Medicare 2017
What You Need to Know
(For now….)

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PROHEALTH CARE

• 30 minutes west of Milwaukee, WI
• Waukesha Memorial Hospital
  • 400 beds
  • Partnership with Medical College of Wisconsin Family Practice residency program
• Oconomowoc Memorial Hospital
  • 156 beds

Understanding is crucial

• Office of Inspector General (OIG) review of Medicare billing by Mount Sinai Hospital in New York, reported this April
• 261 inpatient and outpatient claims reviewed from 1/01/12 – 12/31/13
• 110 found to be billed inappropriately with overpayment of $1.4 million
• Extrapolated to $41.9 million
• http://www.beckershospitalreview.com/finance/oig-mount-sinai-hospital-overbilled-medicare-by-41-9m.html

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Three clocks – the midnight clock

• Begins when “symptom-related care starts”
  • IV placed
  • Catheterized urine sample collected
  • Blood drawn
  • EKG performed? Chest x-ray taken? Nebulized Rx given?
• Begins no matter where the care starts
  • Emergency department
  • Immediate care clinic (if owned by the hospital)
  • Referring hospital
• **Crux of the “Two-Midnight Rule”**

Three clocks – the observation clock

• Begins when order for observation status or observation services is placed
• Begins no matter where the patient is located in the hospital
  • Emergency Department
  • Procedural suite
  • Medical/Surgical Unit
• Two midnights or more of medically necessary care in observation = violation of the Two-Midnight Rule (patient should be converted to inpatient)
• “…beneficiaries in necessary hospitalizations should not pass a second midnight prior to the admission order being written.” IPPS Final Rule p 50946

Three clocks – the inpatient clock

• Begins when an inpatient order is placed
• Is not retroactive (i.e., previous midnights without inpatient order do not count)
• Eligibility of Part A skilled nursing facility (SNF) benefit depends on necessity of three inpatient midnights
• Lacking three inpatient midnights does not mean the patient cannot transfer to a SNF. Medicare just won’t cover it.
Not necessarily new to 2017 but…
2016 OPPS final rule two midnight exception

- "We are modifying our existing “rare and unusual” exceptions policy to allow for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark, if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care despite an expected length of stay that is less than two midnights."

No two midnight expectation + inpatient = OK

- Medicare Inpatient-Only procedures (We know that)
- Need for unanticipated mechanical ventilation (Yep, old news)
- Physician states patient is high risk or has severe signs and symptoms and warrants inpatient admission (Wait…what?)
  - What is high risk?
  - What makes signs and symptoms severe enough?
  - What kind of documentation will support inpatient admission without expectation of two midnights?

WE ARE NOT SURE – ADMIT AT YOUR OWN RISK!

More “not so new” but important-to-understand updates from 2016

- Previously, APC (Ambulatory Payment Classification) 8009 paid $1,234 for ED visit or direct admission + 8 hours or more of Observation services
- Eligible part B services were billed separately (imaging, procedures)
- APC 8009 was replaced by CA-PC (Comprehensive Ambulatory Payment Classification) 8011 which pays $2,275 for ED visit or direct admission + 8 hours or more of Observation services
- NO OTHER SERVICES WILL BE PAID
  - If a procedure takes place, CA-PC 8011 will not be paid
  - Bill goes out for the T procedure and all other services provided
  - No payment for bed charges or nursing services
  - Examples of T procedures: Cath without stent, colonoscopy, EGD, I&D of abscess, nose packing (Find status indicator on Addendum B)
The effect of observation billing to….

- The patient
  - Observation stay = Medicare Part B deductible ($183) + 20% of $2,275 for C-APC B011 ($455) + meds = about $800
  - Inpatient stay = $1,316 (Medicare Part A deductible)

- The hospital
  - Patient OBS with abdominal pain, labs and ultrasound performed, patient discharged following day = $2,275 payment to hospital
  - Patient OBS with abdominal pain, labs and ultrasound performed in addition to an EGD, patient discharged following day = $1,200 payment to hospital for T procedure (EGD)

ALWAYS DO WHAT IS RIGHT FOR THE PATIENT
RECOGNIZE THE COST IMPLICATIONS OF WHAT IS BEING DONE
INPATIENT STATUS DOES NOT SAVE PATIENTS $$$

NOTICE the MOON

- Notice of Observation, Treatment and Implications for Care Eligibility (NOTICE) Act signed into law 8/06/15, was supposed to be implemented using the Medicare Outpatient Observation Notice (MOON) 8/06/16 but CMS extended the deadline to 3/08/17
- MOON instructions provided by CMS via Transmittal 3695 on 1/20/17
  - For use by acute care hospitals and critical access hospitals (CAHs)
  - For patients covered by traditional Medicare, Medicare Advantage plans, and patients with Medicare as a secondary payer
  - For above patients receiving observation services (NOT simple outpatients) for 24 hours (but can be given before 24 hours have passed) even if patient later changed to inpatient
  - Must be given before 36th hour of observation services provided, or by time of discharge, whichever is first

MOON (cont.)

- Content may not be altered in any way with the exception of the two free text areas
- Need to allow space to include patient-tailored information if needed (i.e., can’t pigeon-hole the form to be applicable to any patient)
- The specific reason the patient is not inpatient must be included (see next slide)
- Oral notification is also necessary, with documentation that it was given, required
- Patient signature and date is required, or, if refused, should be noted on form by individual giving the notice with their signature, date, and time
- Make sure time is included! (To prove given before 36th hour)
Reasons patient is not inpatient

- One of the two free-text sections which can be altered on the MOON
- No direction from CMS at this point if checkboxes are allowed
- Checkbox options
  - Your doctor expects that you will need hospital care for less than two midnights.
  - You require more care after your surgery but should be able to be discharged before a second midnight.
  - Your Medicare Advantage plan has told your doctor to place you in observation.
- Other:

Because...who doesn’t enjoy last-minute changes?

- Nine days before MOON implementation deadline, CMS required addition of “clinical rationale that is specific to each beneficiary’s circumstances” regarding why patient is not inpatient
- How so? Not sure....
  - You require hospital care for evaluation and/or treatment of (fill in chief complaint.) It is expected that you will need hospital care for less than a total of two days.
  - Other: (chief complaint)
  - If using this option, need to create another “Other” checkbox to allow for further tailoring of the form to the patient
How will the MOON confuse patients? Let us count the ways....

- The MOON says: For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.
- But:
  - APC 8011 = single payment of $2,225. Payment for each service only happens if T or J1 procedure is performed.
  - Physician services always part B payment whether inpatient or outpatient
- Let's not forget about Medicare Advantage plans....
  - Often ask for observation status over 48 hours or two midnights
  - Have different copay structures using Part C, not Part B
- Makes no sense to give MA patients the MOON, but we are mandated to do it
- Encourage patients to call their plan if they have questions

Expected questions about the MOON

- **Will the hospital charge me for my medications?**
  - The OIG has allowed hospitals to extend the use of self-administered drugs (SADs) since October 2015
  - This would be additive on the MOON if applicable
- **Can I bring my pills from home?**
  - Depends on your hospital's policy
  - Must not be abused
  - Safety concerns (are the pills in the bottle really what's on the label?)
  - Take up pharmacy and nursing time to check, label, store, and ensure they are returned to the patient upon discharge
- **Do I really need to take all of my medications from home?**
  - Could be confusing to really review all home meds and ensure they are not only accurate, but still appropriate
  - Encourage providers to consider referring from ordering over-the-counter vitamins and mineral supplements
- **Can I submit medication charges to my Part D plan?**
  - Yes, but it is generally very difficult to be reimbursed

QIO short-stay audits

- Audits of 25 cases for large providers, 10 for smaller providers, every 6 months
- Degrees of concern
  - Minor = denial rate less than or equal to 10% (yes, including 0%)
  - Moderate = denial rate between 11% and 20%
  - Major = denial rate over 20%
- Two audits with major concern = referral to RAC
- Change in April 2017
  - Top 175 providers in each Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) region with high or increasing number of short stay claims will have 25 cases randomly sampled
  - Other providers with “major concern” in previous reviews will have 10 cases randomly sampled
  - Possible elimination of degrees of concern categories
  - Unclear how referrals will be made to the RACs

Medicare has specific care. Ignoring these can lead to charges of fraud for the physician and/or hospital.
New ABN form

- Introduced 3/30/17
- Mandated use 5/30/17
- Only change is the expiration date
- Versions in English and Spanish at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish.zip
- Make sure your outpatient departments know of this, too!

Episode Payment Models (EPM)

- Effort by CMS to, “shift Medicare payments from rewarding quantity to rewarding quality by creating strong incentives for hospitals to deliver better care to patients at a lower cost.” (https://innovation.cms.gov/initiatives/epm)
- Five year pilot of mandatory payment bundles for hospitals in selected Metropolitan Service Areas (MSAs) scheduled to start 7/01/17
  - https://innovation.cms.gov/initiatives/epm (go to interactive map)
  - Include almost all Part A and B costs starting from initial hospitalization until 90 days post-discharge
  - Comparison to a total price target calculated from hospital’s own historical and regional benchmarks, minus a quality-adjusted discount
  - Payment amounts at risk, positive or negative, increase over the duration of this pilot study from 0% - 20%

Episode Payment Models (cont.)

- Surgical Hip & Femur Fracture Treatment (SHFFT)
  - Will compliment the Comprehensive Care for Joint Replacement (CJR) bundle for hip and knee replacements which started in April 2016
  - Includes CJR MS-DRGs 469 and 470 (elective total hip and knee replacements and total or hemi-arthroplasties performed on hip fractures) with addition of DRGs 480-482 (generally capture the remainder of the surgical hip fractures)
- Acute MI (AMI)
- CABG
  - Acute MI and CABG will be tested together, but not necessarily in same MSAs as SHFFT or CJR
- Cardiac rehab (CR)
  - Additional incentive payments for referring acute MI and CABG patients to cardiac rehab
Lastly...AKI and ESRD facilities

• Previously, patients covered by Medicare qualified for outpatient dialysis only if they had End-Stage Renal Disease (ESRD)
• Physician had to certify that the patient’s condition was permanent and irreversible
• 1/01/17 coverage also provided for dialysis services furnished to patients with Acute Kidney Injury (AKI) at hospital-based and freestanding ESRD facilities
• Uses the ESRD Prospective Payment System (PPS) base rate
• In addition to treatment, the ESRD PPS base rate pays ESRD facilities for the items and services that are renal dialysis services (renal dialysis drugs, biologicals, laboratory services, and supplies)

Keep in touch & stay informed

• American College of Physician Advisors (ACPA)
  • http://www.acpadvisors.org
• American Board of Quality Assurance and Utilization Review Physicians (ABQAURP)
  • https://www.abqaupr.org
• RAC Relief listserv
  • https://groups.google.com/forum/#forum/rac-reli
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