MEDICARE (CAHABA GBA) MINUTES
July 21, 2014 RIC/RAC Meeting

CAHABA GBA REPRESENTATIVES PRESENT:
Ms. Suzanne Evans
Ms. Joy Fowler

FACILITATORS PRESENT:
Ms. Margaret Whatley
Ms. Karen Northcutt

MS. WHATLEY: We have Suzanne Evans and Joy Fowler with us today from Cahaba.

1. **Follow up to Question #3 from the March 10, 2014 meeting. After Transmittal CR8485 has been rescinded. In April CMS had issued CR8485 requiring contractors to report interest and principal refunds separately on the remittance advice along with claim identifiers. It included step-by-step instructions and was to be implemented July 7, 2014, but it has been rescinded and "will not be replaced". Are you aware of any other steps CMS will take to resolve this issue?**

   Response: We are not aware of any other steps that CMS will take at this time.

   Discussion at meeting

   MS. EVANS: At this time, we're not aware of any other steps that are going to be taken. But that could change tomorrow. It could change this afternoon when I get back. But right now there's nothing.

2. **Follow up to Question #5 from the March 10, 2014 meeting. We are billing a 131 claim and a 121 claim for same date of service splitting out the LAB charges. Labs with different HCPCS Codes or same HCPCS Codes (in certain cases) are rejecting in DDE for cannot bill Labs with same date of service. When is Medicare/Cahaba going to turn off edits for the CMS A/B Rebill Project so that all charges that apply would be considered?**

   Is there more information regarding denied overlapping lab charges when billing 121 and 131 claims for Part A to Part B rebilling? Another MAC Palmetto GBA has cited this directive:

   Jurisdiction 11 Part A
   A/B Rebilling Claim Overlaps

   CMS Change Request (CR) 8185 - CMS Administrator's Ruling: Part A to Part B Rebilling of Denied Hospital Inpatient Claims, CR 8240 - Part A to Part B Billing of Denied Hospital Inpatient Claims, and CR 8445 - Implementing the Part B Inpatient Payment Policies from CMS-1599-F outline the process to rebill services when denied on a claim with the 11x Type of Bill (TOB) as a 13x TOB (for the outpatient

services that generally occurred before the admission) and a 12x TOB (for the services that generally occurred on and after the admission).

Please note that the 12X TOB must be submitted and finalized before submitting the 13X TOB. This prevents claims from receiving duplicate edits due to laboratory services on both claims.

When appropriate, CPT modifier 91 should be appended to duplicate lab tests provided on the same Line Item Date of Service (LIDOS), even if one test is reported on the 13x TOB and the repeat test is reported on the 12x TOB for the same LIDOS.

Response: Discuss at meeting.

Discussion at meeting

MS. EVANS: We talked about this last time. And I had requested some claim examples, and I never received them. I know throughout the couple of months since we've met, we have fixed some of these claims.

Joy and I had a conversation on the way down here about the 13X, 12X, 11X. And she had some really good points that she'll share with you. It's kind of overall.

MS. FOWLER: I'll be glad to tell you what I know. And this has all come about in relation to the two midnight rule and denials for your 11X bill type. If you get a medical review denial for your inpatient 11X bill type and, say, your hospital agrees with that and you choose not to appeal, then you would rescind the 11X bill type or pay claim for the 11X bill type.

And then you would submit the 12X with a W2 modifier. And that tells us that there is no appeal in the system for that inpatient claim and that you are billing charges that were previously denied on that 11X bill type.

Now, it's my understanding , and you all can check on this, I'm a nurse, I don't process claims, but because of all my work with the two midnight rule, I've seen this evolve and happen. If you have ER charges, you can bill a 13X bill type, but you have to let the 12X process first; the 11X is put through first, then the 12X, and then you have to put the 13X in last, also billed with the W2 modifier. Now, that's what I understand.

This is coming from a medical review nurse right here. Okay. That is what I understand the process would be.

THE SPEAKER: So can we bill the 13X claim with the W2 on there?

MS. FOWLER: Yes. If a patient came in through the ER and then they were admitted. We denied the claim. On a 12X bill type inpatient claim, you can only bill certain things on the 12X. For instance, ER charges. You can't bill on that 12X bill type. You would have to put that through on a 13X.

THE SPEAKER: Right. And the reason that I ask this question is because we had the 13X bill type go through with the W2 on it. And it wouldn't go anywhere. And so we had a biller take the W2 off, and then it processed. I think that that's always been the question. Not just for our facility. But for every facility in here. Do you put the W2 on the 131 bill type?

MS. FOWLER: Well, there is a CR that talks about putting that W2 also on the 13X. And I think it's 8185.

THE SPEAKER: We'll take a look at that.

MS. FOWLER: I believe it's 8185. And this is also new. And we're through phase one, and we're looking at how these claims are going through and how the system is accepting them. And I can only tell you what I've seen so far. And there could have been some system issues. But, you know, I'm not the one to deal with that. Because I do operate from the medical review standpoint. So that's what I know.

MS. NORTHCUTT: And I have CR8185 here and what it says is a hospital submitting Part B inpatient claims subject to the interim policy shall include the condition code W2 on the claim. By using the W2 condition code for the Part B claims, the hospital acknowledges that the Part B claim is a duplicate of a previously billed Part A claim. And that no other claims are out there as far as the inpatient goes.

So I think the W2 is saying that there's no pending appeal and they don't really say to put it on 131. I think that's where we all get lost.

MS. FOWLER: I don't know. I mean, you would think that with an overlapping date of service for the ER charges that you would have to do that on the 13. But, you know, like you said, they took it off and it went through?

THE SPEAKER: Yes.

MS. FOWLER: All right.

THE SPEAKER: But, that's to say today it happened. Maybe tomorrow it won't. You know?

MS. FOWLER: Right. I understand.

3. **Follow up to Question #9 from the March 10, 2014 meeting. The 2014 correct coding initiative manual states that only one respiratory inhalation treatment can be billed per encounter, is this for hospitals and if so what is the rationale for only one treatment?**

According to a statement by Linda Dietz, RHIA, CCS, CCS-P, coding specialist for NCCI, the treatment can only be reported once per encounter, but providers may have multiple, separate encounters with the same patient throughout the day. Dietz says: ***"There is some confusion about the definition of "encounter" as used in this paragraph when applied to an outpatient hospital site of service. The Internet Only Manual, Medicare Claims Processing Manual, Publication 100-04, Chapter 2, Section 90.6 (Definition of Encounter) defines an encounter as "direct personal contact in the hospital between a patient and a physician who is authorized by State law and, if applicable, by hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient."***

Applying this definition to Chapter XI, Section J, Paragraph 8 of the NCCI Manual, the provider may only report one (1) unit of service(UOS) for a professionals' (e.g., respiratory therapist) visit to provide services reported as CPT code 94640 even if those services require more than one inhalation treatment (e.g., multiple medications) at that encounter. The professional does not have to provide continuous face-to-face service during the entire treatment time but may initiate the inhalation treatment and return to continue or complete it. If the professional completes the inhalation service(s) and terminates the patient encounter but returns later that day to initiate additional inhalation treatment(s) reportable as CPT code 94640, an additional UOS of CPT code 94640 may be reported for this subsequent patient encounter.

Providers should confirm this change with their Medicare contractors and commercial payers to ensure they're following the latest guidelines.

Based on this updated information from NCCI can providers charge for each inhalation treatment during a patient encounter?

Response: We need to abide by CCI, however the key phrase is "during a single patient encounter" and "acute" airway obstruction. So if inhalation is ordered every 8 hours that is "3 encounters"/day but in each of these "encounters" they perform 4 inhalation treatments, then you report only one unit. An ER visit would be considered "an (1) encounter".

Discussion at meeting

MS. EVANS: This is from Dr. McKinney.

MS. NORTHCUTT: I think probably since this question was raised, they expounded on it from CCI. And I'll be glad to share that with you. Basically, they muddied the water even more, of course, on what an encounter and an episode is. And they actually say that you can have more than one encounter for ED.

Example: Where they have breathing treatment times three that the doc just ordered, and then they're doing three and obviously charging three because it's a separate and distinct encounter with the respiratory therapist.

But what they did say was that you really have to have a medically necessary encounter. So if you order times three and you didn't check to see if the patient really needed three, or you did one and then report back and then their condition improves or worsens, then in that next encounter, that would be considered another encounter. I'll e-mail that to you.

MS. EVANS: That would be great.

MS. NORTHCUTT: Because I know this is a very confusing issue and everybody wants to bill the right way and do the right thing. We just have yet to figure out what an encounter means.

THE SPEAKER: Well, any updates? Could you publish a special little thing so that all of us would know about it?

MS. EVANS: I can send them to AlaHA.

4. **Follow up to Question #12 from the March 10, 2014 meeting. If a patient in an appropriate hospital inpatient stay elects Hospice benefits (for general inpatient care for controlling symptom management and pain control) during the inpatient stay, how should the hospital bill the claim? Should the entire stay be billed to Medicare or should the claim be split, billing prior to Hospice election to Medicare and after Hospice election to Hospice?**

   Is there a revision after review of the question from the initial answer given at the March 2014 meeting?

   Response: Discharge from inpatient stay using Patient Status Code 51 (Discharge/Transferred to Hospice (medical facility)).

   Discussion at meeting

   MS. EVANS: Well, at our March 2014 meeting, we said to bill it as one claim. But we've gone back and I've discussed it again with the claims people and they said to discharge from inpatient stay using the patient status code 51 and then bill your hospice claim.

   THE SPEAKER: What if we're not able to discharge that patient? Can you accept a split bill?

   MS. EVANS: Yes.

THE SPEAKER: And that's really right the reverse of what was told to us a couple of years ago.

5. **Follow up to Question #14 from the March 10, 2014 meeting. It appears Cahaba is not consistent with payment for chest x-ray and venipuncture performed during a critical care visit. The instruction is not to modify with a 59 modifier and the line items will not pay but it appears they are paid regardless.**

   After review of the submitted claim examples was Cahaba able to verify if they have correct edits in place?

   Response: Claims were not received, however Medical Review shared this: hospitals should report the ancillary services listed above separately when they are provided in conjunction with critical care. To avoid overpayment, charges for these ancillary services reported on the same date of service as the critical care services will be "packaged/bundled" into the payment for the critical care service. These services show charges as covered, but the payment is actually bundled into the payment for critical care services.

   Discussion at meeting

MS. EVANS: Well, I didn't receive the claims, but Joy does have something she can share.

MS. FOWLER: We had some probes in place several years ago for critical care E&M. And about maybe four or five years ago, facilities were told not to report those ancillary charges. But, then, that instruction changed maybe two, three years ago. And for cost-reporting purposes, facilities were told to list those ancillary charges on the claim with the critical care E&M. And FISS automatically bundles the payment for those ancillary charges into the patient for the critical care E&M.

Now, those charges will still show as covered, but they're bundled into that payment with critical care E&M. The only way for you to get paid for those separately is to bill with the modifier 59, and then the system will pay separately for those.

But if you don't bill those venipunctures, chest x-rays, and whatever, there's a whole list, with a modifier 59, then it's going to show as a covered charge, but the payment is bundled per the system, by the system, into the reimbursement for the critical care unit.

So that's why they look like they're paid. But they are bundled. It's a bundled payment. And it's hidden where we can't see it. But it is a bundled payment. If you want to get paid separately, you have to bill it with a modifier 59.

THE SPEAKER: But you're talking about billing for services after that ER visit, right? I mean, when would it be appropriate to put that 59 on there?

MS. FOWLER: Well, it has to be a separate encounter from the critical care E&M to bill the modifier 59. It's got to be a separate encounter.

THE SPEAKER: We are seeing every now and then line item payment amounts on those line items when there is not a modifier.

MS. FOWLER: To me, when I look at those claims, if I'm looking at a critical care E&M claim where 99291 and 92 have been paid, I can look down through there and see chest x-rays and venipunctures. And to me, it looks like it's all been paid.

But the system behind the scenes bundles that payment according to what CMS has told us. That payment will be bundled unless it's billed with modifier 59. We can't see that. It happens behind the scenes. So it looks like to you everything is paid, and it looks like to me it is. But it's bundled.

MS. NORTHCUTT: So just don't modify a lot of those. You know, it really shouldn't be, for the most case.

MS. FOWLER: For the most part. Yes.

6. **How is 81479 unlisted molecular pathology procedure paid if the reimbursement is not listed on the clinical lab fee schedule? Is this manually reviewed and paid?**

   Response: If the reimbursement is not listed on the fee schedule, there is a list and if the procedure is not on that list, Support Services researches.

   Discussion at meeting
   MS. EVANS: Yes, these are manually reviewed and paid.

7. **Can a hospital ED MD write observation services ordered, additional orders and manage these patients (keep in mind they do not have admitting privileges) as observation patients while in a distinct unit within the ED? Or would the care have to be turned over to another physician for patient management when observation services are ordered?**

   Response: Cahaba would not know who is “on staff” nor their scope of practice. This issue would be up to the hospital staff bylaws, credentialing, etc. to decide who can do what services; remembering the scope of oversight of such clinicians should be consistent across all patients.

8. **We have been having a problem with our Medicare Part A Remits since 05/08/14. The problem, all or part of the Contractual Adjustment is showing as denied charges on the Remit. The payments are correct but the adjustments are not.**

   Response: Discuss at meeting.

   Discussion at meeting

   MS. EVANS: We would need to see a copy of the remit. There's not a global answer for that. So if anybody is having that problem, if you'll send it to AlaHA, then they will forward it to me.

9. **Some RAC review accounts that Cahaba still does not have their system corrected to accept these claims. Since these are past the normal filing limits, the 121 claims require a Condition Code of W2 and it is not allowing us to fix these claims on-line. This has been a known issue with Cahaba.**

   Response: Discuss at meeting.

   Discussion at meeting

   MS. EVANS: Once again, we're going to have to look at the claims. Anytime you submit a question that says "we have a claim," "we see," "I have," I need to have the example of the claim. I send it to support, and they say they need to see the claim, to see how the claim processed. Because not all claims are the same. We need to have a little bit more information. You don't need to send any kind of detail. If you have called the call center, just give me the reference number, I can get all the information I need from there, plus it will have your contact if I have any further questions.

10. **Medicare patients who were not incarcerated were processed as incarcerated. We have not received repayments on these.**

    Response: Discuss at meeting.

    Discussion at meeting

    MS. EVANS: I talked with the claims senior last week, and that process is wrapping up. She says that the payment should be going out.

    So if you have some that have not paid, if you'll let AlaHA know. Then we will look at those specifically to see where the money is. But I know in the last probably two or three months I have had some issues from facilities, not just in Alabama, that are not getting their payments, and we have found them.

    So if you are one of those, if you'll just let AlaHA know, then we'll look at your specific facility and see. But according to them, it should be wrapping up.

11. **Based on the CMS rules, low cost skin substitutes need to be billed with procedure codes C5271-C5276, but providers are getting denials on Apligraf (Q4101) which should be categorized as low cost skin substitute due to reduction in cost by the vendor.**
    a) **When will Medicare change this from High Cost to Low Cost skin substitute to ensure appropriate claim processing?**

    b) **Should the providers continue to bill Apligraf as High Cost until the changes have been made by Medicare in their system?**

    Response: Per Support Services: Q4101 is a High Cost Skin Substitute and they could not find anything saying Medicare is changing it to a Low Cost.

    Discussion at meeting

    MS. EVANS: Support services did research this, and I did too. And we could not find anywhere where it's changed to a low-cost.

    MS. NORTHCUTT: In the proposed rule, it's still at a high-cost for next year.

    THE SPEAKER: They have reduced the price, and it's less than $32. And that's why we were like, okay, how do we bill it now. We're still continuing to bill it as high-cost because it hasn't changed in the system. But they have reduced the price to be below $32.

    MS. NORTHCUTT: CMS didn't catch that on the proposed rules.

    MS. EVANS: We haven't caught up yet.

    THE SPEAKER: So basically, the answer is we continue billing it as high-cost?

    MS. EVANS: Yes.

12. **Why does Medicare not keep the same DCN# when processing a RAC denial, recoupment and repayment? Sometimes they issue a different DCN# when reprocessing payment on a denied claim.**

    Response: This was a result of the April 2014 release. FISS modified the DCN assignment to use a common module when assigning DCNs (to replace the many different routines currently used to assign a new DCN) – to include RAC adjustments. DCNs of automated adjustments will no longer be based on the DCN of the original claim.

Discussion at meeting

MS. EVANS: There was a lot of discussion between Connolly and not only Cahaba, but the other MACs that they represent.

THE SPEAKER: We recently had several of our appeals that were dismissed. Or we didn't even know they were dismissed. We called to check, and they said they did not have them. And that's because we followed the Cahaba instruction that said you use the original claim number to file your redetermination. But then we got information back that for medical necessity denials, you have to use the denied claim number.

Now, this is confusing, and I'm afraid that people are going to be getting their appeals dismissed and don't even know it because it's so confusing.

MS. EVANS: I've shared that with the appeals manager, and I'll continue to hit at her.

THE SPEAKER: Our system has the same issue with the DCN numbers and the appeals being dismissed out of hand. There's no notification, and your appeal rights are being lost; substantial amounts of money. I understand that you're working on that. Your website's instructions still read, as of last Wednesday, that your system can marry those up and not to send duplicates and that is stated on the appeals page. And the form that we're supposed to use also still reads, Use the original number. I understand you've got changes. What should we do?

MS. EVANS: Just send them to me.

THE SPEAKER: Send them to you. Great. Thanks.

THE SPEAKER: You're going to be overwhelmed. I mean, really, you're going to be overwhelmed.

MS. EVANS: Well, if I'm overwhelmed, they're overwhelmed.

MS. WHATLEY: They are glad to have somebody to send it to. So thank you.

MS. EVANS: Yes - glad to.

THE SPEAKER: And, you know, the manual doesn't even require you provide a DCN to file a redetermination. It's not even a required element. So they should not be just dismissing those because it's not really even required. All we would have to provide is a signature and the Medicare provider number, the ID number, patient name, that kind of information. But the claim number is not even required.

THE SPEAKER: Who should we send these to?

MS. EVANS: If you would send your appeal numbers to AlaHA, then they'll send them to me. No PHI or anything like that. But just send them to AlaHA and they can just forward them to me.

THE SPEAKER: Now, the only way that we would have the appeal number would be if we called customer service and asked for the status. And I don't think we use the appeal number for that. I think we use the DCN, I sent you the DCN number on the original claim, and the denied claim, and I think you were able to find them.

MS. EVANS: Well, let's do this. Just send them to me, then. It's Suzanne.evans@cahabagba.com.

THE SPEAKER: Did they indicate why they made this change? I mean, what was the purpose of that?

MS. EVANS: I don't know that. We'll dig.

13. **Congestive Heart Failure has been added to the NCD for cardiac rehabilitation and claims are denying when billed for this diagnosis. When will Cahaba revise their edits to accept these claims?**

    Response: There is a decision memo that addresses this but we have not received anything final.

    Discussion at meeting

    MS. EVANS: Well, there is good news; finally, something good. When I sent these in, we did not have anything but the decision memo. But Friday morning, change request 8758 came out. An effective date of service on or after February the 18th for chronic heart failure. Okay. And there are specific diagnosis codes. I don't think I need to go through all of them.

    THE SPEAKER: This is a really good time to make a good point about decision memos versus the implementation of those into a national coverage determination. Because we get this a lot. The decision memo comes out. It is not binding on the MACs or any administrative law judge or anyone until it is issued as a national coverage determination.

    There is a time frame. This is from the program integrity manual. And so there is a time frame that they have to implement that. Now, when it's implemented, the effective date always goes back to the date of the decision memo, but the problem is that the MACs can't really process and follow the decision until it is manualized into the national coverage determination.

    So that's happening now with the NCD for cardiac pacemakers, implementation has been delayed.

THE SPEAKER: I was looking at the difference in a decision memo and a national coverage determination. And I found that information in the program integrity manual.

So I thought this was a good time to remind everyone that when the memo comes out, it is not implemented until the national coverage determination comes out with an implementation date.

MS. EVANS: Thank you.

14. **We would like to know if there have been any discussions or anything in the works about changing the UB04 141 bill type for Labs and replacing with a modifier. Example: using 131 bill types and using a modifier to indicate Lab only.**

    Response: Release went into the system 07.07.2014. Any claims RTPd before that date need to be F9d back.

    Discussion at meeting

    THE SPEAKER: We bill the 131 for lab?

    MS. EVANS: There are some specific instances when you would do a 141. But for the most of them, you would do a 131.

    MS. NORTHCUTT: If it's a non-patient lab. If it's sent over from a nursing home or skilled or somebody sending just a lab specimen only, then it's a 14X.

    THE SPEAKER: That would be 141?

    MS. NORTHCUTT: Yes. But if the patient is there, you're drawing blood and the patient is actually in the hospital either in outpatient hospital lab or your clinic if it's a hospital-based clinic, then it would be a 131.

    MS. EVANS: If you look at Medicare MLN Matters Article 8572, which is the 2014 update of OPPS, it has that in there about the 141 versus the 131, when you would do a 141. Okay.

15. **Trauma Response should be reported under the following revenue codes: 0681 Level I, 0682 Level II, 0683 Level III, 0684 Level IV. We are trying to bill a Level III Trauma Response, the edits will not allow this revenue code to be billed on a 13x or 11x bill type. All other revenue code are allowed. Please let us know why this one was excluded. Attached are copies of the Cahaba GBA Revenue Code Table Inquiry showing 0683 not allowed.**

Response: Discuss at meeting.

Discussion at meeting

MS. EVANS: Support looked at this, and they found a few things, but they need to see a claim. So whoever submitted that question, if you have a claim, will you send it to me, please? What was attached was the printout about the revenue codes. And there may have been some things attached, but all the information was blacked out. So like the HIC number, the claim number. So I couldn't even go back through that. But if you'll just send it to me.

THE SPEAKER: Well, I guess our question is why would the 683 be not allowed? Because it doesn't make sense.

MS. EVANS: Yes. I looked at that. It didn't.

THE SPEAKER: Because I believe that we're a Trauma 3.

MS. EVANS: Right, if you'll just send me that.

16. **CPT code A9520 which is a new code for 2014 and currently assigned a status indicator G (for payment) this replaced code C1204. Claims are denying when billed with the new code. Can Cahaba review and make sure this code is accepted and paid?**

    Response: This issue is resolved, files were fixed.

    Discussion at meeting

    MS. NORTHCUTT: Would you have to rebill that, or would that be an automatic fix?

    THE SPEAKER: We had to rebill them. And what you had sitting out there in T status, if you F9 them, they would go across and pay.

17. **Currently, the Medicare HETS/CWF (or Cahaba InSite) does not include the NPI of the provider of service for a Home Health or for a SNF. However, they DO provide this info regarding the Hospice that the patient is using. Can this information be included in the CWF, as this is the cause of many of the phone calls to Medicare. The Customer Service reps will tell us if we call, but it would be much more helpful/efficient if they could go ahead and return this information in the eligibility information for the patient. We are just not sure why it can be returned for Hospice but nothing else.**

    Response: At this time there are no plans to add this to the Portal; however, we will add this to our list of possible future enhancements.

Discussion at meeting

MS. EVANS: I have no idea what the turnaround will be, where it will fall. But it's on the list.

MS. NORTHCUTT: Who do you actually submit this to? Internally at Cahaba?

MS. EVANS: Well, I tell them what we need and they escalate it to where it needs to go.

18. Provide an overview of significant Probe and Educate findings, to include:

- **If a patient stays in the hospital as an observation for two midnights does this automatically make the patient an inpatient?**

Response: Under the 2-midnight *presumption*, inpatient hospital claims with lengths of stay greater than 2 midnights will be presumed generally appropriate for Part A payment. However, there must be a physician's order for admission to or a change to inpatient status if documentation supports the expectation that the patient requires a hospital stay spanning 2 midnights.

NOTE - When determining the 2-midnight benchmark, the "clock" begins when the beneficiary begins receiving hospital services:

– Observation care

– Emergency department, operating room, other treatment area services

Discussion at meeting

MS. FOWLER: You know, under the two midnight presumption, if a patient stays for the span of two midnights and they are receiving diagnostic and therapeutic services, then the presumption is that the hospital stay is generally appropriate for inpatient. But the doctor still has to address the inpatient order on those.

In some manner on that record, he has to indicate that, for instance, if the patient comes into the ER, is placed in an obs bed for the first midnight. The doc makes rounds the next day and sees the patient. If he's going to keep that patient a second midnight for diagnostic and/or therapeutic treatments, then he needs to write an order to admit them.

THE SPEAKER: When he upgrades that to inpatient, is there any type of specific documentation that he has to add in his notes as well? I mean, he's going to keep them that second night. But does he have to say I am changing them to inpatient because?

MS. FOWLER: Well, you know, best practice is always for the doctor to be as clear as possible. That's always best practice. However, when we review these records we

instruct the clinicians to look at the record from front to back to find intent, reason for admission, et cetera.

So if you are speaking to your physicians, the best practice for them is to be as clear as possible about the reason why they're admitting. And you don't always get that from everybody. But we do the best we can to try to figure it out.

THE SPEAKER: Have you completed sending out the probe and educate letters? Because I know we have two of four of our facilities that we haven't gotten letters for.

MS. FOWLER: We are in the process over the next week to potentially two weeks of completing the letters and getting them all out. As of today, we're finished with the claim review. And so the staff is now working on getting the letters out. If you have not received a letter, you should be sent that shortly. And you will have the option, if you choose to do so, of an educational phone call.

- **If the H&P, orders and progress notes support medically necessary hospital care, does there also have to be a written statement by the M.D. that the inpatient stay is medically necessary?**

  Response: Medicare review contractors should evaluate the physician's expectation based on the information available to the admitting practitioner at the time of the admission. Physicians need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes. Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and co-morbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which should be documented in the physician assessment and plan of care. The entire medical record may be reviewed to support or refute the reasonableness of the decision, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission. If the physician believes the beneficiary represents a rare and unusual exception to the 2-midnight benchmark, in which the expected length of stay is less than 2 midnights but inpatient admission may be appropriate, the physician must clearly document this rationale and supporting information in the medical record.

  Discussion at meeting

  MS. FOWLER: Best practice is to have that physician write exactly what's going on and exactly what his intent is, you know. But as I say, we try to review the records to pull that out. And some physicians are better than others at explaining what their thought process is.

But encourage your physicians, yes, to go ahead and give us that intent in the record. That way there's no doubt on anybody's part about what's going on with the record.

THE SPEAKER: If you have a patient that comes in over the weekend, and let's say they are Friday night and Saturday night or in Saturday night, Sunday night, and then case management comes in Monday, you still don't have an inpatient order, but the physician says admit to wherever. He's going to discharge the patient that day. Is it appropriate to make them an inpatient before he discharges them based on the two midnight rule?

MS. FOWLER: You know what? I would almost have to see that record to give you an answer. Because there are a lot of things that could have gone on with that.

As far as the technicality of the presumption, a two midnight stay with continued diagnostic therapeutic services would presumably be appropriate for an inpatient.

THE SPEAKER: But you don't have the magic inpatient word. Because our physician still considered admit to mean inpatient. No expected length of stay. Even though they stayed two midnights, the expectation is kind of met.

MS. FOWLER: Right. And as I say, when we look at these records, we look at what's gone on with the patient in the doctor's progress notes. And if we can see his intent there, we don't question that. I mean, it really has to be something that you just really cannot tell what's going on.

THE SPEAKER: But is it appropriate to make them an inpatient right before he discharges them based on that? Or does the inpatient go back to the beginning of the stay?

THE SPEAKER: Ronald Hurst asked that question on one of the CMS calls, and CMS said yes, that it was, assuming that the physician must have forgotten to write the inpatient order.

MS. FOWLER: We should not see that very often. If the physician does that, he needs to say the reason why he's writing a retroactive order. Which that's really a no-no. So whatever physician is managing that patient over the weekend needs to make those decisions. But on a retroactive order, he's simply got to explain himself.

THE SPEAKER: But even not making it retroactive. If they become an inpatient prior to discharge because they make it two midnight expectation.

MS. FOWLER: Right.

MS. FOWLER: When phase two is done, we are pulling the edits so that we do not intend to pull any span of two midnights or more on the front end. So those would not be included. We'll be pulling zero to one day stays.

MS. WHATLEY: We have some guidance from CMS. Do you want to repeat that just to make sure everyone heard you?

THE SPEAKER: I just know on one of the CMS calls, Ronald Hurst asked that question to say that it was clearly documented that there was medical necessity met and the patient had been there for two midnights. But the physician had come in and planned a discharge, and there was not an inpatient order on the account. And what should you do? Because, you know, we just clear them. We never have done that in the past.

And CMS said yes, you should write the inpatient order. And I know you're saying you're not getting a clear order when you just have an "admit to".

But his comment was yes, write the inpatient order. And you're right. That shouldn't happen quite often.

MS. FOWLER: It shouldn't.

THE SPEAKER: But it does happen at times. And I think that the challenge for us is that with us, that's commonly a verbal or phone order. So even if you receive it at that time, if the doctor doesn't sign it before he discharges a patient, you're no better off. And you're hurting the patient because they're not receiving the Part A benefit. So it's a challenge.

MS. FOWLER: It is. It's a challenge. And as I say, we see so many different scenarios on these, that I'm talking to somebody every day about some type of different scenario and what do we do with it and how do we handle it.

But, previous to this, we would have to just look at all the documentation previous to what went on with the patient to see if we could glean that intent there and all those things would work together in the decision.

THE SPEAKER: For patients who are presumed to stay two midnights and are admitted but do not cross two midnights, what specific documentation or even adjective should we use to help clarify that the patient was medically necessary to stay?

I've seen things like dramatically improved that were paid. And if you didn't have those particular adjectives, then they were denied because it was a one—day stay, even though the patient, we felt, met medical necessity.

MS. FOWLER: Right. You know that there is no clear guidance for you case managers who might be out there who are aware of the InterQual criteria getting the green light for severity of illness and intensive service because none of that comes into play anymore when a patient presents.

You know, it's very difficult for your physicians and for the case managers when these patients present because if the patient presents and there is a chance that they could improve overnight in that first midnight the doc might want to consider putting them in an obs bed and keep them overnight to see if they improve enough to go home the next day. Then if they don't admit them that next day when they're going to have to stay that second midnight … I can give you some examples of things that we have paid.

THE SPEAKER: Yes. Those examples would be great.

MS. FOWLER: I mean, just from things that we have seen, we've seen full-blown congestive heart failure patients who are very short of breath, very congested, obviously in an acute phase, multiple IV medications. They're very ill on presentation. And then for some reason the next day, after they get lasix and they may have three or four different IV drips going, they get better and they go home. You know, we would pay that kind of thing.

We have seen CVAs interrupted with TPA that come in through the ER and they're discharged the next day, and we pay those. We have seen MIs where you have a definite abnormal EKG. You have extremely abnormal cardiac enzymes and they're extremely ill. And for some reason, they dramatically improve and go home the next day.

THE SPEAKER: I like the word "dramatically."

MS. FOWLER: Yes. You know, you don't expect them to. And when I look at it, I wasn't expecting them to improve. I would think, well, this patient is going to be here, you know, two or three days. And for some reason overnight, they improve and they're allowed to go home.

Now, those are just some examples. There are others out there, but those are some of the most common things that I've seen over the past several months that we have paid.

But, patients who come in sometimes stabilize to a great extent in the emergency room. So you have to look very closely at treatment in the emergency room. And if they stabilize and their acute symptoms are kind of stabilized and things look pretty much like they possibly might need to be observed for a few more hours, then they might continue to get better or they could go downhill. Those are the type patients that you can put in an obs bed and you can keep them overnight and watch them. And then the next day, the doc comes in. He says, well, we've got to keep them another night because we have to do these things. Then admit them at that time.

I don't know if that helps. Unfortunately, a lot of this is individual clinical judgment, different eyes, different brains looking at these. And sometimes you have disagreement just like doctors disagree, case managers disagree in the hospital. So we're going to have that kind of thing. And that's why you have appeal rights. So that's just the nature of the beast, unfortunately.

THE SPEAKER: I have part two to that question. When they talk about rare and unusual, and this should be occurring rare and unusual, for you or anyone, does this mean you're looking to see percentage-wise how often this should be happening where you would have a one-day stay that is supposed to be a two midnight stay where this occurs? And I'm just trying to find a benchmark on how often this is happening with our other hospitals as well.

MS. FOWLER: We don't have any stats, obviously, because we're just winding up the first round. I know on Cahaba's part, we've paid several one midnight stays. We've paid

several. CMS has said that as a general rule, they expect to see very few one-night stays as inpatient; very few. But there are no number statistics. Some of the other hospitals might know. You might get something from them. But we don't have anything on that right now.

THE SPEAKER: On that example where you were speaking of you have an order that says admit to, and then you were saying that you would change it on the day of discharge to inpatient, the verbiage "admit to" assumed to mean inpatient. So you could get an order to clarify that that was inpatient, but you really do have an inpatient from the date and time that that order was written. It would be best practice to clarify it.

MS. FOWLER: It's always best practice to be as clear as possible and to say admit to inpatient status or change to inpatient status. But I know it's very hard to get that sometimes. And so there are all different sorts of scenarios we have to make decisions on. So it can be a tough situation.

THE SPEAKER: I have two questions. The first one is if you have an observation order that was written by the ED physician and it is not authenticated by the attending, is that something you're going to be looking at?

MS. FOWLER: Well, we don't know, some ER physicians have admitting privileges and some do not. It just depends on the facility. And we don't have that information at Cahaba.

So when we look at these, we don't know if the attending should come back and validate that or not. Because we don't know if the ED doctor has admitting privileges or not. So we have to take it at face value from our standpoint because we don't have that information.

THE SPEAKER: Thank you. I have another question. If you have a physician, attending, who has an authenticated inpatient order, and then on the day of discharge, for some reason, an observation order was put in, but the patient was there two and a half days, the patient was having treatment and diagnostics all through that, and the care really did meet inpatient criteria by InterQual - and I know you don't use InterQual -but I'm trying to say I think it's a clerical error. Is it appropriate to go back and ask that physician to clarify what his intent was even if the patient has already been discharged?

MS. FOWLER: Yes. In fact, you need to.

THE SPEAKER: Okay. Thank you.

THE SPEAKER: Let me clarify. I think in this situation the physician was uneducated, and it just made sense to order that observation. And no, the Code 44 has not been done.

THE SPEAKER: She said that the physician was uneducated and didn't understand so he just thought he should write that order. And so if Code 44 wasn't done and the patient

wasn't notified and a second physician didn't agree, then the observation order is not valid. So it is still an inpatient?

THE SPEAKER: Is that correct?

MS. FOWLER: I think that's probably correct.

THE SPEAKER: It's saying physician that wrote both the orders.

MS. FOWLER: Oh, okay.

THE SPEAKER: But when you change from inpatient to observation, you have to have a second physician approve that. The primary cannot simply write an order for observation for it to be valid. That's part of the Condition Code 44.

MS. FOWLER: Like a UR, physician advisor. Yes. You don't always see that, but that is a rule.

THE SPEAKER: Okay. I have a question. Because you made the statement about how case management and physicians don't all see eye to eye. In the self-audit process, if the attending physician does not concur once we notify him that the hospital has agreed to take Part B because the medical necessity and the presumption really was not there for two midnights - if the attending does not concur with the UR committee, what recourse does the hospital have?

MS. FOWLER: I think if the attending simply says absolutely not,the UR physician says we need to do it, the attending says no.

THE SPEAKER: And the second UR physician is saying this does not meet inpatient criteria.

MS. FOWLER: That's something you will have to resolve internally, something that your medical staff and your UR people are going to have to decide on.

THE SPEAKER: The conditions of participation say that if the attending does not concur, that two physician members of the UR committee can override the attending physician. Is that correct?

MS. FOWLER: I think if that occurs often, it comes down to physician education and having your UR committee work very closely and educate your medical staff. And I know it can be difficult. But, to me, that should not occur all that often, really. I think your UR physicians probably need to do some internal work.

THE SPEAKER: And, why does the attending care? It's still an inpatient. This is a matter of billing. But all that A/B rebilling discussion in the final rule said that you have to follow the conditions of participation guidelines. And if you read the condition of participation, it says if the attending doesn't concur, two physician members of the UR committee can make the decision that a stay was not medically necessary.

THE SPEAKER: The challenge in why the physician cares, that may be because the patient is being financially affected by the bill?

THE SPEAKER: The patient is affected by the bill. Right. The physician is not.

THE SPEAKER: The physician feels like if he holds strong, then the patient is not going to be negatively affected and then, you know, when the patient calls the physician, the physician is going to say the hospital did it. I told them no. So we know that we cannot bill inpatient because they do not meet. We cannot bill. And so we're, at a loss.

THE SPEAKER: It's just reality. I'm just saying it's reality.

THE SPEAKER: I understand. But the other thing is that it can occur that Part B liability is greater than Part A liability. That would be pretty rare too. So even if the physician cares, the patient generally comes out better Part B than Part A.

THE SPEAKER: If they've met their deductible, but not necessarily.

THE SPEAKER: With the deductible? Yes. But, the final rule does say follow the conditions of participation.

MS. FOWLER: These are internal issues that you have to face and just have to deal with them internally. And it can be hard if you have a couple of physicians who want to buck the system.

THE SPEAKER: Well, some of them offer additional information. But we know that it was not supplied prior to discharge. So we can't even use what they're offering most of the time. So that's why I think it comes in a CMS rule, because they set this in place, that everything has to be in that chart prior to discharge.

MS. FOWLER: Right.

MS. NORTHCUTT: Back to the scenario where the admission order is written when the patient is putting their shoes on and leaving. But the intent is documented and they spent two nights. That's still going to look like a zero-day stay from the claim's from and through date so the edits will pull that claim for review.

MS. FOWLER: Right. It might be pulled.

MS. NORTHCUTT: So you would actually pick those up, pretty much.

MS. FOWLER: Yes. And we would have to do the best we can to glean what went on. And these are individual decisions when clinicians look at these.

MS. NORTHCUTT: So I don't think it's going to be a very rare circumstance really, until the physicians start to understand the new rule.

MS. FOWLER: Right. And, we have seen records in the first phase where the admission order is written 30 minutes before the discharge order. And then the clinician has to go back through the record to try to see if she can make a sensible decision to that. Because it gets tough sometimes. It really does. And sometimes somebody will call me and I don't know what to do with them. I have to just sit there and think about it and look at it again in an hour or two. So it can get tough.

THE SPEAKER: I was wondering when you were going to pull the second probe.

MS. FOWLER: When we mail the letter to your facility, we ask you if you want an educational one on one call within two weeks of receipt of that letter. And then we give two weeks for that. If we don't hear from you, we'll add on another 45 days to that. So it's approximately 60 days. Some facilities are not having calls because they understand the rationale. They agree, whatever. But some are. But everybody gets about 60 days.

So 45 days from the date of your call. If you are going to move to phase two, then we would try to put the edit in about 45 days from the date of your call. Okay. And it will be for dates of service past that point too. We're not going to back up on you. From your call, we're going to give you 45 days to go to your medical staff, your UR people, whatever you need to do. We're going to give you 45 days to do that. We are not going to back up dates of service on you and pull the claim. We're going to start 45 days in the future pulling your claims.

THE SPEAKER: We attended a Cahaba webinar. I think it was on May 20th. And it stated in that webinar about the two midnight rule that only physicians could certify for an inpatient admission. Our physicians routinely have a nurse practitioner working side by side with them. And so a lot of times those nurse practitioners do the certification. But of course, everything they do is signed off by the physician.

MS. FOWLER: That's fine.

THE SPEAKER: Okay. Good.

THE SPEAKER: But it needs to be signed prior to the patient being discharged?

MS. FOWLER: Yes. And if we find one that's not, we're going to look back in your doc's progress notes to see if he says any of that and signs it. And we're going to look at the discharge summary.

MS. WHATLEY: Any other questions?

THE SPEAKER: Will you explain to the group, too, how if you had nine reviews pulled, that you automatically went to the second level probe?

MS. FOWLER: Yes. If you're a hospital who has had ten claims pulled in round one, we had the edits on. CMS instructed us to cut the edits off. I think it was April the 4th. So we had to stop the edits April the 4th. And if you had less than ten claims, you just had less than ten claims.

But for hospitals who had nine claims and all nine of them were paid, you will not go to the second round. But if you had nine claims pulled and one was denied, you will.

For the large hospitals with 25 claims, if you had 23 of those paid, you would not go to the second round. But if you only had 23 pulled and one was denied, you would go to the second round. And this is per CMS. This is the way the situation was set up for us.

THE SPEAKER: How do you define large and small?

MS. FOWLER: CMS defines that for us. They gave us a list of large hospitals that they wanted 25 claims. And everybody else got ten. So the great majority of you all out there had ten claims.

THE SPEAKER: We're a small inpatient psychiatric facility that did not have any claims reviewed. They automatically go into the moderate category for round two.

MS. FOWLER: Yes. And you probably will not have any for the second round either.

THE SPEAKER: That's what I thought. Thank you.

MS. FOWLER: But the edit will be out there. Yes.

THE SPEAKER: What if you actually denied five initially, then re –reviewed and changed your opinion and all five of those were okay. So we're five for five, but we're still considered moderate risk?

MS. FOWLER: Because we didn't get all ten claims?

THE SPEAKER: Right.

MS. FOWLER: And CMS is considering this as an educational process. And in the way they explained it to us is if we don't review almost the ten claim sample, we're not sure

that the facility really has a grip on this. So we're going to move them on and let you keep looking at them, just to make sure everybody has a grip on what's going on. That was their rationale to us. Because we questioned that.

So to them this is not as much a punitive process as it is educational for the hospital, just to make sure everybody has a grip on what's going on. That was the reason for that.

THE SPEAKER: What if we know you've got at least seven ADRs, maybe even ten. If we know that you requested ADRs on seven, then why are you only working off of five? Why aren't you working off of at least the seven, if not the whole ten?

MS. FOWLER: I don't know for sure. The only thing that I can say is it might be released claims and it will be the same in the second round. If we happen to pull a claim that had an inpatient only procedure and we caught it before the claim was reviewed, we released it and CMS said do not include that in the probe sample. Or if we saw one that potentially was not coded correctly because we eliminated AMA discharges, transfers. And if we saw one that potentially didn't have the correct discharge status on it and we knew we had to pay that, it had to be released and not counted in the probe sample. So those sorts of things were going on with all of this.

THE SPEAKER: Okay. But isn't inpatient only list admissions part of the two midnight rule?

MS. FOWLER: We release if we pull a claim, with an inpatient only procedure on the claim.

THE SPEAKER: I know. But isn't that part of the two midnight rule?

MS. FOWLER: No. We release those if they're not part of the probe sample. If we find an inpatient only procedure.

THE SPEAKER: They're not part of the two midnight rule?

MS. FOWLER: The language to us is we do not review inpatient only procedures. They can stay less than two days, no problem, if it's inpatient only procedure.

THE SPEAKER: I understand that's the direction that you're getting. But my question again is in the two midnight rule, the language of the rule, does it not also include language, or am I getting confused, about inpatient only? Because I think it does. I think it talks about inpatient only and that the order has to be written prior to the procedure. I may be confused.

MS. FOWLER: No. If it's on CMS's inpatient only procedure list and coded as an inpatient DRG, we don't have a crosswalk. So, we're going to pull some claims that have

inpatient only procedures. And, when our coders look at those, at the inpatient only procedure, we're going to release that claim and it is not a part of the probe sample.

THE SPEAKER: Right. Because it is an appropriate admission and they do talk about it in the rule. But it's your direction on what you're supposed to probe is only medical cases that have not had an inpatient only procedure. So those are why those were released.

MS. FOWLER: Exactly. Exactly.

MS. WHATLEY: Any other questions? Any follow-up? If not, then we'll stop now. Thank you for coming today.