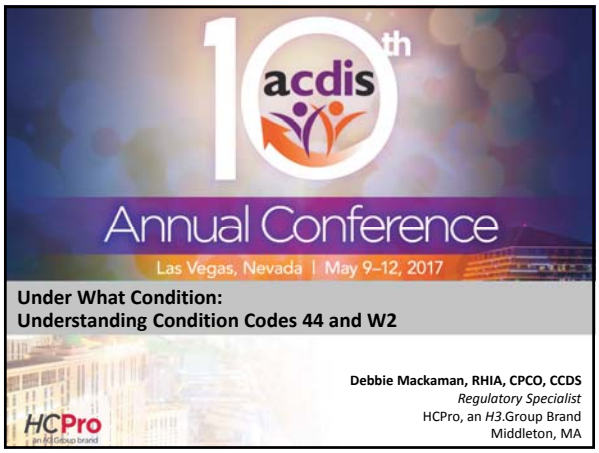
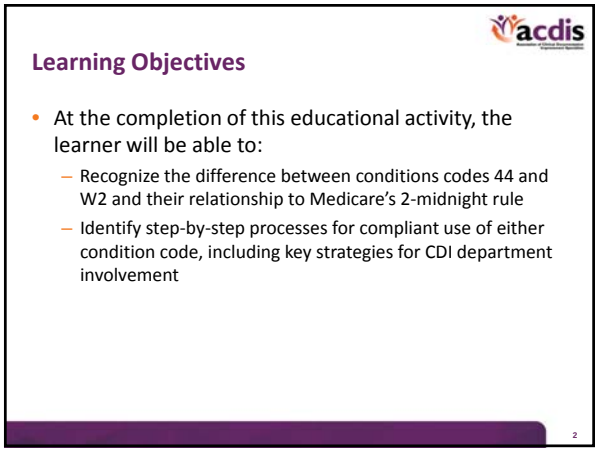




Valid Order to Admit

- 42 *CFR* 412.3(a)
  - A patient is considered an inpatient of a hospital when formally admitted pursuant to a physician order for inpatient admission
- 78 *Fed. Reg.* 50941-42
  - For clarity, the term "inpatient" should be used in the admission order
  - If the order is not properly documented in the medical record, the hospital should not submit a claim for Part A payment
- *CMS Hospital Inpatient Admission Order and Certification,* last updated January 30, 2014
  - Order to admit as an inpatient is required for hospital inpatient coverage and payment under Part A
  - Medicare does not permit retroactive orders
  - Authentication of the order is required prior to discharge

4

Expectation and Medical Necessity

- The inpatient admission must be appropriate for Part A payment because:
  - Physician has an expectation the patient will require hospital care for two midnights or longer
    - Physician does not have to specifically state the expected length of stay (e.g., two midnights) if this information can be extrapolated from other documentation such as the certification, plan of care, treatment orders, or other notes
  - Exceptions to the expectation
    - Patient is receiving an inpatient-only procedure
    - Physician has made a patient-specific "determination" to admit the patient based on the physician's clinical judgment

5

More on the Physician's Exception

- 80 *Fed. Reg.* 70541
  - "For stays for which the physician expects the patient to need ***less than 2-midnights*** of hospital care and the procedure is not on the inpatient only list or on the national exception list, an inpatient admission would be ***payable on a case-by-case basis*** under Medicare Part A in those circumstances under which the ***physician determines that an inpatient stay is warranted and the documentation in the medical record supports that an inpatient admission is necessary.***"
    - » See Attachment A: "BFCC QIO 2 Midnight Claim Review Guideline"
    - » Algorithm published by CMS to provide helpful guidance in application of the 2-midnight rule and the exceptions, including admission on a case-by-case basis

6

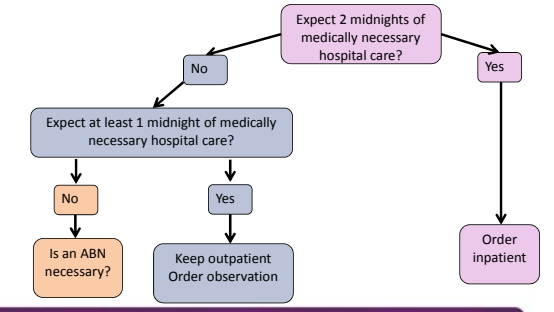
Expectation and Medical Necessity

- Documentation of the need for inpatient admission
  - Physician's documentation should reflect the need for admission and the expected length of stay, based on complex medical factors such as:
    - Medical history and comorbidities
    - Severity of signs and symptoms
    - Current medical needs, such as the need for diagnostic studies that do not ordinarily require the patient to remain at the hospital for at least 24 hours
    - Risk/probability of an adverse event occurring during the time period being considered for hospitalization

7

Ordering Inpatient Status

Day 1 - Initiation of Hospital Care as Outpatient



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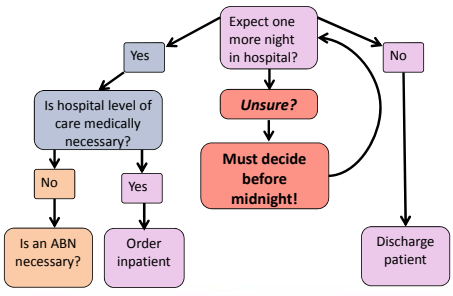
Ordering Inpatient Status

Day 2 – If Inpatient Order Not Documented



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Don't Forget About the Certification

- Beyond a valid order and the documented expectation, the 3rd element for Part A payment is the physician certification
  - For a PPS hospital, certification is required for stays that are 20 days or greater or for stays that reach cost outliers
    - Opportunity for CDIS to monitor and obtain at key time frames
  - For a CAH, a physician must certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH
    - Opportunity for CDIS to verify statement is documented and monitor for services that are not usually provided beyond a 4.0 GMLOS

10

Condition Code 44 vs. Condition Code W2
What's the difference?

Function and Definitions

- Condition codes are used to identify conditions or events that may affect the billing process
  - Not date specific
  - For internal use by the payer
  - National Uniform Billing Committee (NUBC) oversees
- Condition Code 44—Inpatient Admission Changed to Outpatient
  - For use on outpatient claims only
    - Used to identify when a physician ordered inpatient status and the UR committee determined the services did not meet inpatient criteria
- Condition Code W2—Duplicate of Original Bill
  - For inappropriately billed inpatient claims
    - Used to identify an initial billing or rebilling of a prior claim and no appeal is in process
    - Often referred to as a "self-denial"

12

What's the Trigger?

- Identification of an inappropriate inpatient admission
  - The physician ***should*** order inpatient care if:
    - The physician reasonably expects that the patient will require at least two midnights receiving medically necessary hospital care; or,
    - The patient is receiving a procedure designated as inpatient-only; or,
    - The physician determines inpatient admission is appropriate, regardless if two midnights are expected, based on their clinical judgment that is supported in the medical documentation
- When the inappropriate admission is identified, this will determine which condition code to report

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What's the Same?

- Both condition codes 44 and W2 are used when:
  - A physician writes an inpatient order
  - A UR committee member identifies the patient's stay is not appropriate for inpatient Part A payment
    - UR committee must participate in either case
    - Attending is involved in either case
  - Requesting payment under Part B
    - Must report CPT/HCPCS codes for billing and payment for OPPS or cost-based methodology (e.g., critical access hospital (CAH))
    - Similar reimbursement and patient financial responsibility for either condition code

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What's the Difference?

- Timing is everything
  - Review by the UR committee will drive which condition code to use
    - Before discharge—consider CC44
    - After discharge—only CCW2
  - Attending physician involvement with UR committee review
    - Before discharge—consider CC44
    - After discharge—UR committee physicians can make determination for CCW2
  - Notice issued to patient and others
    - Before discharge—consider CC44
    - After discharge—must be issued within 2 days of determination for CCW2

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Summary of Condition Code Elements

Elements	Condition Code 44 (CC44)	Condition Code W2 (CCW2)
UR committee case review	Occurs ***before*** discharge	Occurs ***after*** discharge
Attending physician	Agreement ***required***	***Offered*** opportunity to comment; if no agreement, 2 UR committee members can override decision to admit
Notice requirement	Issued ***before*** discharge	Issued ***within 2 days*** of UR determination
Payment under Part B	***All*** covered services	***Most*** covered services (limited exceptions)

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Case Study #1: CC44

- Patient presents to the hospital at 7:00 a.m. for revision of a total shoulder arthroplasty (23473)
  - Procedure was incorrectly scheduled as an inpatient and an order to admit was obtained prior to the procedure
- At 1:00 p.m., after the initial review, the CDI specialist (CDIS) notifies the physician advisor (PA) for urgent case review
  - UR committee physician determines inpatient care is not reasonable and necessary
  - Case was confused with an inpatient-only procedure (23474)
- CC44 procedures are followed, patient status is appropriately changed to OP at 4:00 p.m.
- Patient stays overnight for monitoring at the direction of the surgeon and is discharged the next day at 7:00 a.m.

What is the impact on the revenue cycle?

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Status Changed From Inpatient to Outpatient

- OPPS
  - Billed on OP claim (TOB 131) with CC44
  - Paid under C-APC 5115 = $9,561 (status indicator = J1)
  - Patient's coinsurance typically 20% of payment = $1,912
    - Capped at current inpatient deductible = $1,316
- CAH
  - Billed on OP claim (TOB 851) with CC44
  - Paid under cost using usual OP interim rate
  - Patient's coinsurance = 20% of charges
    - No cap on coinsurance amount

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Case Study #2: CCW2

- Patient presents to the hospital at 11:00 a.m. for revision of a total shoulder arthroplasty (23473)
  - Procedure was incorrectly scheduled as an inpatient and an order to admit was obtained prior to the procedure
  - Case was confused with an inpatient-only procedure (23474)
- After completing routine recovery, the patient is moved to the IP area at 7:00 p.m. for overnight monitoring at the direction of the surgeon
- The patient is discharged the next day at 7:00 a.m.
- After discharge, UR committee determines inpatient care was not reasonable and necessary because the attending physician did not expect the patient to stay in the hospital for 2 midnights
- Self-denial procedures are followed

What is the impact on the revenue cycle?

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Status Remains Inpatient

- OPPS
  - Billed on OP claim (TOB 121) with CCW2
  - Paid under C-APC 5115 = $9,561 (status indicator = J1)
  - Patient's coinsurance typically 20% of payment = $1,912
    - Capped at current inpatient deductible = $1,316
- CAH
  - Billed on OP claim (TOB 121) with CCW2
  - Paid under cost using usual OP interim rate
  - Patient's coinsurance = 20% of charges
    - No cap on coinsurance amount

20

So why use CC44 outpatient billing procedures over CCW2 inpatient billing procedures—or vice versa—if, in most cases, the payment to the hospital and the patient's financial responsibility are the same?

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Some Advantages or Disadvantages

CC44	CCW2
• Can be a scramble to complete within time frame • Can create physician/patient confrontation during the current course of treatment • Volume, staffing, executive support are factors for success • Only code once as an OP • Only bill once as an OP • Patient is aware of OP status before leaving facility	• Can be a way to see what transpires after order is obtained • UR review/self-denial after discharge helps to guide "thoughtful behavior modification" • Will code and bill multiple times for different TOBs • Patient gets "the letter" days/weeks/months after the fact

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Where Do CDI and Condition Codes Intersect?

- The CDI team can be the conduit in the revenue cycle
  - Provide a supportive role to the UR/UM/CM team and UR committee to identify appropriate admissions and meet all documentation requirements
  - Respected change agents that improve efficiency
- When deploying CC44 or CCW2 procedures, timing is everything
  - CDI teams can move quickly and create forward motion
  - Objective view that bridges documentation and communication with regulations

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Outpatient Billing With CC44

- Requirements
  1. UR committee must determine patient does not meet inpatient admission criteria
  2. Status from inpatient to outpatient is made prior to discharge
     - "Notice" is also provided to the patient prior to discharge
  3. Status from inpatient to outpatient is made prior to submitting a claim
  4. Attending physician agrees with UR committee and documents in the medical record
     - No guidance on what type of documentation
- If ***ALL*** requirements are met, Part B payment is made as an OP

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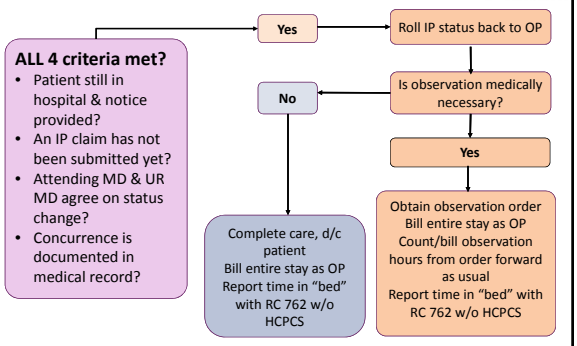
When to Report CC44



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A Word of Caution

- *Medicare Claims Processing Manual,* Chapter 1 § 50.3.1:
  - CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances.
  - However, CMS encourages and expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or Quality Improvement Organization (QIO), and to assist the UR committee in the decision-making process.
  - Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols.
  - As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report Condition Code 44 should become increasingly rare.

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Steps to Consider: CDI and CC44

- CDIS identifies case for review
  - Verify a compliant order for inpatient admission is documented
    - Must be signed prior to discharge
  - Identify if application of the 2-midnight rule is clear
    - Documentation has to support there is an "expectation"
    - Documentation has to support that all care provided is medically necessary
    - If in doubt, forward to PA to request urgent UR committee review
  - Notify UR/UM staff to follow up with UR committee and attending physician
    - Decision has to be made before patient is discharged in order to change patient status back to OP

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Steps to Consider: CDI and CC44

- CDIS monitors documentation requirements
  - Verify documentation of attending physician concurrence with UR committee
    - Attending physician's order for level of care change
      - Such as "Change from inpatient to outpatient"
    - Note(s) that indicates why the change was made
      - Such as "After reviewing case with Dr. XXX, patient is not expected to receive care in the hospital for 2 midnights. Inpatient admission is not appropriate at this time and care can be provided as an outpatient."
    - Consider other clinicians involved in process such as UR/UM/CM staff, discharge planner, social services, etc.
  - Per CMS, all orders and all entries related to the inpatient admission must be retained in the record in their original form
    - Prior entries in the medical record cannot be expunged or deleted

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Steps to Consider: CDI and CC44

- CDIS initiates temporary hold for revenue cycle
  - Notify HIM and PFS to hold account for coding and billing as OP claim
  - Notify UR/CM/PA observation order may be considered if still in "decision" mode
- Confirm "notice" is completed and distributed
  - Patient, hospital, attending physician
  - Consider keeping copy in patient's record
- Outpatient coding and billing processes are completed
  - Entire episode of care is treated as an outpatient as if the inpatient admission never occurred
  - Hospital or CAH must report CC44 on the outpatient claim

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Outpatient Billing With CCW2

- If ***ALL*** requirements for changing patient status from inpatient to outpatient under CC44 are ***NOT MET***, hospital may self-deny ***AFTER*** UR committee conducts a self-audit
  1. Review by 1 UR committee physician
     - 2 physicians are required only if the attending physician disagrees with the UR committee determination
  2. Attending physician is given opportunity to present his or her views
  3. Written notice of UR committee determination is provided within 2 days of decision
     - Patient, hospital, attending physician

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When to Report CCW2

CC44 criteria is not met
- Patient still in hospital & notice provided
- An IP claim has not been submitted yet
- Attending MD & UR MD agree on status change
- Concurrence is documented in medical record

No

Self-deny after UR Committee review
Follow billing process for TOB 110/121/131 or 851
Report CCW2 on TOB 121

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Steps to Consider: CDI and CCW2

- CDIS may identify case for review
  - Forward to PA for further review
  - Notify UR/UM staff to consider adding case to next UR committee agenda
    - Attending physician is notified/invited to present views
  - Notify HIM and PFS to hold account for coding and billing
- Determination is finalized during UR meeting
  - Standards for determination = 2-midnight rule expectation
  - Documentation of UR committee review and determination
    - No required format that review completed

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Steps to Consider: CDI and CCW2

- Confirm notice is provided to
  - Patient, hospital, attending physician
  - May also consider providing a copy to HIM and PFS and retaining a copy in patient's record
  - No required content
- Outpatient coding and billing processes are completed
  - Timely filing is limited to one year from date of service
  - Three claims may be submitted
    1. Part A inpatient provider liable (TOB 110)
       - Occurrence span code M1
    2. Part B inpatient claim (TOB 12X)
       - For services after the inpatient order
       - Condition code W2 & A/B rebilling treatment authorization code
    3. Part B outpatient claim (TOB 13X or TOB 85X)
       - For services prior to the inpatient order

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In Summary

- Revenue integrity crosses all lines
  - Outpatient to inpatient and sometimes back to outpatient
  - Physician education, quality of care, documentation improvement, coding, and billing compliance are cyclical in nature
  - Communication and collaboration are necessary to adapt to constant changes in the healthcare industry
  - Understanding the regulations provides facilities with the option to act quickly (CC44) or more deliberately (CCW2)
  - Identification of opportunities for revenue improvement, advancing efficiency, and promoting teamwork
  - A one-size-fits-all approach will not work for every hospital and community
  - CDI is a valuable tool in both inpatient and outpatient settings

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CDI Will Continue to Evolve and Bridge the Gap

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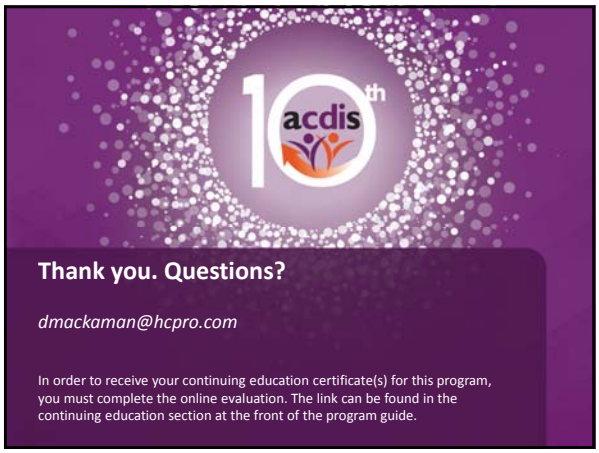
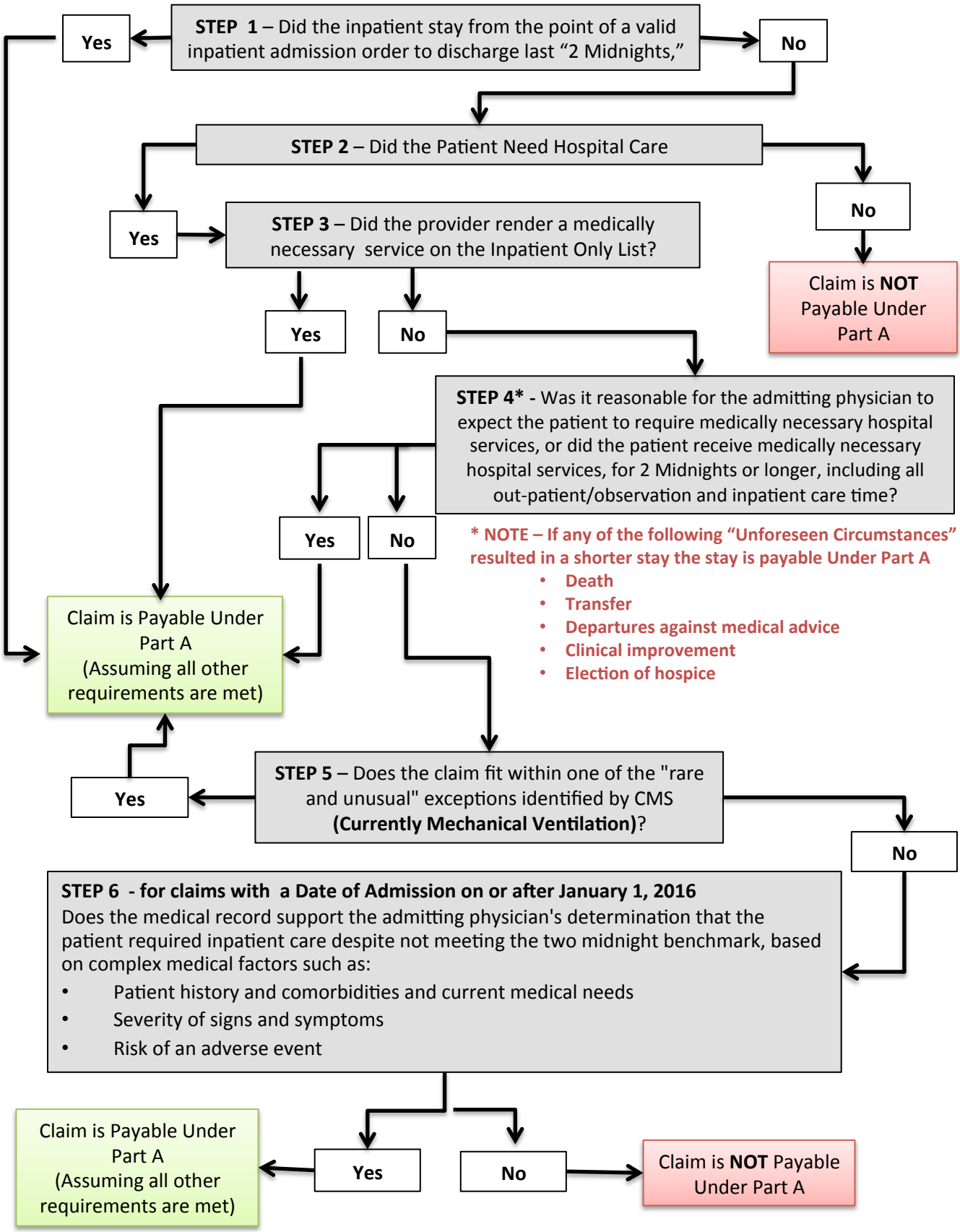


ATTACHMENT A

BFCC QIO 2 MIDNIGHT CLAIM REVIEW GUIDELINE



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