

# Mastering Utilization Review and Patient Status

a NAHRI virtual event 

## Prioritizing Patient Status Reviews

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## Presented By



- **Valerie Rinkle, MPA, CHRI**, is president of Valorize Consulting, LLC, and has more than 38 years' experience in healthcare policy, finance, strategy, and revenue management operations. Her expertise spans all CMS reimbursement methodologies and the operational capabilities necessary to effectively achieve accurate and defensible payment. She has extensive hospital chargemaster, OPPS and physician fee schedule, and provider-based department experience. Rinkle also has significant experience in leading compliance due diligence in support of M&A as well as defense strategies surrounding OIG, DOJ, RAC, and other audit agencies including state Medicaid programs. She has served as an expert witness in litigation. She works with device manufacturer and pharmaceutical manufacturers for their coding and reimbursement support. Rinkle is a frequent public speaker with HCPro and as an annual presenter on OPPS at the Institute on Medicare and Medicaid Payment Policy by the American Health Lawyers Association where she co-presents with CMS representatives.

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## Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Identify how CMS educated Quality Improvement Organizations (QIO) for short-stay patient status reviews
  - Differentiate between different types of patient status reviews
  - Explain the reimbursement implications of different types of patient status reviews
  - Recognize how reimbursement implications can be used to prioritize staffing/assignments for different types of patient status reviews

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### CMS' Training Materials to QIOs for Short Stay Inpatient Reviews

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## CMS' QIO Training Materials

- CMS used to maintain a webpage devoted to inpatient status reviews which outlined the saga of RAC and other audits and denials, appeals, settlements, and the transition of short stay inpatient reviews from the MACs to the QIOs
- The webpage also contained documents related to the 2-midnight rule policy
- In the downloads section, was a document labeled:
  - “BFCC QIO 2 MIDNIGHT CLAIM REVIEW GUIDELINE” and the link is [here](#)
  - The webpage is no longer on the CMS website, but you can still download this form
  - The document was used in the QIO re-training announced [here](#)

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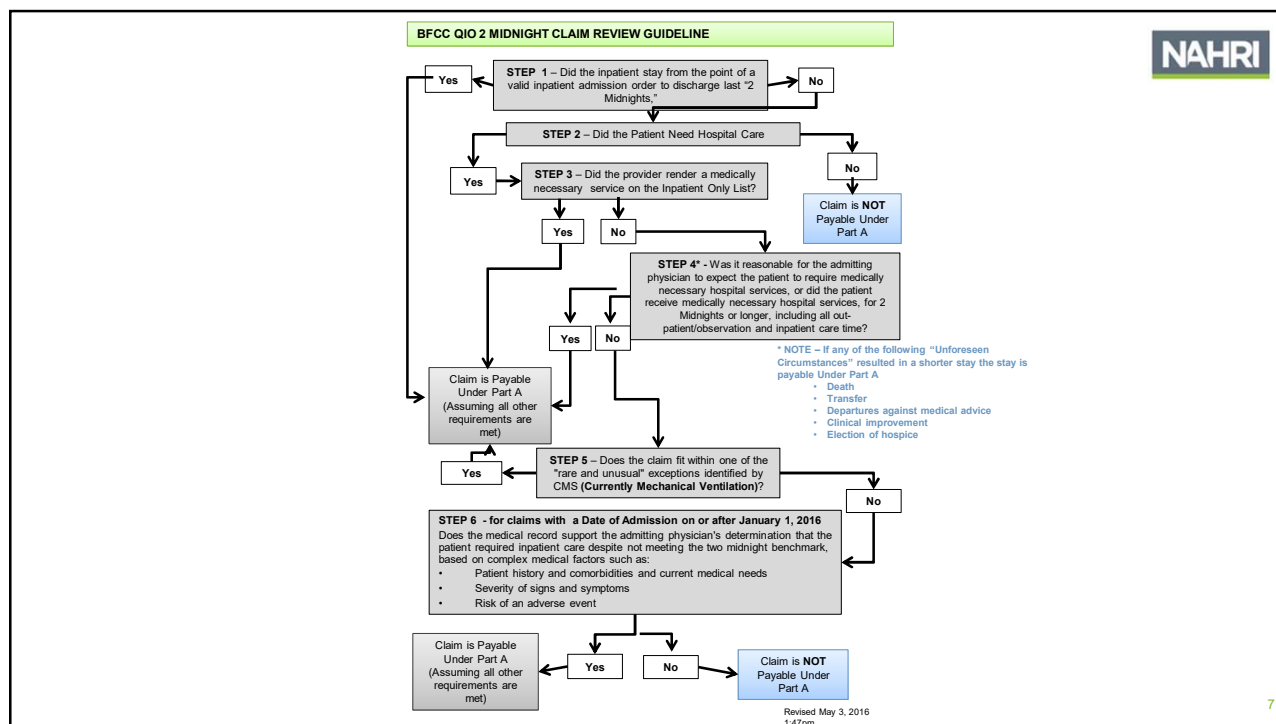
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## Where We Are Today...

- As of August 2021, Livanta was designated by CMS to serve as the national contractor for Medicare claim review services. Under this program, Livanta will review Short Stay (SSR) and Higher-Weighted Diagnosis Related Group (HWDRG) claims from hospitals.
- Livanta's SSR Process:
  - Electronic submission of records selected for review
  - Letters will be sent via fax to the QIO liaison or mailed if fax is not available. No letter is sent if the claim is fully approved upon first review. Hospitals will have access to a case lookup feature on the Livanta website to obtain findings on sampled claims.
  - Before making any correction denying payment, the hospital will be provided an opportunity for discussion. *Take this opportunity!!*
  - If the hospital does not respond, the initial findings will be made final, and the MAC notified of the denial. The beneficiary is also notified when the admission is denied.
  - If the hospital responds to the opportunity for discussion, that response is taken into consideration when making the final determination on the claim.

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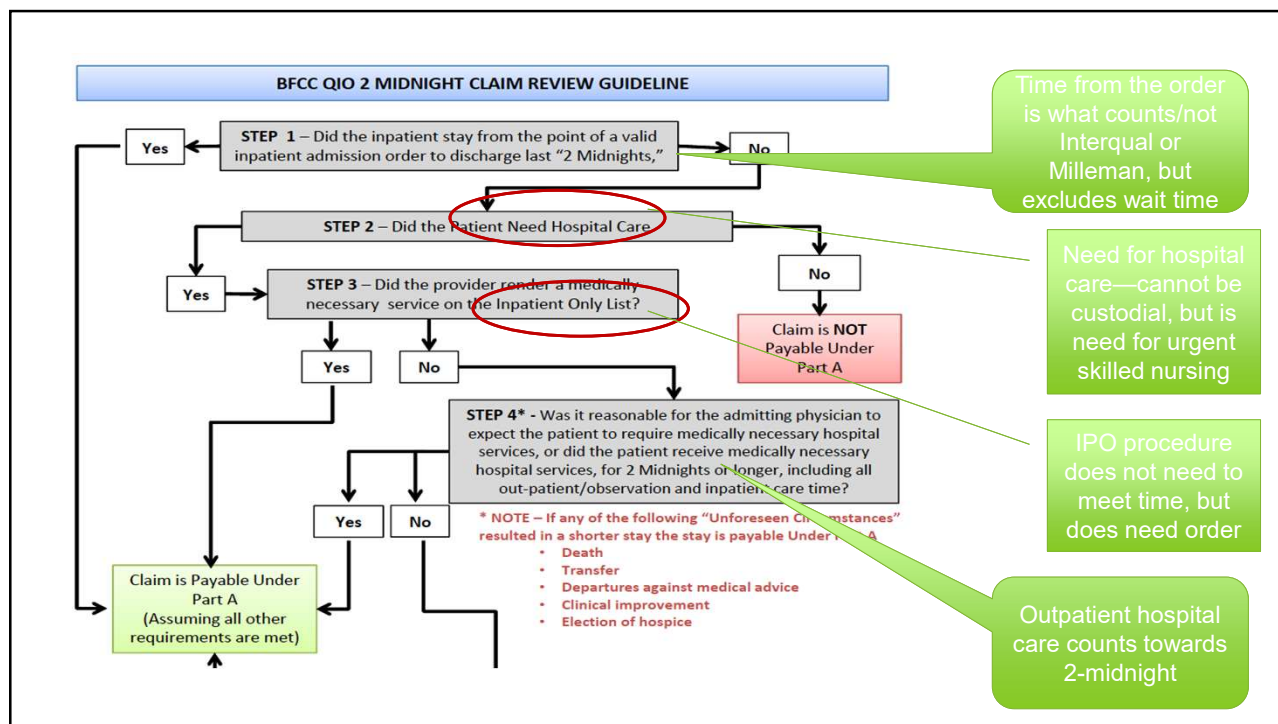
## Is This Algorithm New to You?

- If this is not new to you—great! I will break it down more in the following slides as it sets the stage for prioritizing patient status reviews and understanding CMS' coverage criteria for inpatient stays. That is, the 2-midnight rule.
- If this is new to you, then print it and get with your team to study it. If you have a different understanding about CMS' 2-midnight rule than what will be presented to you in the next couple of slides and what is on this algorithm, then I challenge you to question that understanding versus what CMS publishes here and in its manuals.

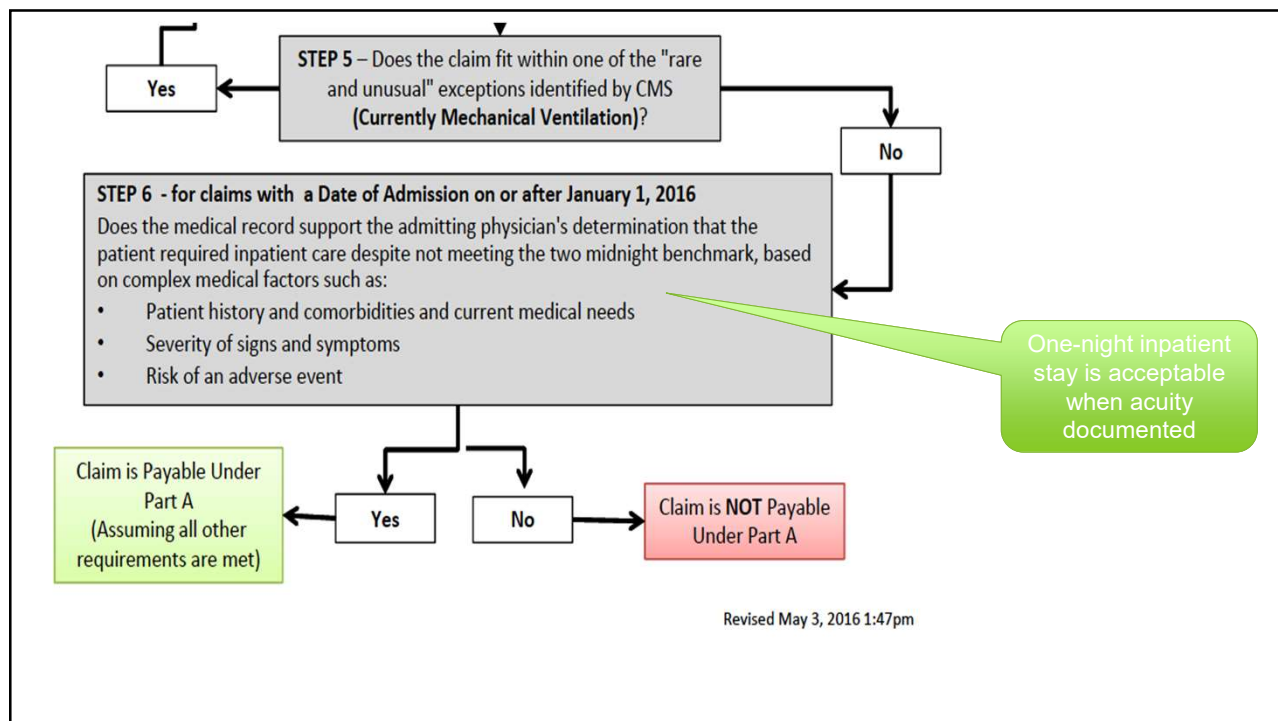
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## Types of Patient Status Reviews

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## Inpatient Reviews

- Scheduled – pre-admission
  - Example: inpatient surgery
- Emergent – urgent admission
  - Custodial
  - Post-surgery admit
  - Transfer
  - Medical necessity for inpatient versus observation
- Continued stay

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## Outpatient Reviews

- Scheduled – pre-admission
  - Example: outpatient surgery that should be inpatient
- Emergent – urgent admission
  - Custodial versus legitimate medical observation
  - Post-surgery for “extended recovery” or “unanticipated medical issue”
- Continued stay
  - ED/Observation care over one midnight
  - ED/Observation care transfer in

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### Reimbursement Implications of Different Patient Status Reviews

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## Inpatient Reimbursement Methods

- Meeting 2-midnight criteria or one-night acuity criteria = MS-DRG
- Inpatient-only procedure = MS-DRG
- Continued stay but no safe discharge plan – MS-DRG and possibly outlier payment
- Continued stay with safe discharge – MS-DRG plus patient payment and patient liability requires properly issuing the HINN 12
- Custodial care – no coverage or payment at all after outpatient EMTALA ER assessment and determination hospital care is not needed

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## Inpatient Correction Opportunities

- Correction Opportunities if Criteria Not Met (e.g., a one-night stay or custodial)
  - Condition Code (CC) 44 – But only if patient has not been discharged and in-person patient explanation able to be made. OPPS payment for entire stay but limited to ED and ancillary services. Nothing for custodial.
  - W-2 self-denial – Bill for denial and rebill outpatient and Part B inpatient. OPPS payment for outpatient stay prior to inpatient order – ED and ancillary services. OPPS payment for inpatient stay—likely only lab and other ancillary services. Nothing for custodial.
- Note there is no difference in payment. Billing is a bit more burdensome for W-2 self-denial scenario, but timing is constrained for CC 44 because the patient can't have left the hospital. Both options require UR member review, but timing can be after patient discharge for the W-2 option.

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## Outpatient Reimbursement Methods

- Order for observation and needing hospital care. OPSS payment of the Observation C-APC that covers ED stay and all ancillaries as long as there is no procedure on the claim. Payment designed to exclude hours under 8 and over 48 and billing requires excluding hours related to other concurrent services.
  - If a procedure occurs, APC or C-APC payment for procedure and other ancillary services are often packaged with no separate payment.
    - If patient stays > 2 nights, payment woefully inadequate to cost.
  - Inpatient only procedure and patient not transferred or admitted as an inpatient: no OPSS payment.
- Note the opportunity to “upgrade” a one- or two-night observation/outpatient case to inpatient to access MS-DRG has much more value to the hospital than chasing one-night inpatient stays to try to do a CC-44 process.

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## Outpatient Correction Opportunities

- Correction Opportunities if Criteria Not Met (e.g., custodial or no order)
  - No order or time does not meet definition of observation services—only bill ED and ancillary services; no observation hours. Such as order for observation to access a bed on a unit when patient needs extended recovery after outpatient surgery.
  - Observation hours over one or two nights and continued need for hospital services—obtain inpatient order, even if patient has discharge order!!!
  - Custodial patients – Nothing from Medicare, ABN needed to bill patient

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## Reimbursement and Self-denial/correction Opportunity

Type of Patient Status Review	Medicare Reimbursement Method if criteria met	Correction Opportunity if Criteria Not Met	Medicare Reimbursement Method when Correction Made
Scheduled Inpatient Admission – including scheduled inpatient only procedure	MS-DRG	Check that orders match pre-admission account status for inpatient only and if not inpatient only also check criteria met for 2-midnight stay  Update orders as needed prior to procedure  W-2 if one-midnight and not inpatient-only procedure	MS-DRG for inpatient-only procedure  OPPS for W-2
Emergent Inpatient Admission – One Night Stay	MS-DRG	W-2 (CC44 unlikely)	OPPS
Custodial Care	NA. Not covered	NA. Not Covered	
Unscheduled Inpatient Admit Post-Surgery	MS-DRG	W-2 if inpatient ordered, one-night and procedure is not inpatient only	OPPS
Outpatient stay >2-midnights	OPPS, but same amount as if stay was less than two days	Get inpatient admission order, even if on day of discharge	MS-DRG
Scheduled Outpatient Surgery – with extended outpatient recovery	OPPS if final coding confirms outpatient procedure, but no payment if final coding is inpatient only	Get inpatient admission order, even if procedure is not ultimately coded to inpatient-only procedure, then W-2 the account	OPPS payment if W-2 and MS-DRG if inpatient only

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## Prioritizing Resources by Type of Patient Status Review

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## What Patient Status “Mistakes” Cost the Hospital Underpayment/overpayment That Cannot be Corrected?

- Answer #1: An observation/outpatient stay greater than 2-midnights – OPPS payment is the same with outside possibility of marginal additional outlier payment
  - Strategy – prioritize reviews of overnight outpatient stays in all areas of the hospital with staff resources
- Answer #2: An inpatient only procedure where the patient is not admitted
  - Strategy – Prioritize review of scheduled surgery procedures to get the pre-registered account and orders correct for inpatient and work with PACU/CDI if outpatient surgery performed is longer/unexpectedly complex and obtain pre-emptive inpatient order. If the case does not code out to be inpatient only, then follow the self-denial W-2 process and payment is per OPPS as if inpatient order had not occurred.

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## What Patient Status “Mistakes” Cost the Hospital Underpayment/overpayment That Cannot be Corrected?

- Answer #3: An emergent inpatient or observation admission for custodial care
  - Note – it is already assumed this is low volume, particularly since COVID-19. If this is high volume, this may be a #1 priority.
  - Strategy – Focus physician education, statistics, CC44, and ABN process on custodial cases.
- Answer #4: An emergent inpatient or observation admission before the patient has stayed overnight
  - Strategy – Consider using Interqual/Milliman solely on these reviews to help assess whether a second hospital night is reasonable and the initial inpatient order is valid/supported or if changing to observation is more reasonable. Then re-review if patient remains in hospital another 24 hours.
    - Do not recommend CC44 if it is possible that patient will remain in the hospital overnight. Only if patient is still in-house and there are discharge orders should CC44 be used, but no difference in payment if proceed with self-denial and W-2 process. This also can reduce the MOON and IMM messages which can confuse patients.

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## Summary

Consider re-focus of limited staff resources for patient status reviews to long outpatient stays first versus short inpatient stays.



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## Thank you!

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