of hospital admissions that require intensive services due to the lability of her Cr and the degree of difficulty in diuresing her HF. IP care and >2MN will be required.
- This 65 yo with chronic pancreatitis has had persistent n/v x 3d and is requiring IV Dilaudid to control symptoms. Previous history shows several days needed to control these flare-ups and he clinically will need that on this admission, thus IP services are required.
- This 88 year old male with diverticulosis is admitted with abd pain and CT showing acute diverticulitis with ileus. Bowel rest, IV antibiotics, pain control and >2 MN of care is needed. IP.

RAC “released”
- Coming soon to a system near you....
The Recovery Audit Contractors (RAC) are given permission by CMS to open up certain focused audits. Outlier cases are expected to be targeted. SRHS looked at our data (PEPPER reports) and have found exposure in certain orthopedic areas. "Exposure" means we do more than comparative systems. Given the "exposure", we completed an internal audit of these outlier cases.

CMS Audit is Expected

- The Recovery Audit Contractors (RAC)
- Given permission by CMS to open up certain focused audits
- Outlier cases are expected to be targeted
- SRHS looked at our data (PEPPER reports) and have found exposure in certain orthopedic areas
  - "exposure" means we do more than comparative systems
  - Spine cases and Total Joint
- Given the "exposure", we completed an internal audit of these outlier cases

Outlier Case Results/Plan

- The documentation is present, but maybe not consolidated
- Certain steps needed for operative approval for any case
- Office note documentation may support, but the hospital documentation may be lacking (as surgeon has mental knowledge of the work-up)
- The hospital care is appropriate, but when the RAC calls for the records, the SRHS Appeals Team sends only the SRHS record and does not call for office records to support the procedure
- Without the supporting office documentation many IPO surgical cases could be denied for "lack of medical necessity."
- Appealing such cases currently takes 24-28 months without guaranteed success via the appeals process

Audit Strategy

- Continue documentation to cover the "medical necessity" of the procedures you order
- No need to re-document this on the pre-op Hx/Px, but making reference to and including a copy of your office note where this decision was made is valuable
- Some have signed the office note again (with the current date) with a notation "no changes in medical decision making since this note" and added it to the chart to be a part of the medical record (best practice option)
Transmittal 534 released on 08/08/14
Feedback to CMS was strong
Transmittal 540 replaced 534 on 09/04/14
Effective 09/08/14
Transmittal 541 replaced 540 on 09/12/2014
Minor language modification. Effective 09/08/14
541 states its purpose....
...to allow (auditors) to have discretion to deny other "related" claims submitted before or after the claim (being audited). If documentation associated with one claim can be used to validate another claim, those may be considered "related".

CMS Transmittal Updates

CMS Example:
A surgery is performed as an Inpatient level of care
The Medicare Administrative Contractor (MAC) [Palmetto GBA] denies the service as not meeting medical necessity
"Pre-payment denial"
Not all pre-op work-up done to deem the procedure needed (total knee, spine, etc.)
The Part A (hospital) fee is denied
541 now allows the "related" Part B (surgeon's) fee be denied as well

Explaining Transmittal 541

What we know:
541 is not in effect yet (at least 1 month to start after "announced" and no announcement as of yet)
If Part A surgical goes away, "related" Physician Part B goes as well

What we don’t know:
If Part B (physician) care was delivered prior (1-2 days prior) that was “related” to the denied claim, it may be denied as well
If another physician is involved in the care (Cardiology consulting on surgical pre-op), it is unclear if those services (E/M and procedural) will be denied if "related" to the denied claim
Surgical is clear, but what about medical (COPD exacerbation)
Once denied, the appeals process appears to be separate from that point on
541 Strategy to Med Staff
- Get it right from the outset
  - Let the Utilization Management Team help as they are on your side
  - Physician Advisor Team
  - Case Management Team (ED, floors)
  - Keep up with the regulations and recent CMS interpretations
  - Try to streamline the process

closing
- Thanks!!
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