Novitas Solutions
Audit and Reimbursement Update
New Jersey HFMA
September 9, 2014
Agenda

• Introduction
• Organizational Structure
• Audit Issues
• Wage Index Review
• Cost Report Appeals
• HITECH
• Appeals Settlement
• Two Midnight Rule
Organizational Structure

- Novitas is a wholly owned subsidiary of Diversified Service Options
- Currently hold two MAC contracts
- JL which are the states of Pennsylvania, Maryland, New Jersey, Delaware and District of Columbia
- JH which are the states of Colorado, New Mexico, Texas, Louisiana, Arkansas, and Mississippi
Organizational Structure

- Revised Organizational Structure to improve effectiveness and efficiencies of the organization, quality of production, and communications

  - Personnel and roles:
    - Steve Holubowicz, Sr. Director over Audit and Reimbursement
    - Adam Weber, Director of JL Audit
    - Bruce Snyder Manager of JL Audit & Acting Manager of Reimbursement & Settlement
    - Kyle Bobb, Supervisor of JL Audit
    - Mark Hudak, Supervisor of JL Audit
    - Dave Cipollone, Supervisor of JL Audit
    - Pete Lawson, Supervisor of JL Audit
    - Ray Bossong, Supervisor of Settlement
Organizational Structure

• Audit offices for JL:
  – Pittsburgh, PA
  – Harrisburg, PA
  – Hunt Valley, MD
  – Work from home staff

• Reimbursement & Settlement for JL:
  – Pittsburgh, PA
  – Work from home staff
Send cost reports to the following location:

- Novitas Solutions, Inc.
- JL Provider Audit & Reimbursement
- PO Box 44303
- Jacksonville, FL 32231
  (regular mail)

- Novitas Solutions, Inc.
- JL Provider Audit & Reimbursement
- 532 Riverside Avenue
- Jacksonville, FL 32202
  (via Priority mail or carrier)

Send checks to the following location:

- Novitas Solutions - Part A
- Attn: Cashier
- PO Box 3385
- Mechanicsburg, PA 17055
  (regular mail)

- Novitas Solutions - Part A
- Attn: Cashier
- 2020 Technology Parkway
- Mechanicsburg, PA 17050
  (via Priority mail or carrier)

Please note that overpayment checks should not include the amount related to HITECH.
If you have any questions related to this matter, contact settlement@novitas-solutions.com.
Audit Issues/Findings

- Audit Schedule
  - We will be conducting audits starting this spring and could continue into the fall. We will be auditing cost reports with FYE 2011-2012
  - Audits selected were based largely on dollars at risk and CMS had to approve our audit plan
  - Next NPR/Settlements will be the cost reports that utilize the FFY 10/11 SSI ratios.
  - Cost reports will be NPR’d now through November 2014
  - No estimated NPR timeframe for cost reports that use later SSI ratio
  - If you do not qualify for DSH normal NPR timeframes still exist
Subcontractor Work

- Subcontractors are used on an as needed basis by us to help with our workload.
- We use firms that have experience with Medicare Auditing.
- Any work that is performed by a subcontractor we review to ensure it meets our guidelines.
- Going forward, we will send letters to providers that will be audited or desk reviewed by a subcontractor.
Requesting Documentation

- Audits – You will receive an engagement letter no earlier than 6 weeks and no later than 4 weeks prior to your entrance conference.
- Desk Reviews – In general will have two weeks to supply information to the auditor.
- Re-Openings – In general will have two weeks to supply information to the auditor.
- Sometimes requests come in from CMS that requires information to be obtain in shorter timeframes. We will do our best to avoid these circumstances.
- We need providers to help us by providing documentation so we can meet the start and complete dates.
- When submitting bad debt logs or DSH logs with the cost report we prefer the file in excel format.
SSI Realignment

• Per 412.106 (b) (3), “If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital’s name, provider number, and cost reporting period, and the resulting percentage becomes the hospital’s official Medicare Part A/SSI percentage for that period.”

• If requesting an alignment must be sent to the Director of Provider Audit and postmarked by the three-year anniversary date of the final determination

• The request must contain sufficient supporting documentation to warrant a reopening and must clearly express the reason for the request

• The request should also include a reimbursement effect
SSI Realignment

- Mail SSI realignment requests to the Director of Provider Audit at the following address:

  Director Provider Audit – JL
  Novitas Solutions
  Union Trust Building
  501 Grant Street
  Suite 600
  Pittsburgh, PA 15219

  All SSI realignment requests will be sent to CMS for re-running the SSI data.

  Note: Based on history, it takes CMS some time to re-run the SSI data.
Wage Index Review

New Jersey HFMA
Wage Index Review

Agenda

• 2016 Timetable
• Proposed 2017 Timetable
• Occupational Mix
• Wage Review issues
May 23, 2014

• Release of preliminary FY 2016 wage index file based on unaudited FY 2012 Worksheet S-3 wage data file (cost report fye 12/31/2012). The FY 2012 wage data file includes Worksheet S-3 wage data from cost reports submitted to MACs through approximately May 14, 2014. The file excludes hospitals designated as CAHs.
FY2016 Timetable

July 11, 2014

- Release of preliminary CY 2013 Occupational Mix Survey Data, based on CY 2013 occupational mix surveys submitted by hospitals to MACs by July 1, 2014. The file excludes hospitals designated as CAHs.
October 6, 2014

• Deadline for hospitals to request revisions to their Worksheet S-3 wage data and occupational mix data as included in the preliminary PUFs and to provide documentation to support the request. **MACs must receive the revision requests and supporting documentation by this date.** MACs will have approximately 9 weeks to complete their reviews, make determinations, and transmit revised data to CMS’s Division of Acute Care (DAC).
October 15, 2014

• Only for hospitals with FY 2012 cost reporting periods that begin on or after August 15, 2012, deadline to request revisions to their defined benefit pension plan data only. MACs must receive the revision requests and supporting documentation by this date. All other hospitals that do not have FY 2012 cost reporting periods that began on or after August 15, 2012 must submit revisions to their defined benefit pension plan data by October 6, 2014. In addition, this date of October 15, 2014 only applies to pension plans that are classified as defined benefit pension plans. Requests to revise data of all other types of pension plans (such as defined contribution plans) must be received by the MACs no later than October 6, 2014.
FY2016 Timetable

December 8, 2014

• Deadline for MACs to notify State hospital associations regarding hospitals that fail to respond to issues raised during the desk reviews. The purpose of the letter is to inform the State association and its member hospitals that a hospital’s failure to respond to matters raised by the MAC can result in lowering an area’s wage index value and, therefore, lower Medicare payments for all hospitals in the area.
December 16, 2014

• Deadline for MACs to complete all desk reviews for hospital wage and occupational mix data and transmit revised Worksheet S-3 wage data and occupational mix data to DAC.

• This is the transmit date; Novitas must complete all wage reviews prior to this date. To prevent poor data being transmitted to CMS, please work with your MAC auditor well in advance of this deadline.
FY2016 Timetable

February 13, 2015

• Release of revised FY 2016 wage index and occupational mix PUFs on the CMS Web site. These data are been desk reviewed and verified by the MACs before being published. Also, a file including each urban and rural area’s average hourly wages for the FYs 2015 (final) and 2016 (preliminary) wage indexes will be provided on the CMS web site.
March 2, 2015

• Deadline for hospitals to submit requests (including supporting documentation) for: 1) corrections to errors in the February PUFs due to CMS or MAC mishandling of the wage index or occupational mix data, or 2) revisions of desk review adjustments to their wage index or occupational mix data as included in the February PUFs (and to provide documentation to support the request). **MACs must receive the requests and supporting documentation by this date.** No new requests for wage index and occupational mix data revisions will be accepted by the MACs at this point, as it is too late in the process for MACs to handle data that is new in a timely manner.
FY2016 Timetable

April/May 2015

• Approximate date proposed rule will be published; includes proposed wage index, which is calculated based on the revised wage index data from February; 60-day public comment period and 45-day withdrawal deadline for hospitals applying for geographic reclassification.
April 8, 2015

Deadline for the following:

• 1. MACs to transmit final revised wage index data (in HCRIS HDT format) to DAC for inclusion in the final wage index.

• 2. MACs must also send written response to hospitals regarding the hospitals’ March 2, 2015, correction/revision requests by this date.
April 15, 2015

• Deadline for hospitals to appeal MAC determinations and request CMS’ intervention in cases where the hospital disagrees with the MAC’s determination. During this review, CMS does not consider issues such as the adequacy of a hospital’s supporting documentation, as CMS believes that the MACs are generally in the best position to make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process). Requests must be received by CMS by this date. A copy of the appeal with complete documentation shall be sent to the MAC. The request must include all correspondence between the hospital and MAC that documents the hospital’s attempt to resolve the dispute earlier in the process. Data that was incorrect in the preliminary or February wage index data PUFs, but for which no correction request was received by the March 2, 2015 deadline, will not be considered for correction at this stage.
April 15 (cont’d)

• Note: Hospitals shall send an electronic and a hard copy of the appeal with complete documentation supporting their request; appeals submitted via fax will NOT be accepted. Electronic copies (including all supporting documentation) shall preferably be sent in PDF files to ensure compatibility with CMS software. Spreadsheets can be sent in Excel.

• Appeals shall be sent electronically to wageindexreview@cms.hhs.gov

• Hard Copies shall be sent to the CMS Central Office at:
Centers for Medicare & Medicaid Services c/o Wage Index, CMM/HAPG/DAC
Room C4-08-06
7500 Security Boulevard
Baltimore, Maryland 21244-1850
April 15 (cont’d)

• Note: If the supporting documentation files being sent via email are too large to be sent through email, then send supporting documentation to CMS at the address above on a USB drive. Also, send an electronic copy of only the appeal letter to the email address above. Note in the email that complete supporting documentation will be sent via USB drive. Hospitals must still send a complete hard copy with complete supporting documentation to the address above. The hard copy and USB drive shall be submitted to CMS by the April 15, 2015 deadline
FY2016 Timetable

Late April, 2015

• MACs to alert hospitals to the availability of the final wage index and occupational mix data files for their review in the May 1, 2015 PUF, and to inform hospitals that this will be their last opportunity to request corrections to errors in the final data. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final May PUFs. Data that was incorrect in the preliminary or February 2015 wage index data PUFs, but for which no correction request was received by the early March 2, 2015 deadline, will not be considered for correction at this stage.
May 1, 2015

- Release of final FY 2016 wage index and occupational mix data PUFs on CMS Web page. Hospitals will have approximately 1 month to verify their data and submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data.
FY2016 Timetable

- June 1, 2015
- Deadline for hospitals to submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data as posted in the May 1, 2015 PUF. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final May 1, 2015 PUFs. CMS and the MACs must receive all requests by this date via mail and email to the addresses above.
FY2016 Timetable

August 1, 2015
• Approximate date for publication of the FY 2016 final rule; wage index includes final wage index data corrections.

October 1, 2015
• Effective date of FY 2016 wage index.
Proposed FY 2017 Timetable

Posting of Preliminary PUF:
  Mid May 2015

Deadline to request revisions:
  Early August 2015

Deadline for MAC Desk Reviews:
  Mid-October 2015

Posting of February PUF:
  Late January 2016
Occupational Mix

- Hospitals who have not yet submitted CY 2013 occupational mix survey data to their MACs by the July 1, 2014 deadline must submit CY 2013 occupational mix surveys, with complete supporting documentation, by the deadline to request revisions to a hospital’s wage and occupational mix data, which is October 6, 2014. In order for a hospital to preserve its appeal rights on the occupational mix survey data that it submits, the occupational mix survey data must be desk reviewed by the MAC.

- Hospitals may download a spreadsheet to submit their CY 2013 Occupational Mix Survey Data to their MACs from [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/Medicare-Wage-Index-Occupational-Mix-Survey2013.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/Medicare-Wage-Index-Occupational-Mix-Survey2013.html).
Wage Review Issues

Dietary and housekeeping

• Some providers report *neither* internal expense nor contracted expense. Some costs MUST be reported. Novitas will be contacting you if needed.

• The contracted costs have to be actual and not estimated. CMS has MACs test for the costs to be within certain reasonable ranges, zero is not an option.
Employee Benefits

- Worksheet A, line 4, column 1, is only for the staff working in the Employee Benefits Department – worksheet A, line 4, column 1 is not for reporting benefits of all hospital employees. ” (no emphasis added)
  - Many providers put PTO of the entire hospital into this line.
  - PTO must be reported in the salary column (1) of all various department cost center lines.
Cost Report Appeals
New Jersey HFMA
Cost Report Appeals

Agenda

• PRRB appeal vs Intermediary Appeal
• Request for PRRB Appeal
• Jurisdiction
• PRRB Resolution Appeal Paths
• Appeal Process-No Resolution
• Reopening vs. Appeal
• Useful Links
• Novitas Appeal Contacts
PRRB vs. Intermediary Appeal

• Intermediary Appeal
  - The amount of program reimbursement involved in controversy must be at least $1,000 but less than $10,000.

  - See 42 CFR 405.1809 (b)(2)

• PRRB Appeal
  - The amount of program reimbursement involved in controversy is $10,000 or more.

  - See 42 CFR 405.1835 (a)(2)

The following slides will focus on PRRB appeals
Cost Report Appeals

Request for PRRB Appeal

- **Individual Appeal**
  - Must be filed using PRRB Model Form A within 180 days of Notice of Program Reimbursement
  - An individual appeal request may be for only one cost reporting period
  - Must have total amount in controversy of at least $10,000
  - An authorized representative of the Provider must sign the appeal or attach an Authorization of Representation letter with the initial filing on the Provider’s letterhead, signed by an owner or officer of the Provider.
  - Additional issues may be added up to 60 days after the 180 day period of filing the appeal request. (240 days from the NPR date)
Cost Report Appeals

- **Group Appeal**
  - Must be filed using PRRB Model Form B unless formed by a transfer from an existing individual appeal, then use PRRB Model Form D.

  - Providers in a group appeal must have final determinations for their cost reporting periods end within the same calendar year. (unless approval received from PRRB)

  - Amount if controversy of $50,000 must be met by the full formation of the group.

  - The PRRB will recognize a single Group Representative for all Providers in the group. Authorization from each Provider must be included (unless joined via transfer).

  - Commonly owned or controlled Providers (CIRP) with the same issue and calendar year must file a mandatory group appeal if the combined amount in controversy is > $50,000.
- Number of Providers to form a Group are dependent on type of group appeal
  a) Optional Group Appeals - 2 different Providers are required
  b) Mandatory Common Issue Related party (“CIRP) group appeals require one Provider to initiate the appeal but at time of full formation at least two Providers must be in the group.

- Group Representative selects the Lead Intermediary that services the majority of Providers listed on the initial appeal request unless the representative has a good faith belief that upon group completion, a different Intermediary will ultimately service the greatest number of Providers.

- The issue under appeal must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling.
Jurisdiction

- Individual Appeal
  - Jurisdiction will be reviewed by the MAC at the time of Appeal Request
  - Jurisdictional challenges will generally be filed by Novitas as soon as the time to add additional issues has lapsed.
  - Reasons for jurisdictional challenges include the following:
    a) Does not meet $10,000 amount in controversy
    b) Appeal Request not timely
    c) Refusal to Accept Amended Cost Report
    d) No Final Determination (no adjustment)
    e) Denial of a Reopening
Cost Report Appeals

Jurisdiction

• Individual Appeal

- A jurisdictional challenge may be raised any time during the appeal

- The PRRB may review jurisdiction on its own motion at any time

Note: Most of the documents needed for a review of jurisdiction are items required to be submitted per PRRB Model Form A. However, if a Provider requests an appeal based on a protested item, a breakdown of the protested amounts should also be provided. This breakdown must tie to the as filed protested amounts submitted on the cost report.
Cost Report Appeals

**Jurisdiction**

- **Group Appeal**

  - Within 30 days of receipt of appeal request, the MAC does an initial review of jurisdiction to determine whether the group establishes a single common issue and that the parties creating the group have preserved their right to appeal (excluding the amount in controversy).

  - Within 60 days of full formation of the group, the Provider Group representative must forward a Schedule of Providers (SOP) and supporting documentation which demonstrates that the Board has jurisdiction over the Providers in the group.

  - Within 60 days of receipt of the final SOP and supporting documentation, the MAC must review for proper jurisdiction and submit its jurisdictional findings to PRRB.
Cost Report Appeals

PRRB Resolution Appeal Paths

There are 3 separate processes that can be used to attain a resolution of an appeal:

1) Full Administrative Resolution
2) Mediation
3) Joint Scheduling Order (JSO)

All of these processes can be done either prior to or after submission of position papers. However, it is the responsibility of both parties to ensure that the PRRB is kept informed so that any deadlines per the PRRB acknowledgement and Critical Due Dates are not missed.
PRRB Resolution Appeal Paths

- Full Administrative Resolution
  - Must address all issues in the PRRB Case
  - Requires Approval by Appeal Support Contractor (ASC)
  - Administrative Resolution signed by all parties (Provider representative, MAC and ASC)
  - Must follow all appropriate regulations and laws
  - If a Full Resolution cannot be achieved, a partial resolution will be done and the unresolved issues will go forward to hearing.
Cost Report Appeals

PRRB Resolution Appeal Paths

- Mediation
  - Must address all issues in the PRRB Case
  - No ASC Approval needed
  - Once mediation accepted by PRRB, all deadlines are suspended
  - Final Mediation agreement signed by all parties (Provider representative and MAC)
  - Must follow all appropriate regulations and laws
  - If Mediation does not result in resolution, the case proceeds to hearing
PRRB Resolution Appeal Paths

• Joint Scheduling Order

- Written scheduling plan that should ultimately result in an Administrative Resolution. All issues must be addressed and transfers completed.

- If agreed to by all parties, position papers do not need to be submitted.

- Once a JSO is established, the deadlines in this document become the PRRB’s deadlines and are, upon motion, subject to sanctions for failure to apply.

- Requests for extensions to deadlines in JSO must be filed with the PRRB at least 3 weeks before the due date and will be granted only for good cause.

- Must follow all appropriate regulations and laws
Cost Report Appeals

**Appeal Process-No Resolution**

All issues that can be resolved prior to a hearing should be done through the Administrative Resolution process. If one or more issues in the case cannot be resolved, a hearing will be held (live, record or teleconference). The following is the appeal process once a case gets to the hearing process.

- PRRB hears the case and renders a decision
- If applicable, the CMS Administrator reviews the case and either affirms, overturns or remands the PRRB decision.
- Either party may take an unfavorable decision to either the District Court of the United States for the judicial district in which the Provider is located or in the United States District Court for the District of Columbia.
- Either party may take an unfavorable decision to the Court of Appeals
- If still unfavorable, the last step would be to request the Supreme Court to hear the case.
Reopening vs. Appeal

Both an Appeal and a Reopening are means of resolving cost report issues.

Reopenings

- A cost report reopening request must be received within 3 years of settlement (NPR date)
- Reopening Requests are responded to within 180 days
- The denial of a reopening is not appealable

Appeals

- A cost report appeal must be filed within 180 days of NPR
- Follows the natural progression of the appeal process.
Cost Report Appeals

Reopening vs. Appeal

Advantages

Reopening - If granted, issues are handled expediently

Appeals - Guarantees that issue will be addressed

Disadvantages

Reopening - If request denied, could lose appeal rights

Appeals - Moving through the appeal process takes time
   All issues must be jurisdictionally valid
Useful Links

PRRB Rules:


PRRB Current Alerts:


PRRB Live/Record Hearing Procedures and Evidence

Cost Report Appeals

Novitas Appeal Contacts

Christopher Smith, Appeals Coordinator
E-mail: christopher.smith@novitas-solutions.com
Phone: 412-802-1721

Rick Biere, Senior Appeals Analyst
E-mail: ricky.biere@novitas-solutions.com
Phone: 414-918-2664

Linda Swiderski, Senior Appeals Analyst
E-mail: linda.swiderski@novitas-solutions.com
Phone: 414-918-2688

Joe Bandola, Appeals Analyst
E-mail: joseph.bandola@novitas-solutions.com
Phone: 412-802-1777
HITECH
HITECH
Matching your EHR Payment Period to the Correct Cost Report Period

- The Medicare Cost Report is used to determine the final payment amount for the EHR Incentive so it is important to use the correct Cost Report Period.
  - **Must be a 12-month cost report period (between 360 and 371 days)**

- The Cost Report Period is determined using the Hospital’s Meaningful Use Effective Date and the Federal Fiscal Year.

- As specified by the HITECH UDR Program, we select the correct cost report period by determining “which cost reporting period for the Hospital begins during the Federal Fiscal Year that the Hospital’s Meaningful Use Effective Date falls in.”
  - **See examples provided on the next three (3) slides**
MAP08903
FS79078

PROVIDER: [Redacted] NPI: [Redacted] PMT YR: 1 TRANS NUM:

INITIAL PAYMENT:
INP PART A: 29966 INP PART C: 7394 TOT INP: 63352
CHAR CHRG: 5050276 TOT DISCHRG: 13904 TOT CHRG: 629566538

MED SUB D %: .5945 CAH %: TRANS %: 1.00
DISCHRG AMT: 2551000 BASE AMT: 2000000 CAH COST:

PMT CATEGORY: 1 APPEAL CASE NUM: AUDIT CASE NUM:
COST RPT B DT: 07/01/10 COST RPT E DT: 06/30/11

ACTUAL PMT/RECOUP AMT: 2705569 PRE-RED PMT/RECOUP AMT:
RED PMT %: RED AMT:
MU STATUS: M MU EFDT : 10/01/11 MU TERM DT:
RECORD STATUS: CHOW IND:
TRANS DATE: 12/21/12

INNOVATION IN ACTION
Example 1: FYE 06/30 Provider
A Provider with a Meaningful Use Effective Date of 10/01/2011 occurs in Federal Fiscal Year (FFY): 2012

Which Cost Report Period Begins During FFY 2012?

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<td>2012</td>
<td>Oct-Nov</td>
<td>Dec-Jan</td>
<td>Feb-Mar</td>
<td>Apr-May</td>
<td>Jun-Jul</td>
<td>Aug-Sep</td>
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</table>

10/01/2011 \(\rightarrow\) Federal Fiscal Year \(\rightarrow\) 09/30/2012

07/01/2012 \(\rightarrow\) Cost Report Period \(\rightarrow\) 06/30/2013
Example 2: FYE 08/31 Provider
A Provider with a Meaningful Use Effective Date of 10/01/2011 occurs in Federal Fiscal Year (FFY): 2012

Which Cost Report Period Begins During FFY 2012?

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<th>2011</th>
<th>2012</th>
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<td>Jun-Jul</td>
<td>Aug-Sep</td>
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<tr>
<td>10/01/2011</td>
<td>Federal Fiscal Year</td>
<td>09/30/2012</td>
</tr>
<tr>
<td>09/01/2012</td>
<td>Cost Report Period</td>
<td>08/31/2013</td>
</tr>
</tbody>
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HITECH
Tentative and Final Settlement Procedure

• When we finalize our audit adjustments on a Medicare Cost Report and submit the records to issue an NPR, we will also finalize the data elements for the HITECH payment
• Novitas’ Accounts Receivable will create a record in FISS to record the amount due to or from the Hospital
• The Payment Contractor, National Government Services (NGS), will use this FISS data to issue the payment or demand letter, as appropriate
• Hospitals should not comingle or net HITECH payments with Normal Medicare Payments
Who should you call?

All questions regarding your HITECH (EHR) Incentive Payments should be directed to the Payment Contractor, National Government Services (NGS):

**EHR Customer Service**

1 (888) 734-6433
Novitas Solutions
Medicare Part A Presents:
Two Midnight Rule
Probe and Educate
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- This presentation is a general summary that explains certain aspects of the Medicare program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

- Novitas Solutions does not permit videotaping or audio recording of training events.
Abbreviations

- ACS – acute coronary syndrome
- AMS – altered mental status
- BP – blood pressure
- CABG – coronary artery bypass graft
- CAD – coronary artery disease
- CHF – congestive heart failure
- CKD – chronic kidney failure
- CVA – cerebrovascular accident
- D10 – dextrose 10% injection
- EF – ejection fraction
- ER – emergency room
- H&P – history and physical
- LOS – length of stay
- MRI – magnetic resonance imaging
- NSTEMI – non-ST-segment elevation myocardial infarction
- TIA – transient ischemic attack
Agenda

- Overview of the Two Midnight Rule
- Inpatient Status Review
- Case Scenarios
- Resources
Objectives

- Provide an overview of the Two Midnight Rule (CMS 1599-F)
- Discuss Probe and Educate review process
- Review case scenarios for identified Probe and Educate errors
OVERVIEW OF THE TWO MIDNIGHT RULE
Two Midnight Rule

- Surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital payment under Medicare Part A when the physician
  - Expects the patient to require a stay that crosses at least two midnights, and
  - Admits the patient to the hospital based on that expectation
Unforeseen Circumstance

• An unforeseen circumstance may result in a stay of less than two midnights despite the physician’s appropriate expectation of a two or more midnight stay at the time the inpatient order was written
  – Death
  – Transfer
  – Departure Against Medical Advice (AMA)
  – Unforeseen recovery
  – Election of hospice care
• May be considered appropriate for inpatient
• Must be documented in the medical record
Clock Time

• Clock time starts
  – When beneficiary begins receiving medically necessary services following arrival at the hospital
    • Observation services
    • Emergency department, operating room, other treatment services
  – Does not include
    • Wait times prior to the initiation of care
    • Triaging activities (such as vital signs)
    • Time in spent in waiting room while awaiting treatment

• Remember that while the total time in the hospital may be taken into consideration when the physician is making an admission decision (i.e. expectation of hospital care for two or more midnights), the inpatient admission does not begin until the inpatient order and formal admission occur
Exceptions to the Two Midnight Rule

- In certain cases, the physician may have an expectation of a hospital stay lasting less than two midnights, yet inpatient admission may be appropriate
  - Medically necessary procedures on the Inpatient-Only List
  - Other circumstances
    - Approved by CMS and outlined in sub-regulatory guidance
    - New Onset Mechanical Ventilation*
    - Additional suggestions being accepted at SuggestedExceptions@cms.hhs.gov (subject line “Suggested Exceptions to the 2-Midnight Benchmark”)
- *NOTE: This exception does not apply to anticipated intubations related to minor surgical procedures or other treatment.
INPATIENT STATUS REVIEW
Probe and Educate Period

- Probe and Educate period
  - Probe and educate process will continue through 3/31/2015
  - Conduct reviews on claims submitted by Acute Care inpatient hospital facilities (ACH), Long Term Care Hospitals (LTCH), and Inpatient Psychiatric Facilities (IPF)
    - Critical Access Hospitals (CAH) are excluded from the probe and educate process
    - Inpatient Rehab Facilities (IRF) are excluded from the two midnight inpatient admission and medical review guidelines per the CMS-1599-F
Probe and Educate Medical Reviews

• Additional Development Requests (ADRs)
  – ADRs sent until sample size is fulfilled
  – ADR edit identification edit number
    • 5HMID- JH providers
    • 5LMID- JL providers
  – Suspend location in the Fiscal Intermediary Shared System (FISS) will be MZMID
    • Moved to location B6001 following generation of ADR
    • Claims not selected for review will automatically cycle out of MZMID location
  – Results letter including results of all claims reviewed will be sent at the end of the probe
Status of Novitas Probe and Educate Reviews

- As of May 70% of cases have been completed
  - JH – 673 cases completed
  - JL – 457 cases completed
- 1:1 Education calls will continue
- Global education via teleconference will be available
### Top Reasons for Denial - JL

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>Percentage of Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Documentation did not support two midnight expectation</td>
<td>46.7%</td>
</tr>
<tr>
<td>2. No Records Received</td>
<td>27.6%</td>
</tr>
<tr>
<td>3. Documentation did not support unforeseen circumstances interrupting stay</td>
<td>10.9%</td>
</tr>
<tr>
<td>4. Other</td>
<td>3.4%</td>
</tr>
<tr>
<td>5. Order missing</td>
<td>2.5%</td>
</tr>
<tr>
<td>6. Order not validated</td>
<td>2.4%</td>
</tr>
<tr>
<td>7. Certification not present</td>
<td>2.1%</td>
</tr>
<tr>
<td>8. Certification inadequate</td>
<td>1.9%</td>
</tr>
<tr>
<td>9. Order unsigned</td>
<td>1.6%</td>
</tr>
<tr>
<td>10. Procedure not reasonable and necessary</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
CASE SCENARIOS

*Note that these case scenarios are being provided for educational purposes only. Compliance with the two midnight rule is considered on a case-by-case basis, in accordance with the information contained in the medical record.
Case Scenario 1

- Documentation does not support the two midnight expectation
- **2/6/2014**
  - 21:30 – Patient presents to ER with complaints of right arm tingling, numbness, cold sensation over the past two days.
  - 23:18 – Electronic entry of certification – “Admit to inpatient and LOS 2 or more midnights.  Reason: TIA r/o CVA”
  - 23:51 – Dictated H&P includes plan to admit to telemetry, neurology consult completed within ER, scheduled MRI, q4hour neurology checks, and labs.  Documentation in the H&P indicates patient likely to be discharged tomorrow.
- **2/7/2014**
  - 16:30 – Patient cleared by neurology for discharge.  MRI brain mild nonspecific changes and CT angiogram of brain unremarkable, symptoms resolved and patient discharged.
Case Scenario 1

Denial Message

- 5MEXP
  - Medicare payment for the admission is denied. Although it was necessary for this beneficiary to seek and receive medical care, the clinical information received does not support a two midnight expectation. If the physician expects to keep the patient in the hospital for 0-1 midnights, the services are generally inappropriate for inpatient admission. Please refer to 42 CFR 412.3 (e).
Case Scenario 2

- No Inpatient Order
- No expectation patient will stay two midnights
- 11/08/2013
  - 10:00 – Patient presents to ER with AMS, hypoglycemic, and elevated BP. Patient was given intravenous solution of D10 in ER, patient was fed, and every 2 hour blood sugars were monitored for 24 hours.
  - 12:40 – ER physician indicates disposition as ‘observation’
  - 13:51 – Physician H&P dictated indicating “Patient is clearly stable for observation admission. She will be admitted to the telemetry unit”.
- 11/9/2013
  - 9:11 – Discharge order written.
Case Scenario 2
Denial Message

- **5NMDO**
  
  Medicare payment for the admission is denied. Review of the medical records indicates that there is no physician order to cover the inpatient admission. Please refer to 42 CFR 412.3 (e).
Case Scenario 3

- Unforeseen Circumstance (after formal admission)
  - CMS case example

- Disabled 50 year-old man presents to ED from home with history of cancer, now with probable metastases and various complaints, including nausea and vomiting, dehydration and renal insufficiency.

- 1/1/2014
  - 10:00 pm - presents to the ED at which time the admitting provider evaluates and orders diagnostic/therapeutic modalities.
Case Scenario 3 (continued)

• 1/2/2014
  – 4:00 am - Physician writes an order to admit. Patient is formally admitted with the expectation of medically necessary hospital level of care/services for 2 or more midnights.
  – 9:00 am - Appropriate designee and the family discuss with the primary physician the desire for hospice care to begin for this patient immediately.
  – 3:00 pm – Patient is discharged with home hospice.
Case Scenario 3 Outcome

- Hospital may bill this claim for inpatient Part A payment. Claim will demonstrate 1 midnight of inpatient services. This represents an unforeseen circumstance interrupting an otherwise reasonable admitting practitioner expectation for hospital care. Upon review, this would be appropriate for inpatient admission and payment so long as the physician expectation and unforeseen circumstance were supported in the medical record.
Appeals Settlement
Appeals Settlement

As noted in a Federal Register Notice released by the Office of Medicare Hearings and Appeals in January 2014, “the unprecedented growth in claim appeals continues to exceed the available adjudication resources to address [such] appeals…”

CMS believes that the changes in Final Rule 1599-F (published in August 2013) will not only reduce improper payments under Part A, but will also reduce the administrative costs of appeals for both hospitals and the Medicare program.
Appeals Settlement

- [http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html](http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html)

- CMS is now offering an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount).
CMS encourages hospitals with inpatient status claims currently in the appeals process to make use of this administrative agreement.

The following facility types ARE ELIGIBLE to submit a settlement request:
Acute Care Hospitals, including those paid via Prospective Payment System (PPS), Periodic Interim Payments (PIP), and Maryland waiver; and Critical Access Hospitals.

The following facility types are NOT eligible to submit a settlement request:
Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS);
Inpatient Rehabilitation Facilities (IRFs);
Long-Term Care Hospitals (LTCHs);
Cancer hospitals; and Children’s hospitals.
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Questions

Thanks for attending