MEDICARE (CAHABA GBA) MINUTES
March 10, 2014 RIC/RAC Meeting

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

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

MR. HALEY: We've got Suzanne Evans and Joy Fowler with us here today for Cahaba.

The way we've got the questions organized today, we have Two Midnight Rule questions and then everything else. We're going to start with everything else first and then we'll end with the Two Midnight Rule questions. That way, we're free for discussion and back and forth and that type of thing. They're well aware of a lot of the questions, and they've been hearing you and they've been hearing us and certainly providers from other states. It's a hot topic, I know, for Cahaba and probably all the MACs. So we'll start with the non-Two Midnight Rule questions.

1. **Follow up to question #2 from November 4, 2013 RIC/RAC meeting, which was a follow up to question #16 from the July 15, 2013 meeting. Why are packaged charges, that Medicare typically does not pay, denied for MUE? It was discussed at the meeting that these are adjusted as a contractual, but they are denied.**

   Response: The claim passes through the Outpatient Code Editor (OCE) first, gets the 'packaged' OCE flags assigned, and then the claim continues on and processes through the Medically Unlikely Edits (MUE). If the units are greater than the MUE max, then the MUE edit will be applied to the line. The MUE edits do not discriminate between packaged and non-packaged service lines, they just check to see if the line charges are covered or non-covered when determining whether to apply the MUE edits or not. Both of these scenarios apply to the claim example, so that is why both the 'packaged' OCE flags and the 51 MUE were applied to the line.

   <u>Discussion at Meeting</u>
   MS. EVANS: We sent this question to support, and they sent it to FISS, because they looked at it and they were not sure either. So this response is per FISS.

2. **We continue to receive denials from Cahaba indicating the claim could have been billed in outpatient status, but the beneficiary underwent an inpatient only procedure. Upon appeal (Redetermination) Cahaba denies the case again with the rationale it should have been provided in the outpatient level of care although the Redetermination letter clearly provided the CPT and the reference indicating the procedure was inpatient only.**

   a. **How does Cahaba review a surgical admission to determine if a case is designated by Medicare as Inpatient Only?**

b. Is Cahaba obtaining the CPT codes and applying Addendum E of OPPS?
c. Does Cahaba have a crosswalk of ICD9 to CPT in their system to identify inpatient only claims?
d. If Cahaba does not have the resources to identify Medicare designated inpatient only procedures what are the options for the provider to prevent these types of denials?

Response: Answer to all points above: Cahaba has a Certified Coding Specialist (CCS) working with the clinical staff. Nurse reviewers are instructed to refer all claims and appeals with a possible inpatient only procedure for coding validation. The medical record (including operative notes, progress notes, etc.) is reviewed by the clinician and the CCS. The appropriate ICD-9-CM procedure codes are translated to corresponding CPT/HCPCS codes by the CCS and are compared to the listing in Addendum E. The decision rationale should state the claim or appeal was reviewed by the CCS.

Discussion at Meeting

MS. EVANS: Joy Fowler, a senior in our Medicare medical review Part A department who's got a wealth of knowledge answered this one.

MS. FOWLER: Well, good morning everyone. Is this in relation to the Two Midnight Rule, or does this question include all claim types, anything that might be sent in?

THE SPEAKER: All types.

MS. FOWLER: Everything?

THE SPEAKER: Yes.

MS. FOWLER: Okay. The procedure is basically the same. We do have a certified coder who works within our medical review Part A unit. And if we get a claim in with a medical record that appears as if it's an inpatient only procedure or if there's a letter with the medical record, and the letter will actually say this is an inpatient only procedure, that claim is automatically given to her. She goes through the record using all the applicable areas of the record, including the procedure note, the physician's documentation. And she uses all the resources that coders use, and she will recode that record and she will look again at that procedure. And if it is an inpatient only procedure, we will pay the claim if she is in agreement with the coding. And we see a lot of this on appeal. You know, if we happen to miss it on the first claim, we see it also on appeal. And if there is a letter where the provider states this is an inpatient only procedure, then we give it to her.

THE SPEAKER: I guess, though, why we framed this question was more of an automated way so that it doesn't get denied in the first place. You know, you should have something in the system that says, hey, this is an inpatient only procedure, hence, it will be inpatient. So that's

the kind of question that we understand that it goes to the reviewer it shouldn't be going there in the first place.

MS. FOWLER: I understand your point. The problem that we have from the contractor standpoint is that our claim in FISS has ICD-9 CM procedure codes. And of course, the inpatient only list is the HCPCS codes. And there is no way to translate that over from FISS. There is not a translation tool at this point to do that for us. So our coder has to do that herself. When we get these claims, there is no automated translation tool. That's unfortunate, but there is not.

MS. NORTHCUTT: And, Brenda, if you could create one, you'd be a millionaire.

MS. FOWLER: Believe me, we wish there were one. It would save us a lot of work. It would be much better for you all. And I have been on your side for many years. So I do understand what you go through with that. But, unfortunately, for us, from the contractor side, we do not have that tool in place. We do not.

THE SPEAKER: Are there any plans to put something in place, I guess?

MS. FOWLER: We know there is a great need for that.

THE SPEAKER: So the answer is no?

MS. FOWLER: Yes, we do.

THE SPEAKER: Yeah. Thank you. I'm glad to hear that there is a coder that's looking at that, because that was our concern. You know, they end up staying in appeal forever, and it causes a lot of administrative burden on us for something that should be fairly cut and dry other than the cross-coding issue. And I'm not sure that I've ever seen on a response letter something that said the coder reviewed it, but I'll be looking for that moving forward. Because we have had quite a few - and I know other providers have experienced the same - where we have put it in our letter, but the redetermination comes back and it does not reference that a coder looked at it, which is frustrating to us as providers. Because we really just want to do what we can do to make it as easy for that to get resolved as quickly as possible.

MS. FOWLER: And I'm understanding exactly what you're saying. When our coder reviews - especially on appeal, she will document that the claim was reviewed by a certified coding specialist. And really should be documented if a claim is the first level claim on FISS. now, that's not saying at times she might not forget to put that at the very end when she's putting her rationale into this. But we can certainly get back with her and just make sure that she makes a concerted effort to do that all the time. She should be doing that every time she reviews.

And the nurse on the first level if the claim doesn't come to us as coding only, if we're not verifying the DRG, those claims go to our clinicians, our nurses first, and they have to look at that claim and if the provider doesn't say or make a note somewhere, the nurse could miss the

fact that it's an inpatient only procedure, because we don't have a crosswalk in place. And so because of that, it falls to you. You have to appeal. And then, hopefully, on appeal, in the letter, there would be something to us about, hey, this is an inpatient only procedure. Then it would go to her and we would pay. So yes. I totally understand your problem.

THE SPEAKER: Thank you.

THE SPEAKER: I was just wondering what kind of volume that coder has with all of us in the room sitting together.

MS. FOWLER: She has three states. So it is an impossible situation. Yeah. Yeah. And, you know, in the past, we have had maybe a coder and a half, maybe a coder plus one part-time. So you see what we're dealing with. We're dealing with very limited resources. So there is one coder for three states at this point.

MR. HALEY: Anything else?
(No response)

MR. HALEY: I'm going to preface the third question. You probably saw the e-mail we sent out late in February announcing the "pause" in the RAC program. And of course, this question predates that by a little bit. But just to give you a quick heads-up on that, you should not be receiving any more RAC requests at this point. They should all come out of the system. You may still have some that are in process with Cahaba or in some sort of pre-appeal state, but you should not receive any fresh, new record request or anything from Cahaba. That is going to be the case until June 1st, I believe. And then after that, at some point between now and the future, they're going to re-release the Statement of Work and move forward with the next reviews of the RAC.

And there are some issues that are out there, I think, in what we sent around as well that CMS has heard. They're trying to make some changes to how the RAC was administered, how the MACs react to that, and then some guess we'll see when we see, exactly what changes are made to the program.

But just to give you a heads up, most of you had seen tailing off over the past three or six months anyway of your RAC claims, and they should pretty much go down to zero.

THE SPEAKER: I do believe they can still issue automated denials up until June 1st, because they can submit claims to the MAC for adjustment. They're not supposed to request any records, but they can continue to submit overpayment claims to Cahaba until June 1st.

MR. HALEY: So with that caveat, question number 3.

3. **In some cases, the payment for an overturned RAC denial is put in the PS&R report. The hospital needs a payment transaction on the remittance advice with Remarks Code N432 to know the denial is overturned. And, without a payment transaction on the remittance advice, we are unable to close the balance on our account. Will**

Cahaba provide the hospitals with a letter or some other kind of verification of payment when the payment is made in the PS&R report instead of on the remittance advice?

Response: Discuss at meeting.

Discussion at Meeting

MS. EVANS: Well, I don't have an answer. She was out the last couple of weeks and didn't give me an answer. I think we got the immediate answer to the question, the amount and the identification. But as far as the letter and any kind of correspondence, I'll have to get back with you on that. And I don't know if this new TDL that came out, the CR that came out where they're going to start identifying all of our stuff on our remits, if that will affect it or not. I don't know. But I'll get back with you about that answer.

THE SPEAKER: So during the November meeting, I talked to a lady that was here. We were getting a J1 on our remits. And that was just saying that they had been notified that we were going to receive payment. Now, was that supposed to have moved over to the PS&R, or was that in a B2 status? Because we were still getting J1 stuff. Does that make any sense?

MS. EVANS: It makes sense, but I don't know the answer. I'll ask her. So you're still getting J1s?

THE SPEAKER: Right. But who is the person to contact about that?

MS. EVANS: Do you have a specific remit that you need?

THE SPEAKER: I've got specific accounts with me.

MS. EVANS: I can't carry them with me. If you will email them to me. And please be sure and send them secure.

THE SPEAKER: And so you would be able to figure out, if I give you a specific ICN number?

MS. EVANS: That would be great. Or if you have the remit date and the amount, I can send it to them and they can do that.

THE SPEAKER: So I guess my question is, I know that other people have gotten B2 which is your lump sum money with no way to identify it. But did anybody else get J1 before they got B2?

MS. EVANS: Has anybody had J1?

THE SPEAKER: Yeah. Everybody gets J1.

MS. EVANS: J1 is first, then it turns into a B2? Sounds like a bingo game.

THE SPEAKER: But there's just no particular date as to when that will happen, then? Because, at first, it said non-reimbursal. Did everybody else's say non-reimbursal to start with? The lady that I talked to at the last meeting...

MS. EVANS: Was that the lady that came with me last time?

THE SPEAKER: Yes, ma'am.

MS. EVANS: Okay. If you'd just send that to me and let me talk with her about it, and we'll see what we need to do. Just send me what you have, and we'll work on it.

THE SPEAKER: Okay.

MS. EVANS: And I'll get back in touch with you.

THE SPEAKER: But this example has to do with no transaction at all on the remittance that would result in a J1. So if you don't get a transaction at all where they're paying you, then you have nothing to post in your account and you have nothing to send to a supplemental insurance. And my impression after discussing this with several people in reimbursement is it probably was just an accident, that the wrong button was hit and it sent it to PS&R instead of sending it to remit. That's what I think and that may not be true, but I kind of deduce that from just conversation.

MS. EVANS: Was that on the one that you sent me? Okay.

THE SPEAKER: And we have the example.

MS. EVANS: I don't know. When they get this fixed, I'm not going to have much work to do.

THE SPEAKER: It was suggested to me to just print the page off of the Medicare remote that shows the payment to use to send a supplemental insurance. But it's a little complicated for them to try to figure out what you're sending them when you do that.

MS. EVANS: They may not like that.

THE SPEAKER: And then when I ask, well, could you recoup it from the PS&R and put it back where it's supposed to be, and I was told, no, we probably couldn't do that either. So anyway, it's a little bit of a complex issue. But we do appreciate you looking into it.

MS. NORTHCUTT: And we were just saying how much money that is holding up, especially for those that really need it right now, because all the reimbursement has been cut.

MR. HALEY: All right. Anything else on that one?
(No response)

4. **We have had RAC recoupment for the denial of an acute care hospital claim being recouped from the acute care psych hospital reimbursement (both with different provider numbers). Shouldn't denials for the psych hospital only be recouped from the psych provider number and denials for the acute care hospital only be recouped from the acute care provider number?**

   Response: If the provider numbers are associated with each other, the monies will recoup from whichever provider number is being repaid**.**

   Discussion at Meeting

   MR. HALEY: So let's say you have a situation where one provider number has more than 100 percent of its remittance recouped and there's an associated provider number it's $100,000 on one provider number and the psych has $50,000. You're going to recoup $110,000. You're going to recoup a hundred from the acute care and then ten from the psych as if they're associated?

   MS. EVANS: It's my understanding. Is somebody having an issue with that?

   MR. HALEY: Same tax ID number? Yeah. And what does "associated" mean?

   MS. EVANS: Did somebody have an example of that? Was this somebody's specific question that they were not getting reimbursed appropriately?

   MR. HALEY: Well, actually, you've seen some of that e-mail traffic that we've had with Connolly. I think you've been involved I don't know if that's what spawned this question in particular, but that is an example of that particular hospital having more than just its inpatient. They're all inpatient recoupments, but it's impacting the non-acute side or it's impacting the psych side of the hospital.

5. **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?**

   Response: Will discuss at meeting.

Discussion at Meeting

THE SPEAKER: That's our question. I haven't been able to provide Suzanne with a legitimate example of that. But when you have a lab charge on the 131 and a lab charge on the 121 with the same CPT code, we've had examples where they were denied for overlapping circumstances. But I've just got to get you an example of one.

THE SPEAKER: Suzanne, I think every facility is having that same problem.

MS. EVANS: If you have an example. Here's my problem, when I go to support with questions like this, and this is a support question because we want to know what the system is looking at, they want to see examples. They don't want a narrative. They need to be able to look at it. This claim paid appropriately, this claim did not. Why? What did it hit, what it did not hit.

So anytime you have a question that relates to a claim payment, I really need to have the claims. Either the ICN numbers or the HC numbers and dates of service. If I have a good and a bad, then that way they can look at it and see was it something in the system, was it another little quirk in that claim that caused it to do that. So anytime you have anything like that, if you would send me that information, that really will help speed up our resolution. And I'll go back and talk about this again and see.

THE SPEAKER: Other facilities were calling in to ask the contractor and stating that they were having the same problem. The 121 bill goes across. It gets paid. But then your 131 bill rejects.

MS. EVANS: Does what?

THE SPEAKER: Rejects for overlapping.

MS. NORTHCUTT: Is it just lab, Fran, or just anything that is on the claim?

THE SPEAKER: Anything within its same date of service.

MS. NORTHCUTT: The 131 stops and they're rejecting for duplicate. And we're not going to get paid for it anyway. That's the double whammy we're stopping the claim for something that's now packaged within that hospital visit, just as a side note. Or that 131 bill type is basically going to be a hospital visit, and the 121 is going to be a hospital visit so unless it's a drug screen, it is now going to be packaged or a molecular pathology. Otherwise, it's going to be irritating that it's going to hit and not get paid.

THE SPEAKER: Well, what happens, though, is they deny the entire claim. They don't deny a line item. So maybe we need to roll it.

6. **We have recently seen an increase in dismissals due to Cahaba claiming non-receipt of the appeal and/or medical records when we have delivery confirmation.**

   Response: Appeals that have not been received cannot be dismissed. We do not dismiss for lack of records. If we receive an appeal that is not valid (lacking signature, DOS, description, etc.), we will dismiss the appeal. If we receive an appeal without needed records, we will request those records. If the records are not received within the 14 days of the request, we will decide the appeal with the information on hand. Usually these are found unfavorable because they are lacking documentation to support the care, but they should not be dismissed.

   a. **What is our recourse when we submit our medical record and we have a receipt confirming delivery and the case is dismissed?**

   Response: We should not be dismissing for lack of records. We generally only dismiss if it's an invalid appeal or if it is something that is non-appealable.

   b. **How can we be assured if the records are not accounted for that the records were lost internally at Cahaba or externally so that we can determine if there was a HIPPA breach which requires reporting?**

   Response: If the provider has confirmation, they can provide us with the tracking number and we can determine if the records were delivered to Cahaba, and if so, locate it within the building.

   c. **What is Cahaba going to do to ensure received records are accounted for?**

   Response: We handle the receipt of records like any other incoming mail. They go through our mailroom, are date stamped with the date received, batched and scanned into the appropriate workflow to be handled.

   d. **When will the electronic product (Insight) for confirmation of appeal status and of ADR status be available?**

   Response: It will be, but there is no date assigned yet.

Discussion at Meeting

MR. HALEY: Actually, I have to add to that. Your provider outreach folks got in touch with me on Friday. We're looking at a date in late April to do a webinar. We'll get some information out when that gets nailed down, hopefully in the next week or so, whenever they work out the details. But we're looking probably around the end of the month of April.

MS. EVANS: So that is ongoing. It's moving along.

An example was given: GINQ3663666 APPL 1484362

Response: This is an open redetermination, received 01.15.2014, so it is less than 30 days old (at the time of response). We have not dismissed this appeal or made a decision in any way.

MS. EVANS: And I looked at it Friday, and it was still open.

Any comments? I know this is a headache. I know it is. Thank you.

7. **Are lactation services covered and if so what codes are used to bill for this service?**

   Response: No

8. **We have had several medical necessity denials for hydration therapy when a covered diagnosis code 787.91 is billed. Is this an oversight in the Cahaba edit?**

   Response: A mass adjustment was done; claims that had not completed processing may have been missed at the time the mass pulled the claims and had already gone through the ECPS event to deny. If you have any of these claims, email them to me.

Discussion at Meeting

MS. EVANS: We've had, across all three states, claims that are affected by this. So email them to me, and we will get them fixed for you. And please remember, anytime you send anything, to send it secure.

MR. HALEY: And as an add-on to that, if you want to go through another party, Peggy and I both have a direct line with Suzanne. If you have a specific issue or a general issue, we're happy to forward issues to Suzanne , and we do it almost on a daily basis.

MS. EVANS: And let me just say that these specific things are just for these topics. Anytime you have escalating inquiries, please continue to send them to Ingram and Peggy. I'm the only one that does this and so they're a little concerned that if I have a catastrophe, that there is no back-up. So we are in the process of training some girls to be my back-up if, God forbid, I get hit with a Mack truck or something. But they don't have access to my private e-mail. So we send it to a box, and it gets filtered back to me. So it's not that I don't want to take your stuff. You know I do. But I just want to be prepared that if something were to happen, that I was missing in action for a little bit, that your issues would be taken care of. So over in the next couple of months, you may see a name Pam or Carla. And I've been trying to let you know if they're going to do it. They're just trying to learn what the process is. So they're very aware of how to handle these issues and where they need to go. But if you see them,

they're not taking over. I'm not letting them have my stuff. But they do need to know what the process is. So they'll just learn it and then drop it, and I'll continue.

9. **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?**

   Response: These coding edits only apply to services billed under Part B.

   Discussion at Meeting

   MS. EVANS: Karen and I had a little side bar here a few minutes ago about this question. Dr. McKinney does regret not being able to be here today. He's on the road traveling. So he does send his regrets. But he texted me on the way down here with his answer, and she's going to send me her documentation, and we'll look at it a little further. But that was his response.

   Most of these codes are for equipment. And since the same equipment is used repeatedly, then a unit of one is appropriate. And the drugs can be billed however many times used. But we talked about that, and we really don't think that's the answer that we want. So I will continue to study that with Dr. McKinney.

10. **If a claim is billed as an inpatient and the claim is denied due to lack of an inpatient order (technical denial) can the hospital rebill this claim as an outpatient because there was never an inpatient order?**

    Response: You can do the ancillary charges on TOB 13X

    Discussion at Meeting

    MS. NORTHCUTT: Is that all charges that were associated as if that inpatient didn't occur?

    MS. EVANS: Whatever the ancillary services are.

    MS. NORTHCUTT: Because when I think of ancillary, I think of lab radiology, like a 121. But it would be if you have a surgery or something else?

    MS. EVANS: Yeah.

    MS. NORTHCUTT: So it's all charges?

    MS. EVANS: Yeah.

    MS. NORTHCUTT: Not accommodation?

THE SPEAKER: Are you saying we can bill on the ancillary the surgical?

MS. NORTHCUTT. Yeah. Under a 131 bill type. What it's saying is because it was billed as an inpatient. But it was denied because it didn't have an inpatient order. So it was never an inpatient because it never had an order. So it was an outpatient. And being an outpatient, then we would bill under 131 bill type with all your services that you provided except for room and board is what she said. Unlike a 121, if you had an inpatient order and they didn't meet, then that's where you have that Part A to Part B rebilling, which is going to change the 121.

THE SPEAKER: What if you have just a billing error? Otherwise technical internal billing error. Your patient got put in the wrong bucket, so to speak.

THE SPEAKER: What was that question?

THE SPEAKER: What if your patient is billed as an inpatient and the doctor, let's say the physician actually billed this observation, but somewhere along the line, it got billed inpatient and the doctor wrote an order for observation, but somewhere in the system it got billed inpatient and it was clearly a clerical error on the hospital's part? What's our options then? Before an audit and after an audit.

MS. NORTHCUTT: Because it sounds like it didn't have an order for the inpatient.

THE SPEAKER: Depends on if it's within timely filing. So if it's within timely filing, you can rebill it outpatient, cancel inpatient claim. If it's outside timely filing, the rebill project 1455 requires an inpatient bill. So you couldn't change it. You'd have to follow the instructions in the 1455. Does that make sense?

THE SPEAKER: Thank you.

MR. HALEY: Anything else on that one?
(No response)

11. **Please help with the following Hospice overlap denial:**
    - **Patient came to ED with cardiogenic shock, very ill.**
    - **Patient was discharged to hospice (note patient was NOT on hospice when she presented to the ED).**
    - **Medicare is denying the hospital ED claim because it overlaps with hospice.**
    - **Hospice won't pay for the ED services because of the diagnosis.**
    - **Is it ok to rebill with condition code 07?**

    It appears condition code 07 is the only way Medicare will reimburse the claim, but the circumstances don't exactly match 07.

    Response: Use condition code 07.

Discussion at Meeting

MS. EVANS: I took this up to the senior claims person, and she said you would use condition code 07. And I've had some examples of that where we've done that, and it has processed and paid.

12. **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?**

Response: Entire stay is billed to Medicare.

Discussion at Meeting

THE SPEAKER: So you're saying if someone elects hospice care in the middle of an inpatient stay, you bill the entire stay to Medicare? What's going to deny for hospice overlap? And, currently, what we do is we split that bill. Because you can't bill it 07 because it's obviously hospice related. So I just wanted to clarify it.

THE SPEAKER: Because, currently, we have someone who's inpatient and they elect hospice in the middle of their stay.

MS. EVANS: During their stay?

THE SPEAKER: During their stay, the middle of it. And we end that Medicare bill right there, we start a new bill for the hospice, and then the hospice picks up the reimbursement after that. And we find those after the fact because we bill it and it denies, saying hospice overlap. We find, well, they started on the 15th with hospice. So we need to bill the 11th through the 14th to Medicare.

MS. EVANS: Let me double-check it. I talked with Cathy, and she said only if it was a SNF would you separate it out. But if it was that the patient elected hospice in the middle of their inpatient stay on Medicare, that you would bill it entirely to Medicare. But let me check on it and see.

THE SPEAKER: Okay. Thank you.

THE SPEAKER: Suzanne, about two years ago, we presented this, and Dr. McKinney came back and said that you would bill the entire stay. However, it got changed. So Debbie and I were going to have to readdress this again. And now if you call customer service, they will even tell you to submit the whole claim. So it's very confusing.

MS. EVANS: They'll tell you to submit the whole claim?

THE SPEAKER: Yes. To Medicare.

MS. EVANS: Under Medicare?

THE SPEAKER: Under Medicare.

MS. EVANS: Let me go back and talk, and we'll get back.

THE SPEAKER: I will just say the way that we handle that is if you have an acute inpatient stay, at the point that they move to an inpatient hospice, they're discharged from acute care, so they're no longer acute care. And so your claim date for the acute care should stop on that day, and then your inpatient hospice claim is billed separately, directly to the hospice agency. Medicare doesn't pay for that. So when you're talking about inpatient, I don't believe there should be an overlap.

THE SPEAKER: We don't handle it the very same way like that at our facility. So I think it's determined how you're handling it at your facility. What we did in the past, prior to two years ago, was we would split it. This part would go to Medicare, this part would go to hospice. Then according to what Dr. McKinney had told us that we have in the RIC minutes, that the entire stay would go. So , like I said, if you call customer service, they tell you to bill the entire stay to Medicare.

MS. EVANS: Is it paying?

THE SPEAKER: They did.

THE SPEAKER: I wanted to clarify too.

THE SPEAKER: They are paying?

THE SPEAKER: That is what we do. We discharge the patient from the acute care setting. They're still in house, but they're under hospice. So if we submit this entire stay to Medicare, it ends the discharge. And we bill hospice a separate claim. So that's why I just wanted to make sure we have our terminology correct to what I was saying. But that is how we bill our claims, and they do pay.

13. **According to SE1333 regarding Part A to Part B rebilling, routine services such as IV therapy and nebulizer treatments cannot be billed on the 121 bill type. If the respiratory therapist performs the nebulizer treatment can the hospital bill these services on the 12X bill type?**

    Response: Revenue Code 0410 (respiratory therapy) 'N' for TOB 12X.

Discussion at Meeting
MS. EVANS: No. You can't bill Revenue Code 410, respiratory therapy, on a 12X.

14. **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.**

    Response: Will discuss at meeting.

    Discussion at Meeting
    MS. EVANS: I don't have a response for this. I'm still waiting on some information from the person who submitted the question, some dates of service. So we looked at the claim. We've got some claims that paid, and they looked at them, but they wanted to look at the ones that are paid appropriately. So I'll get back with that.

15. **Can a physician group bill under reciprocal or locum tenens billing when a new hire physician is not credentialed and there is a sharp increase of volume and the regular physician is unavailable to provide the visit services?**

    Response: Services provided by a substitute physician over a continuous period (consecutive) of longer than 60 days, the regular physician must bill the first 60 days with modifier Q6. The substitute physician must bill for the remainder of the services in his/her name. The regular physician may not bill and receive direct payment for services over the 60-day period.

    Discussion at Meeting
    MS. EVANS: I talked to provider enrollment about this. So it needs to be done within 60 days if you're going to do it that way.

16. **If the MD gives an inpatient status order as phone/verbal and is unable to sign off on that order prior to discharge, but his/her partner is available to sign off on this order prior to discharge, is this appropriate? The MD signing off isn't the MD that gave the order, so we want to make sure this isn't going to create an issue.**

    Response: A verbal or telephone inpatient admission order must be authenticated (signed, dated and timed) by the ordering practitioner (or by another practitioner with the required admitting qualifications in his/her own right and knowledge of the patient) in the medical record prior to discharge, unless the hospital or State require an earlier time frame.

Discussion at Meeting

MS. EVANS: So they can.

THE SPEAKER: Let's suppose that the EDP has admitting privileges and they bring the patient in in an observation. The attending is a verbal order as inpatient, and the patient is getting ready to be discharged and he has not signed that order. Can that EDP, who actually admitted that patient in ops, sign that order at that point, if the attending is not on campus and you can't get that order signed, because he did have knowledge of the patient, he admitted the patient?

MS. EVANS: And did he follow the patient through its course?

THE SPEAKER: No. But he has admitting privileges. And he has treated that patient in the ED.

MS. FOWLER: I believe that if the ER physician has admitting privileges, yes, they can sign. But most ER physicians do not, so they would not be able to. But if the ER physician has admitting privileges, yes.

MR. HALEY: We're going to start with the Two Midnight Rule questions.

17. Discussion of Two Midnight Rule and Inpatient Certification.

a. Discuss how Cahaba will be reviewing the elements of certification and suggestions for provider best practice.

Response: The physician certification includes the following information: Authentication of the Practitioner Order, Reason for IP services, The estimated (or actual) time the beneficiary requires (or required) in the hospital, and Plans for post-hospital care. As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary. (BEST PRACTICE – Separate form; NOT required)

Discussion at Meeting

MS. FOWLER: I just want you all to know that before October the 1st, my hair was totally black. We understand. This has been a considerable source of anxiety, stress, angst,

whatever you want to call it, for you as the provider and for us as the contractor; very much so. Because we receive our technical direction from the same source.

And so to answer the question, the physician certification includes the authentication of the practitioner order, the reason for inpatient services. According to the technical direction, the estimated length of time the beneficiary will require in the hospital and the plans for post-hospital care.

We will use any and all of the medical record up to the very end, including the discharge summary, to try to find this information. Every piece of the medical record will be used to try to find the information for the certification.

THE SPEAKER: Even if the discharge summary is date and timed after the patient has been discharged?

MS. FOWLER: Let me say this: It depends on the physician's progress notes, what he says in those and if they're dated and timed and if the information is there rather than the discharge summary. Okay. If we can find the information that we need anywhere in the record, we will use it. Up until the end and including the discharge summary. Okay. If I have a discharge summary that is not dated and timed, and that happens, I'm doing everything I can, and this is very time-consuming. I'm doing everything I can to go back in that record to look at every single piece to see if I can find that information. If it's there, I'll accept it. If it's not there, I won't. Okay?

THE SPEAKER: I have a question very similar to that.

MS. FOWLER: Sure. Sure.

THE SPEAKER: So if you have a certification statement and, as CMS says, say in your statement that my decision is based on the documentation in my history and physical and the discharge summary and that's signed before discharge, but then the H&P might not be signed before discharge. You have it signed. So is that okay? I mean, does that cover you because he's saying I'm going to put it in there, but maybe he doesn't sign the actual H&P but he signs the certification before discharge, saying, yeah, I thought about it and this is what I'm going to document it.

MS. FOWLER: Right. And yes. If we can find something signed in that record where we can make the requirement, we'll use it. Okay. We'll use it if it's there.

I think CMS's stance is there doesn't have to be a separate form and I think this was part of the question, best practice. There doesn't have to be a separate form. Okay. And the doctor doesn't have to say any specific thing in the record. He doesn't absolutely have to say I expect this patient to be here two midnights. But we have to be able to look at the record and glean that information. We have to try to pull out that physician's intent from that record.

Best practice is for the physician to say it straight out. Signed, dated, sealed, and delivered, that's best practice. But, you know, we do see that sometimes but, frankly, we don't see that very often yet.

Now, when this process gets on down the road and we get more accustomed, and your medical staff becomes more accustomed to the situation, you know, it's all new for everybody, then things will probably be a little bit better.

THE SPEAKER: I have one more question. Early on, Medicare said that the inpatient admission order itself could be used to construe the estimated length of stay. They put that in the document.

MS. FOWLER: Right.

THE SPEAKER: So when you're doing the review, are you looking for the doctor to say because to them, they feel like we're asking them to pull out this crystal ball that says, yeah, patient is going to be here six days or seven days or eight days.

MS. FOWLER: I tend to agree with that statement.

THE SPEAKER: Do we need to be asking our physicians that? Because they're not happy about it. Or is by them saying, yes, this patient is inpatient, then that meets the certification element? Because we know that they're estimating the patient is going to be there two midnights.

MS. FOWLER: Well, according to CMS, they do not have to make a specific statement. They do not have to say I expect this patient to be here two days, three days. But we have to be able to look at the record, look at the order for admission, look at his order for treatment, and follow up and glean the intent of that length of stay, which is what we are attempting to do now. Okay. When we started, we were very strict with what we were looking at. And then, of course, as you all recall, everything was put on hold. We started things up again. So at this point, we are trying to take any information in that medical record that we can glean to meet these requirements. A direct statement is not required.

THE SPEAKER: As long as it says, I guess, we put this in our admit order, we put this in our electronic admission order, is that its expected length of stay is two midnights or greater.

MS. FOWLER: Right.

THE SPEAKER: That way, at least it covers for two and then some more if there is. Because they don't have a crystal ball. But that's how we did it.

MS. FOWLER: Right. And that's fine.

THE SPEAKER: That's there, though. They sign off. It's like one document which has all those elements, and they say it's greater than two midnights.

MS. FOWLER: Yeah. But even if you have a form that the doctor signs the other information has to fall in place for us to use it. And sometimes we see forms that are incomplete, that they'll have a checkmark at the top, something written, but it's not signed or some other area is not complete. But we can find the information in the medical record. So just because you have an incomplete form on the record doesn't mean we're going to deny it. We're going to try to pull out anything we can from that medical record.

THE SPEAKER: And we appreciate that.

THE SPEAKER: But back to the question. If the other information is on the H&P but the H&P was not dated and timed prior to discharge, are you going to be able to use the H&P?

MS. FOWLER: We probably would not, but we would be looking at progress notes and discharge summary. Yeah. There are all kinds of scenarios here, so it's difficult.

THE SPEAKER: If the H&P was not dated and signed prior to discharge and there was no separate certification statement that was signed and dated prior to discharge, I understand you could not use the H&P. But if the certification statement said because Medicare said, you know, that this could be done. My decision is based on information that I am going to document in my H&P, in my progress notes, in my discharge summary. And he signs that statement for discharge and then he goes and dictates his H&P. And in a non-completely electronic world, sometimes that's not authenticated until after discharge.

MS. FOWLER: Right. That's true.

THE SPEAKER: But you've got a signature where he said, in my thought process, that that's where I'm going to put it, and it's going to be documented. That was my question.

MS. FOWLER: Yes.

THE SPEAKER: But we have a case denied right now in that exact same scenario, and the only reason we can figure out, there is a form signed and dated but it refers to H&P. And that's the only thing we can come up with of why we think it may have been denied, is that the H&P was not signed and dated prior to discharge. But the form was, and it was dictated during the admission. But it was not signed and dated. So that's why I was really wanting them to answer that question. Because we really don't really know until we have that opportunity to have that documentation.

MS. FOWLER: Yeah. Was this claim done early on?

THE SPEAKER: Yes, it is.

MS. FOWLER: Well, you all are aware we will reopen denied claims.

THE SPEAKER: Yes.

MS. FOWLER: Claims that were denied early on in this process are being reopened and and reviewed again with the updated direction. And then also while we were waiting on our updated technical direction from CMS, we were looking at claims and we were paying, but we were not denying anything. We were holding them until we got the updated technical direction. And then we went back to those to review them again, which has been a very terrible process for us to have to go through, and I'm sure you all too, because you're losing track of everything, what's going on with this.

But, if that claim was denied early on in the process, then it is in the process of being reopened and looked at again. So, hang on before you appeal.

THE SPEAKER: Well, define "early on."

MS. FOWLER: I would say this was effective October 1, since the very beginning. I think we started really adjudicating claims in December, I mean, since the very first claims were denied. We're having to go back and we are reopening every single one of those claims that were denied and looking at them again.

THE SPEAKER: But our claims that we've just recently gotten our denials.

MS. FOWLER: Do you have a results letter from our educator, or are you saying you're seeing them on FISS?

THE SPEAKER: Just the remittance.

MS. FOWLER: Just the remittance?

THE SPEAKER: And something off of FISS, though. We do have something off of FISS.

MS. FOWLER: Right. I would say if you're looking in the past three weeks, that would be a part of the probe sample. Yeah. But, now, when you get your letter the new probe sample.

MS. EVANS: The current probe sample.

MS. FOWLER: Yeah. Because we're in the process of re-adjudicating these. But you're going to get a letter with every single claim listed. Okay? We're still working on that. But you will get every single claim that was reviewed with a rationale. Okay?

THE SPEAKER: If for some reason we do not in a certain time, do we contact you? Is there a time frame that we would say, hey, we didn't get a letter and we're supposed to?

MS. FOWLER: Okay. Now, understand we're reopening and reviewing lots of claims for the second time. We are also double-checking when we feel we have your probe sample

finished. The sample has to be finished. Yes. Either your 10 claims or your 25 claims. All of those claims have to be completed before you will get a letter. Okay? All of them.

MR. HALEY: Do you have a range of time that you're reopening the claims? Is it October 1 through when?

MS. FOWLER: Back from the very beginning. Yes. We're reopening all the denied claims and applying the new technical direction.

MR. HALEY: Since when? Like, through January 30 or Feb '14? I mean, what's kind of the window. Obviously, starting October 1st when the rule went into effect through when?

MS. FOWLER: We got the technical direction on February the 10th. So anything denied prior to that, we're looking at again.

THE SPEAKER: So just to kind of clarify what you have just been telling us, if you got probe sample denials, you should not appeal.

MS. FOWLER: Exactly.

THE SPEAKER: And wait until we get a letter from you?

MS. FOWLER: Absolutely.

THE SPEAKER: And that letter should come sometime in April, March? Don't know yet?

MS. FOWLER: You know, I hate to even tell you. Probably I would say within the next month we're going to be finishing a lot of probes. So I would say maybe within the next four to six weeks.

THE SPEAKER: Once we get that letter, then we'll send out the probe and educate calls?

MS. FOWLER: Yes.

THE SPEAKER: And then assuming we would need another one, we would go back in FISS for the second wave of probes?

MS. FOWLER: Yes. The second probe.

THE SPEAKER: For the second 10 and 25. And then there would be a third wave, which would be the numerous claims.

MS. FOWLER: Yes if it's a major concern, yes. There would be a third where many, many claims will be pulled.

THE SPEAKER: And the major concern is anything over three denied in the initial probe? 3 of 10 is moderate?

MS. FOWLER: Yes, moderate to significant concern is 3 of 10.

THE SPEAKER: Of 10.

MS. FOWLER: Of 10.

THE SPEAKER: So we'll get a letter sometime in the next month. Assuming that you have three or more out of your 10, you will get a second probe of 10 or 25, depending on your size?

MS. FOWLER: You will get a letter and an opportunity to talk to our educator, and then the second probe will be initiated.

THE SPEAKER: And then if you have that again, you will go into the hundred probe?

MS. FOWLER: Yes.

THE SPEAKER: And that will all be done by October 1st?

MS. FOWLER: Should be. Well, depending on the situation with all the contractors in the country. You know, CMS tends to extend things sometimes, depending on how things are going. But right now, the date is October 1st. Yes.

THE SPEAKER: Thank you very much.

MS. NORTHCUTT: And let me just say, just because I know I have to deal with this a lot, on this particular example, when you get the letter, is that when you also have your education. And do you get to appeal those three out of the ten if you still disagree?

MS. FOWLER: Sure. You have appeal rights on all of this.

MS. NORTHCUTT: So you would still be in the appeal process?

MS. FOWLER: Yes. Uh-huh.

MS. NORTHCUTT: But you would already have your second probe going. I mean, you could.

MS. FOWLER: You could, yes.

MS. NORTHCUTT: So it really might not be till the third probe till you know if you won your first one to know if you're going to be probed again.

MS. FOWLER: You know how all these things overlap. So yeah.

MR. HALEY: I have a request. And this is the first time I think a lot of us have heard this, if any of us have heard it. Is there any way that we can hash out a point by point, just a quick little statement or letter or something that says this is what we intend to do over the next six months with the Two Midnight Rule in terms of, you know, take the claims or re-reviewing, that type because there's so much confusion. I'm getting questions. Everyone is questioning it. And we understand your situation. But at the same time, I think it would be helpful, I think, for everybody here.

MS. EVANS: Kind of like a timeline?

MR. HALEY: A timeline or just a here's what we're doing.

MS. FOWLER: Well, CMS has directed the contractors to allow them to post these updates and timelines on their website. So they have posted a lot of this on their website. But I will tell you that because the situation is as it is, the contractors are in different stages with reopenings and the claims that were being held that are being reviewed and re-reviewed and released. And so, you have to basically go to CMS's website to see their timeline on everything.

MR. HALEY: I guess my question in point was, are you sticking directly to the CMS timeline and that you're looking at claims from October 1 through February 10th?

MS. FOWLER: Yeah. We have to. Yeah.

MR. HALEY: And that's out on the CMS website specifically that says that?

MS. FOWLER: Yes, it is.

THE SPEAKER: My question is about that February 10th, because they said that any of the claims under re-review will not be held to the 120-day appeal timeline due date. So I need to know if I got a denial on February 25th or February 11th, am I going to be held to the 120 days for that, or is that one under re-review? I think that's why it's so important that date we know. I think on Medicare, it says any claim prior to January 30th would be in the re-review program.

MS. FOWLER: Well, now, we held a lot of claims too and did not actually put through denials if we thought we needed to deny. And that has taken place, I'd say, maybe in the past

two weeks. I would wait until the probe samples finished and you get your letter and potentially one-on-one call if you choose to have it. Yeah.

THE SPEAKER: So the letter and the call is for the first probe. You're going to educate us through the first probe?

MS. FOWLER: Right.

THE SPEAKER: So say that happens and you guys educate us on the 25th of April. And so then on our second probe are you going to pull any accounts prior to the 25th of April?

MS. FOWLER: No, we will not. No.

THE SPEAKER: Thank you.

THE SPEAKER: Can you explain to me what the verbiage will look like if this is done, to know that it's a probe and educate denial? The reason why I ask that is, early on we got two denials, and the verbiage there is very different from some we just got very recently. And so I'm looking at it very anxious, and I have angst. And I'm sure others do as well.

MS. FOWLER: Are you talking about the actual rationale for the denial?

THE SPEAKER: Yes, ma'am. So that's how I'm getting them. So when I read the rationale, I want to make sure that I'm dealing with a probe and educate.

MS. FOWLER: Yeah. If you see a claim with the rationale that says the Two Midnight Rule, you know that's the Two Midnight Rule probe and educate process. And we do still have claims in the system that we continue to adjudicate that are under the old system. And you may be seeing some of those too. But what you need to look for is the phrase "the Two Midnight bench mark" at the beginning of the rationale. And the denial codes are a little different too. They're different than what you've ever seen.

THE SPEAKER: I stepped out and I'm afraid that I did miss this. But on the rationales that we're getting now, if they're paying specifically what about that Two Midnight Rule that was denied? Didn't say if it was because of the order or the lack of medical necessity. Is there something that's going to be specific so that we would know where we needed to improve it?

MS. FOWLER: Yeah. For one thing, we made the denial reason code specific to what the situation is with the claim. Like, one code stands for fails to meet two midnight expectation. There's another code that will tell you there's no admission order present or admission order is invalid. The codes are very specific.

THE SPEAKER: And there's a key?

MS. FOWLER: On the claims. Well, it should be. You should be able to see that, because the narrative of those codes should be out there for you to see on the system. Other than that, the rationale should tell you whether that claim meets the two midnight expectation or fails it or if there is a problem with the order or some part of the certification. The narrative part of that rationale should tell you that.

THE SPEAKER: Because I haven't seen that.

THE SPEAKER: It would help to have a list of the new denial codes and the descriptions just so you know what to look for.

MS. FOWLER: Okay. I have a question. Under the old system in the hospital, when you were looking at these things, where did you see the narrative description of, say, 54155? Where would you see that? Is there a place for you to see that?

THE SPEAKER: Not for me. I haven't seen anything, unless our bills can relate to anything. I haven't seen anything. Because I'm used to just a 56155.

THE SPEAKER: We just know that's what it means. 56155 is medical necessity. We just kind of learn it.

MS. FOWLER: You just kind of learned it just over the process of time? Okay. By matching it up. All right. Okay.

THE SPEAKER: You're talking about the reason code that's stored in FISS, correct?

MS. FOWLER: Right. It should be.

THE SPEAKER: So if you go into FISS through your claim status, you should hit F1 and that code description should be there for those hospital users. It may be something you've got to go through the billing department if you don't have FISS access.

MS. FOWLER: Right. It's housed in FISS in the same location that all the other reason codes are housed.

THE SPEAKER: I think it's probably because the people who are reviewing the rationale are not the billing people.

MS. FOWLER: Okay.

THE SPEAKER: So we need you to go back to our billing people and say please look in F1 and tell us what that means.

MS. FOWLER: I was a little confused, because I thought, I know they've got access to that. Okay. Great.

THE SPEAKER: We can work with our billing.

MS. FOWLER: Okay. Wonderful. Thank you.

b. What documentation do you expect to see in the medical record, beyond the certification elements, to support a reasonable expectation of Two Midnights?

Response: There can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting. Medicare review contractors evaluate the physician's expectation based on the information available to the admitting practitioner at the time of the admission. The expectation is based on patient history and co-morbidities, severity of signs and symptoms, current medical needs and risk of adverse events.

Discussion at Meeting

MS. FOWLER: You know what? I think we talked about this. Yeah. We covered this one. We are desperately looking at everything in the record.

c. Define medically necessary hospital services.

Response: Reasonable and necessary diagnostic and therapeutic services that are continued for the span of two midnights, including treatment time in the Emergency Room (excluding triage time), time spent in the OR, an observation bed or other treatment area. Delays in the provision of care or factors of convenience to the hospital or the patient will not support admission decisions or length of stay.

Discussion at Meeting

MS. FOWLER: And this is the key for all you case managers and people who deal with looking at these records. The definition of "medical necessity" has changed with the advent of the Two-Midnight Rule. There is no longer a level of service issue with any of this, services that can only be provided on an inpatient level of care versus outpatient.

For instance, a patient who waits from Friday till Monday for a heart cath. Okay. Classic exam. Or, someone who can't get to the hospital to pick up Momma or Daddy and they're delayed a day, that sort of thing. So the level of care issue that we dealt with since my hair wasn't gray, and that's been a long time, no longer exists.

MS. NORTHCUTT: So on some of the original ADRs, when it said it meets outpatient level of care as the denial is that still appropriate?

MS. FOWLER: That is no longer a part of the rationale. Yeah. Yeah. That was a part of the rationale in the beginning when all this started. And now we've revamped, and the rationales will look different.

THE SPEAKER: I have a question that's kind of related. What about patients who rapidly improve? Because we see that a lot.

MS. FOWLER: Yes.

THE SPEAKER: I mean, I look at the ER notes and I'm like, oh, if I was the ER doctor, I would definitely think this 90-year-old person would have to be here two days. And then all of a sudden, the next day, they're like, I want to go home, and the doctor is sending them home, you know.

MS. FOWLER: We do see that.

THE SPEAKER: What kind of documentation do we have to have I mean, because, you know, the doctors are not typically saying, well, I expected two midnights, but they rapidly improved. I mean, it's not going to be that black and white in the record.

MS. FOWLER: It's a clinician's judgment at the time of the review. They will look at the situation, the patient was in the emergency room and how sick they were. And then if it's a situation where the patient rapidly improved, the doctor expected them to be there longer, it was reasonable that they probably would have been there longer, and they improved rapidly, then, yeah, that would be a claim that if all other elements are present, then we would likely pay that. Yeah.

THE SPEAKER: I think the case management screening criteria because I'm a case manager.

MS. FOWLER: Yes.

THE SPEAKER: And we're having a hard time getting away from that. We still use that as a guide, correct?

MS. FOWLER: Yes. As a guide only.

THE SPEAKER: But if a physician says that he believes that they need to be inpatient, we need to go with what the physician says, correct?

MS. FOWLER: You have to go with the physician. Yes. Basically, remember, there is no level of care anymore. That no longer applies. If the patient comes in with whatever issue and is receiving diagnostic and/or therapeutic treatment for a span of two midnights.

THE SPEAKER: Well, is there any way that you are going to see observation because a lot of times we have a patient that comes in observation, stays 24 hours. The physician says I think they need to stay another two nights or so. They stay another night. And that looks like a one-day stay. Will you guys be able to see the observation and the one night?

MS. FOWLER: Absolutely. We add all of that time prior to. I mean, when these claims are pulled, when the edits are set up, we pull one-day stays basically. But many of the claims we get have obs time and ER time in front. And that is a part of the Two Midnight. So yes, that's the way it's done.

MS. NORTHCUTT: Do you look at the occurrence code 72 that they've proposed?

MS. FOWLER: Well, no, we don't. We haven't yet as a part of the edit because it's not really required.

MS. NORTHCUTT: Because they invented something to put on the bill that will wave at you and say, you know, this is really two spans to midnights but only has one inpatient day.

MS. FOWLER: Right.

MS. NORTHCUTT: So I didn't know if that was working anywhere.

MS. FOWLER: Well, if the facilities are not required to use it, then, you know we would not edit.

MS. NORTHCUTT: Yeah.

THE SPEAKER: On one of the CMS calls, someone asked a question and the doctor or CMS answered it this way too, about the patient has stayed one midnight in outpatient obs. Everybody kind of feels that's what they needed to do. And then you recognize maybe 12:00 the next day. They've been there one midnight. That the patient will stay the following midnight but you're not going to stay two more midnights past that. You know, so they have their time back and forth. And the way that someone asked, if you even recognize that the patient is about to go out the door, should you go ahead and get the inpatient order. Ronald Hirsch asked that question on one of the CMS calls. And CMS said, well, obviously, if the physician forgot to write the inpatient order, you should go ahead and do that. And I'm thinking, well, how do you determine that he forgot to write it, you know? I mean, did you hear that? Because Ronald Hirsch asked it saying even if you know they're about to be discharged and they've met their two midnights and somebody just didn't get the inpatient order, you should go ahead and write the inpatient order. And that's so against anything we've ever done.

THE SPEAKER: But from that point forward is what they said.

THE SPEAKER: Yeah.

THE SPEAKER: Yeah. It would definitely hit your one midnight.

THE SPEAKER: And they answered it like, well, obviously, the physician forgot, you know, thinking, well, okay.

MS. FOWLER: Well, the only thing that I will say about that is that if I see a progress note in that record and it says plan to admit this patient and all this stuff is going on, I could probably use that. So I'm looking at everything in the record.

d. Providers are receiving probe audit denials from Cahaba with the rationale "Services could have been rendered appropriately at an outpatient level of care".
   1. With the new regulations what differentiates outpatient level of care from inpatient level of care?
   2. What is the best practice for determining the difference?
   3. On what is Cahaba basing their determination?

Response: Answer to all points above: Due to receipt of updated instruction from CMS, Cahaba will re-open these claims and adjudicate based on revised guidelines.

Discussion at Meeting

MS. FOWLER: I think we just talked about this. Do you all have any other question about that? You know, it's very, very hard to change a mind-set in a day or week or a month or six months. So from your standpoint in dealing with hospitals and physicians, it's very, very difficult. And from our standpoint, the contractor's standpoint, from those of us who have been looking at claims and making medical necessity decisions for years and years and years, and all of a sudden one day we change and we're doing something totally different that's totally foreign, it's very difficult to make that change overnight. So we're going to make mistakes. I'm going to make mistakes. Our clinicians are going to make mistakes, the hospitals are going to make mistakes. We need to try to work together. We're not going to be perfect on this. It's going to take a while for us to get this under our belt. And by the time we think we may halfway have control of it, then something else is going to change probably.

Yeah. We've got ICD10. You're right. Why did you say that? But any other question about that situation? I think we've discussed the level of care.

THE SPEAKER: Since it's no longer there.

MS. FOWLER: It's no longer there.

THE SPEAKER: This kind of ties into the level-of-care question. Right now we're using internal and external physician advisors. And being that there aren't any level of cares anymore, when do you suggest that we utilize these services if the physician has stated I want this to be an inpatient?

MS. FOWLER: Well, the example that you gave a while ago about the patient rapidly improving, and you're looking at the situation in the ER possibly on a one-day stay. You may need the physician's opinion on was this patient critically ill enough for the admitting physician to have expected that patient to be here two nights, and the patient improved overnight. Or was the patient really not ill enough, should we have just kept them on an observation bed. Those sorts of things.

THE SPEAKER: Because we're trying to utilize those services within that first 24 hours, and that physician has already made their determination. So we don't know if the patient is going to get out or if they're going to discharge within one day. So we're trying to capture these in the forefront to help support and help validate that inpatient status.

MS. FOWLER: Which is practically impossible.

THE SPEAKER: That's kind of a paradigm.

MS. FOWLER: It's impossible. It's practically impossible to do. You have to have a medical staff who's on board with this. I really don't know what's going on with this patient. Let's just keep them on an obs bed until tomorrow. When I see them tomorrow, if I see they're going to have to stay another night, then I'm going to admit them. And until the medical staff gets on board and gets into that train of thought, it's going to be a difficult process. Yeah.

THE SPEAKER: Because we're kind of slapping their hands now. Because we're still in that level-of-care mind-set.

MS. FOWLER: And so is everyone. It's going to be a transition process. Yeah.

e. At what point should providers expect to receive a 1:1 phone call to discuss probe audit findings and what individuals from Cahaba and the provider are expected to participate in the call?

Response: Instructions regarding this educational process will be forthcoming after completion of the entire probe sample for each provider. Claims will be reviewed based on updated guidance from CMS.

Discussion at Meeting

MS. FOWLER: Now, we have a clinical educator, and she will be handling the phone call. At this point, we haven't even had any of these phone calls yet. So I don't know exactly

what staff you can expect to have on the phone with you and at your discretion, who you have on the phone from your end. But you will get a letter first with all 10 or 25 probes in that letter, the rationale explained. And then you will be offered the phone call, and we'll be giving the numbers or the e-mail address to call to arrange the one-on-one educational call.

THE SPEAKER: Will the letter include all that information?

MS. FOWLER: Yes. It will have all that in there.

18. Can the MAC review psychiatric facilities exempt under TEFRA for the Two Midnight Rule when exempt units do not fall under IPPS? If so please provide a supporting reference.

Response: Based on research, TEFRA was a type of reasonable cost payment system. January 1, 2005, it was replaced with the IPF PPS payment system. Psychiatric hospitals and psychiatric units that used to be paid reasonable-cost under TEFRA, § 1886 (b) of the Act, are now paid under the IPF PPS.

IOM 100-02 Chap 2 Inpatient Psychiatric Hospital Services 10.1

Discussion at Meeting

MS. FOWLER: Any questions about that? So the answer to that would be yes. We can pull those claims, since they're paid under PPS, with the reference given there.

19. Cahaba has requested 24 medical records from our facility to review our compliance with the Two Midnight Rule. Out of these 24 records, 7 involve a Medicare designated *inpatient only procedure*. Because admissions of patients who undergo inpatient only procedures are excluded from the two midnight requirement and because of our recent encounters with Cahaba and Connolly incorrectly denying claims with inpatient only procedures, we are very concerned we are at risk of an overinflated assignment of probe audit error rate.

a. What can providers do to have these excluded from the two midnight probe audits for status review?
b. What should the provider do if an inpatient only claim is inappropriately denied with resultant incorrect assignment of a probe audit error rate because inpatient only procedures are specifically excluded from the two midnight requirement?

Response: Answer to all points above: Cahaba has a process in place for screening claims with possible inpatient only procedures. The Certified Coding Specialist attempts to screen claims in LOC B6001 for inpatient only procedures. ICD-9-CM procedure codes are translated to corresponding CPT/HCPCS codes by the CCS and are compared to the

listing in Addendum E. If an inpatient only procedure is found, the claim is released. Because the CCS may be unable to screen every claim, nurse reviewers are also instructed to refer all claims and appeals with a possible inpatient only procedure for coding validation. The medical record (including operative notes, progress notes, etc.) is reviewed by the CCS. The appropriate ICD-9-CM procedure codes are translated to corresponding CPT/HCPCS codes by the CCS and are compared to the listing in Addendum E. If an inpatient only procedure is found, the claim is released. Despite having this process in place, there may still be claims denied with a possible inpatient only procedure. Providers may address this issue at the time of the 1:1 educational phone call and/or may appeal the initial decision.

Discussion at Meeting

MS. FOWLER: We talked about this a while ago. It's the exact same procedures for these claims as any of the other claims, trying to crosswalk. With the two midnight probes, our coder has been trying to prescreen when the claims hit Location B6001, when the ADR goes out. And we've had one of our claims people working with Part A, one of our reporting people has been releasing those, which I think has caused confusion for the hospitals really. But we're trying to, if we saw an inpatient-only procedure, to release it, and then we would pull another claim to replace it. That has been our procedure to date because we do not have a crosswalk.

Aside from that, when the clinician reviews the claim, if she sees a potential inpatient-only procedure, and all of our clinicians have the inpatient-only list, the narrative descriptions for the codes. So they know really the most frequent procedures that would be inpatient only. But I'm not going to tell you they don't miss them and you know they do. They send those claims to the coder, and then she recodes the claim. And if it's an inpatient-only procedure, then we would pay the claim.

THE SPEAKER: Is your coder reading the operative report?

MS. FOWLER: When it hits the location B6001, the only way we've had to catch them is for her to look at the procedures that are built. She translates those into the CPT codes. And if that code is on the inpatient-only list, then we release that claim and we replace it with another one.

THE SPEAKER: ICD9 procedure codes are so vague.

MS. FOWLER: I understand that. But we're giving you the benefit of the doubt on that.

THE SPEAKER: So are you saying once you identify that it is an inpatient-only procedure, you're not doing any further audit at all?

MS. FOWLER: No. No. If we catch it before, and our coder does the best she can, but we've got one coder for three states. So we're not catching everything. So if she translates one of your codes that you have built and it is on the inpatient-only list, we're releasing the claim and we're pulling another claim.

And then, there are other times that we might release and pull another claim, so that it appears to you as if the probe sample is a little higher. For instance, if we see a claim where the patient was transferred hospital to hospital, transferred out, we're not supposed to review that claim. And so we release it and we pull another claim for the probe sample. If we find a patient who is released AMA, we exclude that. We pull another one.

So, there are reasons why your probe sample seems higher. Because we're releasing some of these claims and not reviewing them, and we're having to pull additional claims.

THE SPEAKER: I have a question. When you're re-reviewing the initial ten in the probe sample, will that affect how many you're going to do in the second round of probes?

MS. FOWLER: It's a totally new error rate. Yeah.

THE SPEAKER: We were just curious. We were talking about does that one coder have an encoder they put in the IC9 and CPT codes.

MS. FOWLER: Oh, yeah, she does.

THE SPEAKER: I was going to say thank you for answering all these questions. I think I feel a whole lot better about the whole two midnight thing after having you come talk to us. So thanks for coming.

MS. FOWLER: As I said, we're going to make mistakes. We are struggling. We have the exact same struggles you do. We're just in a different scenario than you are. So we will make mistakes. We have no problem backing up and doing something again if we find that we need to do that. And we understand how confusing it is for you. We're going to have to work together to try to get to the other side of this very confusing process. And there'll be another change before long that we'll have to revise.

MS. NORTHCUTT: There's a bill proposed on March 6th if anybody hasn't read it yet. I read it yesterday afternoon. You know what I like to do on my weekends. It's the Two Midnight Rule Coordination and Improvement Act of 2014, where they're asking for the development of criteria and how they're going to pay short stays. And if it's passed, then they want to have another criteria where the stakeholders all get together and form what that criteria looks like by October 2015. But they still want the MACs to do the probes.

But talking about the crosswalk, I did want to say that they want a mandated I10 codes to CPT code crosswalk that results in a DRG to APC crosswalk by 2017. In that regard, you can basically almost see the short stays being bundled into an encounter like we all thought it would be in the first place. I think it will probably get down to here's your chest pain, here's your COPD, here's your lump sum money. We don't care if you keep them one day or three days.

But, anyway, if you haven't seen it out there yet, it was printed March 6th, and it's a bipartisan bill. So when you say, yeah, it will probably change again, they're already rattling.

MS. FOWLER: Oh, well.

MS. NORTHCUTT: So there you go.

MS. FOWLER: Guarantee. That's the name of the game.

Additional Discussion at the Meeting

THE SPEAKER: I have one last question. And this came out since we asked the questions. The physician denials that CMS has said that contractors can now issue in an automated fashion, they updated the program integrity manual and said that if an inpatient hospital admission is denied, the contractor can automatically take back the physician's payment for seeing the patient in the hospital. Have you heard of any of that going to be implemented?

MS. FOWLER: That does not apply to the Two-Midnight Rule yet.

THE SPEAKER: Right. It doesn't.

MS. FOWLER: I've not had a meeting about that yet.

THE SPEAKER: Are we done with two midnights? I was thinking of asking a question about ICD10.

THE SPEAKER: I have one question about this self-audit process. And it says that the physician has to concur in order for us to, say, bill that patient Part B if we determine after reviewing, hey, we really don't think that we should bill for Part A. Is there anything that's specific that we need to have as a facility that says that physician concurs? You know, it's different when on the condition code 44 side. You're going to get his signature on that order change to outpatient. But now we're actually leaving the claim, of course, as A and taking Part B. So what would you be looking for? That beneficiary actually was writing and going to appeal that part of the process.

THE SPEAKER: We couldn't find anything that said there had to be anything with the physician's signature on it. But we're struggling with how are you going to know that he was involved. We have to notify him, the physician?

MS. FOWLER: You probably would.

THE SPEAKER: You have to.

MS. FOWLER: Yeah. I don't know, if it's not a part of the medical record, I don't know how we would know.

MS. NORTHCUTT: Aren't you going to do a take-back on the inpatient claim anyway?

THE SPEAKER: This is a self-audit.

MS. NORTHCUTT: It's a self-audit.

MS. FOWLER: On a self-audit?

MS. NORTHCUTT: I don't think there's going to be a signature.

THE SPEAKER: I mean, we can document that we spoke to the physician and the physician agreed, but we're wondering and we spent a lot of time talking about it. But, when the physician comes back and says, no, they didn't talk to me, we're like, yes, we did.

MS. FOWLER: Yes, it could be. So I don't know.

THE SPEAKER: The patient is discharged.

MS. FOWLER: Yeah.

MS. NORTHCUTT: Scary thing, I guess, about that, and we've rolled it around and looked at the conditions of participation and everything else without patient notification. And I think that's been kind of overlooked in this whole process, is that really you have two days after discharge, after that determination is made to contact the patient and let them know that their status had changed.

MS. FOWLER: Well, if you're going to take back the inpatient payment and bill it outpatient, I won't be looking at it anyway.

MS. NORTHCUTT: Yeah. You won't get it.

MS. FOWLER: I won't get it.

THE SPEAKER: And we want to make sure that we're doing the right things.

MS. FOWLER: Yes.

THE SPEAKER: Unless the patient appeals the outpatient, which they do. They say, no, I don't think I should be outpatient, and they might send it to you.

MS. FOWLER: You know, I've not seen that yet. After several years, I've not seen that happen.

THE SPEAKER: We're concerned that the patients are going to be upset. You know, they're obviously going to be upset, and we want to make sure that we have followed the

process. Because then they can turn around and sue us and say you didn't follow the process, you didn't do this right. You know, so we just want to make sure we follow the process right.

MS. FOWLER: Right. I understand.

THE SPEAKER: But I think the original question was how do you know.

MS. FOWLER: Yeah. I won't be pulling the inpatient claim if you're going to bill it Part B.

THE SPEAKER: I understand. We're going to bill Part B. My concern is that the beneficiary is going to kick back after a while.

MS. FOWLER: Yes.

THE SPEAKER: Because there's a lot of communication out there that says you need to demand for inpatient.

MS. FOWLER: Right.

THE SPEAKER: So if they're going to appeal this, how do we protect the facility, the hospital, to say that we did follow the steps and we did the process correct, and where would it be expected if a beneficiary appealed it to Cahaba? Say I don't like this decision. I want somebody to look into it. Where are you going to look at the facility and say where is your concurrence from the physician?

MS. FOWLER: Yeah. This is after. The record is already complete. I mean, you know —

MS. EVANS: It almost sounds to me, and I know this, you might need to talk to your in-house attorneys or something to see since we don't have a real definite answer for that. And I can see the patient being upset, because they're going to have to pay more money.

MS. NORTHCUTT: No. You can self-audit any time after the patient is discharged. That's the problem. Condition code 44 is inpatient to outpatient while the patient is still here. And then they come up with Part A to Part B rebilling when you self-audit after the patient is discharged. And that's what's thrown the new monkey wrench in of how do you tell the patient when they're not there anymore, how do you get an order from the doctor when they're not there anymore. And I think they're going to say you really need to do all of this before the patient leaves, in general. But I don't even know where the documentation would land.

MS. FOWLER: That would have to be determined. That's not something that we would know.

MS. NORTHCUTT: Yeah.

MS. FOWLER: To be determined.

MR. HALEY: That's all then. Thank you for coming today.

Follow-up Suzanne Evans
The question was who gets the probe review letter. I checked with the nurse handling this:

> **It will be addressed to the attention of the Compliance/Administrator to the Medical Review Correspondence Address that is in FISS.**