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Task 13
Physician Review of Inpatient Admission

Quality Improvement Organization Program

- **Purpose**
  - Improve the quality of care delivery to Medicare beneficiaries
  - Protect the integrity of the Medicare Trust Fund, by ensuring that Medicare only pays for services and goods that are:
    - Reasonable and medically necessary
    - Provided in the most appropriate setting
- **The Quality Improvement Organizations (QIOs) have a significant history of collaborating with hospitals and other stakeholders to ensure high quality care for beneficiaries**

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History

- **In recent years, through the Recovery Auditor (RA) program, the Centers for Medicare & Medicaid Services (CMS) identified high rates of errors for hospital services rendered in a medically-unnecessary setting (i.e., inpatient rather than outpatient)**

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History

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

BFCC-QIO Inpatient Review Role

- Beginning on October 1, 2015, the Beneficiary and Family Centered Care QIO (BFCC-QIO) assumed responsibility for conducting initial patient status reviews of providers to determine the appropriateness of Part A payment for short stay inpatient hospital claims
- The BFCC-QIO (KEPRO for CMS Areas 2, 3, and 4) will conduct "Revised Determination Reviews" on a sample of inpatient hospital Part A claims for appropriateness of inpatient admission under the Two-Midnight rule for acute care inpatient hospitals, long-term acute care hospitals (LTAC), and inpatient psychiatric facilities

BFCC-QIO Inpatient Review Role

- **BFCC-QIO patient status reviews will focus on educating doctors and hospitals about the Part A payment policy for inpatient admissions**

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BFCC-QIO Inpatient Review Role

- On October 30, 2015, CMS released updates to the Two-Midnight rule regarding when inpatient admissions are appropriate for payment under Medicare Part A
- These changes continue CMS' long-standing emphasis on the importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries
- These updates were included in the calendar year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule

Recovery Auditor (RA) Review Role

- Patient status reviews will be referred to the RAs for those hospitals that have shown trends of consistently high denial rates based on BFCC-QIO patient status review outcomes, and after discussion with CMS
- Parameters for a high denial rate have yet to be determined by CMS

Two-Midnight Rule

- **In general, the Two-Midnight rule states that:**

  Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation

- **Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights**

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Two-Midnight Review Rule

- **In the 2016 Outpatient Prospective Payment System final rule, CMS maintains the benchmark established by the original Two-Midnight rule but permits greater flexibility for determining when an admission that does not meet the benchmark should nonetheless be payable under Part A on a case-by-case basis**

Two-Midnight Review Rule

- **For stays expected to last less than two midnights, CMS has adopted the following policies:**
  - For stays in which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the Inpatient Only List or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician
  - The documentation in the medical record must support that an inpatient admission is necessary and is subject to medical review

To access the hyperlink above, please right click the underlined text, and select "Open Hyperlink." From the CMS website, click on CY2015 OPPS Addenda (located in the "Related Links" section at the bottom of the webpage.) The Inpatient Only List is Addendum E.

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Two-Midnight Review Rule

- CMS is reiterating the expectation that it would be unlikely for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight
- CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review

Two-Midnight Specifications

- **The rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners**
- **For hospital stays that are expected to be two midnights or longer, *if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment***

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Two-Midnight Specifications

- The Two-Midnight rule does not prevent the physician from providing any service at any hospital, regardless of the expected duration
- This includes stays in which the physician's expectation is supported but the length of the actual stay was less than two midnights due to unforeseen circumstances, such as unexpected patient death, transfer, clinical improvement, or departure against medical advice

Two-Midnight CMS Guidance

- **In the CMS guidance, Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After October 1, 2015, (p. 3) and repeated in January 1, 2016 (p. 4)**
  - "…if the reviewer determines, based on documentation in the medical record, that it was reasonable for the admitting physician to expect the beneficiary to require medically necessary hospital care lasting two midnights, the inpatient admission is generally appropriate for payment under Medicare Part A"

To access the hyperlink above, please right click the underlined text, and select "Open Hyperlink."

Two-Midnight CMS Guidance

- **Also in the same CMS guidance: 1862(a)(1)(A) of the Social Security Act limits Medicare payment to reasonable and necessary medical treatment:**
  - SEC. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services—(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

Short Stay Review

- **CMS provides monthly total adjudicated Short Stay claims from which BFCC-QIOs draw samples**
  - Beginning April 2017, the Short Stay Review methodology has been refined to focus on the top 175 providers (per contracted area) with a high or increasing number of short stay inpatient claims
  - This targeted approach will allow CMS to improve oversight of hospital billing under the Two-Midnight policy
  - Providers will be requested to send a 25 case sample

Short Stay Review

- Additionally, providers that were noted to be a Major stratification at the end of the previous round and if not within the previously stated group, will be requested to send a 10 case sample
- One file per state
- Pulled from CMS claims database
- Claims should not contain stays with Inpatient Only procedures associated with them

Short Stay Review

- **Claims involve the following facilities:**
  - Acute care hospitals
  - Long-term acute care hospitals
  - Inpatient psychiatric hospitals
- **Excluded facilities include the following:**
  - Critical access hospitals
  - Inpatient rehabilitation hospitals

Short Stay Review

- **Excluded claims involve:**
  - Claims in which the discharge disposition code:
    - 07 (Left against medical advice [AMA])
    - 20 (Expired)
    - 02 (Discharged/transfer to a short-term general hospital for inpatient care)
  - Claims which involve procedures listed on CMS' Inpatient Only List
  - Other "do not pursue" claims
  - Indirect Medical Education (IME), Medicare Advantage, and Medicare secondary payer claims

Nurse Reviewer Guidelines

- **<u>Step 1</u>: Did the inpatient stay, from the point of a valid inpatient admission order to discharge, last "two midnights"?**
  - To assist with the Nurse Reviewer's determination, InterQual® will be utilized to determine findings from the medical record as to what condition, symptoms, diagnosis, and predominant clinical findings were to "check" if the beneficiary criteria qualified for the medical necessity of the admission
- **<u>Step 2</u>: Did the patient need hospital care?**
- **<u>Step 3</u>: Did the provider render a medically necessary service on the Inpatient Only List?**

Nurse Reviewer Guidelines

- **Step 4: Was it reasonable for the admitting physician to expect the patient to require medically necessary hospital services, or did the patient receive medically necessary hospital services, for two midnights or longer, including all outpatient/observation and inpatient care time (assuming all other requirements are met)?**
- **Step 5: Does the claim fit within one of the "rare and unusual" exceptions identified by CMS (currently mechanical ventilation)?**

Nurse Reviewer Guidelines

- **<u>Step 6</u>: For claims with a date of admission on or after January 1, 2016:**
  - Does the medical record support the admitting physician's determination that the patient required inpatient care despite not meeting the Two-Midnight benchmark, based on complex medical factors such as:
    - Patient history, comorbidities, and current medical needs
    - Severity of signs and symptoms
    - Risk of an adverse event

Peer Reviewer Assessment Form

- The Peer Reviewer Assessment Form (PRAF) will be completed by the Nurse Reviewer after review of the medical record
- The PRAF is then sent to the Peer Reviewer. This will provide the Peer Reviewer with a quick description of findings from the medical record
- Please review the PRAF template on the next slide to familiarize yourself with the document

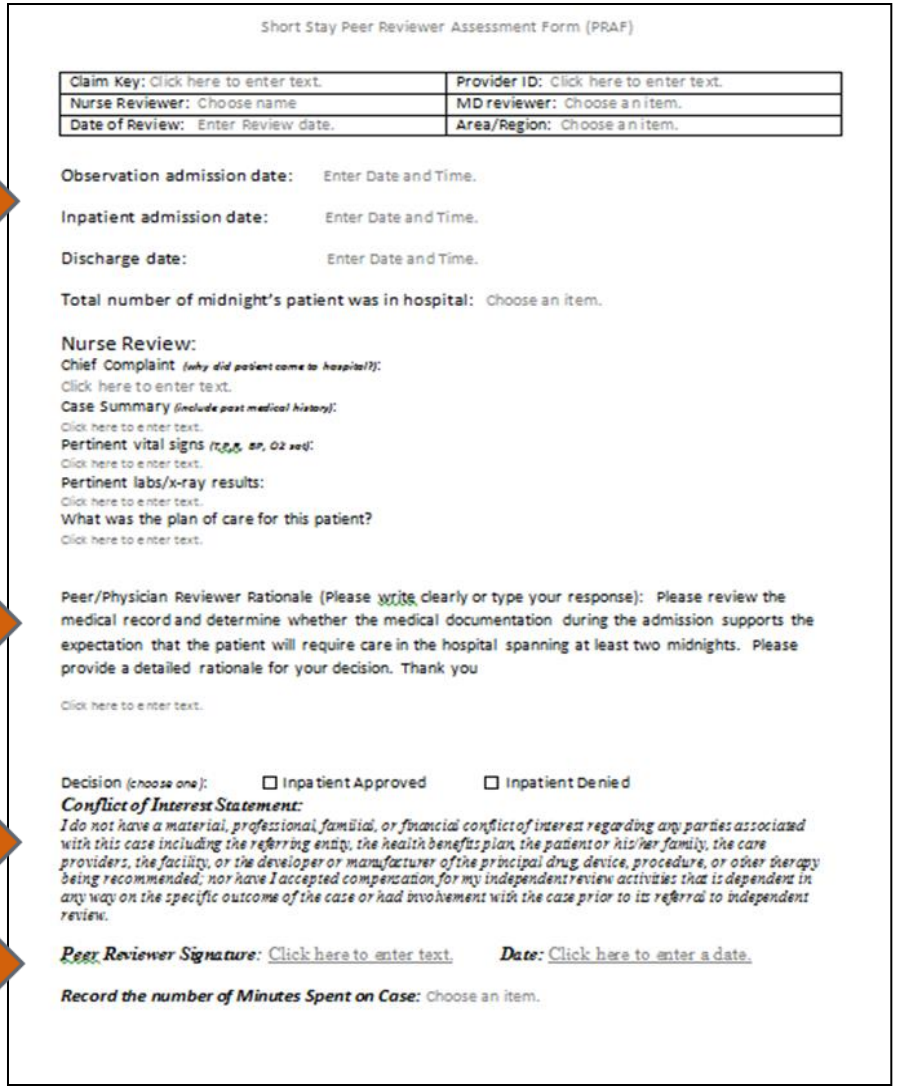
Peer Reviewer Assessment Form

Here you will find the dates of service, the beneficiary's chief complaint, and any Nurse Reviewer notes.

Please provide the rationale for your conclusion concerning whether or not the beneficiary met or did not meet the Two-Midnight admission requirements This information will be added to the provider letter for further explanation of the determination.

Read the Conflict of Interest statement.

Sign, date, and add the you time spent on the case.



Short Stay Peer Reviewer Assessment Form (PRAF)

Claim Key: Click here to enter text.	Provider ID: Click here to enter text.
Nurse Reviewer: Choose name	MD reviewer: Choose an item.
Date of Review: Enter Review date.	Area/Region: Choose an item.

Observation admission date: Enter Date and Time.

Inpatient admission date: Enter Date and Time.

Discharge date: Enter Date and Time.

Total number of midnight's patient was in hospital: Choose an item.

Nurse Review:

Chief Complaint *(why did patient come to hospital?)*:
Click here to enter text.

Case Summary *(include past medical history)*:
Click here to enter text.

Pertinent vital signs *(T, P, R, BP, O2 sat)*:
Click here to enter text.

Pertinent labs/x-ray results:
Click here to enter text.

What was the plan of care for this patient?
Click here to enter text.

Peer/Physician Reviewer Rationale (Please write clearly or type your response): Please review the medical record and determine whether the medical documentation during the admission supports the expectation that the patient will require care in the hospital spanning at least two midnights. Please provide a detailed rationale for your decision. Thank you

Click here to enter text.

Decision *(choose one)*: ☐ Inpatient Approved ☐ Inpatient Denied

Conflict of Interest Statement:
I do not have a material, professional, familial, or financial conflict of interest regarding any parties associated with this case including the referring entity, the health benefits plan, the patient or his/her family, the care providers, the facility, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended; nor have I accepted compensation for my independent review activities that is dependent in any way on the specific outcome of the case or had involvement with the case prior to its referral to independent review.

Peer Reviewer Signature: Click here to enter text. ***Date:*** Click here to enter a date.

Record the number of Minutes Spent on Case: Choose an item.

Peer Reviewer Role

- The Peer Reviewer then reviews the medical record, completes the PRAF, and provides his/her determination in the Reviewer Rationale portion
- This information will be added to the provider letter for further explanation of the determination
- The Peer Reviewer must evaluate whether the Two-Midnight inpatient admission is met based on the facts of the case

Peer Reviewer Role

- **The Peer Reviewer will determine whether services and/or items for which payment may be made under Medicare were reasonable and medically necessary on an inpatient basis could be effectively provided on an outpatient basis or in a health care facility of a different type**

Peer Reviewer Role

- Per CMS, Peer Reviewers will assess hospitals' compliance with admission order requirements and the Two-Midnight benchmark
- After completion of the medical record review, result letters will be generated for each provider sampled
- Based on the review results, further actions may be required
- Once the Peer Reviewer has completed the PRAF document, it will be sent back to the Nurse Reviewer to complete the process

Provider Outreach and Education

- **Based on the findings of the sample, the Initial Review Results letter is sent**
- **Provider stratification for education and corrective action is dependent on the provider denial rate percentage**

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Provider Outreach and Education

- In addition, a clinical educator may present teleconferences with hospitals in order to review the clinical information sent in the Initial Review Results letter
- Other KEPRO team members may also be present for the teleconference, such as the Manager and Medical Director/Physician Reviewer
- CMS representative(s) may monitor the teleconference

Provider Outreach and Education

- At minimum, CMS expects detailed results letters to include individualized, claim-by-claim denial rationales and encourages the BFCC-QIO to include the written clinical details that are to be discussed during any 1:1 telephonic education
- The letter shall include a specific phone number and/or point of contact, clearly indicated on the face of the letter for providers to request or schedule education

Education and Corrective Action

- **Minor Concern**
  - A provider with a denial rate of 10 percent or less of the reviewed claims for the provider specific sample
  - The BFCC-QIO shall educate the provider via the results letter
  - The provider has an opportunity to discuss the denied claims with the Peer Reviewer during the provider education

Education and Corrective Action

- **Moderate Concern**
  - A provider with an denial rate from 10.01 to 20 percent of the reviewed claims for the provider-specific sample
  - The BFCC-QIO shall educate the provider via the results letter
  - The BFCC-QIO shall offer to educate the provider using 1:1 telephonic provider education with the results of each claim reviewed discussed in detail
  - The 1:1 provider education is optional for Moderate concerns

Education and Corrective Action

- **Major Concern**
  - A provider with an denial rate of 20.01 percent or greater of the reviewed claims for the provider-specific sample
  - The BFCC-QIO shall educate the provider via the results letter
  - The BFCC-QIO shall educate the provider using 1:1 telephonic provider education with the results of each claim reviewed discussed in detail

Physician Reviewer Role: Provider Education

- Physician educators must review the medical records for the cases with medical necessity denials prior to the call
- During the education call, the physician educators should point to specific information in the medical record that supports or fails to support a reasonable expectation of care that would span two midnights or greater

Physician Reviewer Role: Provider Education

- Physician educators should avoid general statements, such as, “This is a typical chest pain case,” to explain why a case failed to meet medical necessity. Specific elements found in the medical record should be used for education. For example, “The record notes that the CP was non-exertional and atypical. The documented plan was to cycle the cardiac enzymes and obtain a stress test to further risk stratify.” Every case should be reviewed as its own separate case without unintentionally injecting bias into the case because it is a common complaint for presentation.

Physician Reviewer Role: Provider Education

- Physician educators should only utilize information known to the physician at time of admission when determining if a reasonable expectation of care that would span two midnights or greater was present
- Physician educators should provide suggestions for areas of documentation improvement based upon what has been noted in the record review that could be used to support an expectation of care that crosses two midnights or greater

Physician Reviewer Role: Provider Education

- If the hospital representatives introduce information that was not seen during the physician's review of the record, the KEPRO physician should inform the facility that that information was not available during the review of the record and inform them that they will be provided an opportunity to submit that information for review prior to our final determination

Physician Reviewer Role: Provider Education

- Educational points highlighted on the calls should demonstrate if information contained in the medical record complies or does not comply with elements in CMS' Two-Midnight policy
- Physician educators should ensure that they are familiar with the elements of the Two-Midnight policy

Physician Reviewer Role: Provider Education

- Physician educators should provide some education on each call that helps the facility to understand and apply the Two-Midnight policy to their inpatient vs. observation decisions
- If the topic of national review criteria arises during the call, physician educators should be clear that although CMS has noted that some providers consider commercial criteria products, such as InterQual® and Milliman, useful in clinical practice, CMS has not adopted such guidelines as binding policy for medical review purposes

Reconsideration

- A provider may choose to request a reconsideration of the initial determination
- A provider may send in additional documentation
- The additional documentation is forwarded to the Peer Reviewer with notation on the PRAF to review the hospital's response to the preliminary letter, determine whether the inpatient admission was medically necessary, and provide detailed rationale for the decision

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Reconsideration/ Re-Review

- Typically, the Reconsideration review is conducted when a provider is not required to attend a teleconference but does want to submit additional, supporting documentation for the record
- In this instance, the Physician Reviewer would review the additional supporting documentation and make a final determination as to the outcome of the case
- As with the initial review, the Physician Reviewer will complete a PRAF with the determination and return to the Nurse Reviewer

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Reconsideration/ Re-Review

- A re-review occurs when a provider has a teleconference and submits additional documentation for review to support their rationale
- The Physician Reviewer will review the additional supporting documentation and make a final determination as to the outcome of the case
- As with the initial review, the Physician Reviewer will complete a PRAF with the determination and return to the clinical educator

Resources

- CMS Inpatient Hospital Reviews
- BFCC-QIO Two-Midnight Claim Review Guideline
- Fact Sheet: Two-Midnight Rule
- CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals & Other Providers

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