Hospitals Reform Inpatient-Only, Case Management Processes to Avoid Denials

For better or worse, the two-midnight rule is a catalyst for re-engineering some hospital processes and procedures. As hospitals adapt to CMS’s new method for determining whether admissions are payable under Medicare Part A, some are reviewing more one-day stays, screening orders for inpatient-only procedures and revamping case management.

In addition to improving compliance with the two-midnight rule and physician certification requirements that debuted in the 2014 Inpatient Prospective Payment System (IPPS) regulation, hospitals are motivated by the desire to avoid large-scale audits under the CMS probe-and-educate program and prevent protracted appeals of claim denials.

“There has been a learning curve on the two-midnight rule,” says Keith Knuth, M.D., case management physician advisor at Community Health Network in Indianapolis.

Partners HealthCare in Boston is making a number of changes in response to the two-midnight rule and physician certification requirements, says Stephen Gillis, director of compliance coding, billing and audit. Its member hospitals have put their heads together in a “patient status performance improvement initiative,” called “the PEPSI group.” Gillis says: “There are limits on being able to add staff, so we are trying to

continued on p. 5

Proposed Change to Medicare Cost-Report Appeals May Hit Reimbursement Hard

CMS is moving to stop hospitals from seeking cost-report reimbursement from the HHS Provider Reimbursement Review Board if it was never claimed on Medicare cost reports. Hospitals would be required to include all claims on cost reports as a condition of payment, according to the proposed 2015 inpatient prospective payment system (IPPS) regulation. This is a bid to improve administrative efficiency, end legal wrangling with hospitals and add finality to the cost-report reconciliation process, CMS says.

But some hospitals say CMS would be choking off an avenue of appeal of cost-report reimbursement denials and is unrealistic about how long it takes to gather and reconcile cost report data. “This is something of a game-changer on how future appeals may be litigated,” says Steve Harris, director of reimbursement at Tampa General Hospital. “Hospitals would basically have no right to payment for anything they did not specifically claim on their cost report. Any items not quantified in an originally filed, amended, or reopened cost report would be off limits at appeal.” Harris, who thinks the proposal puts hospitals in “a very unfair position,” says they should submit comments to CMS by the June 30 deadline if they are concerned about the proposal.

The IPPS provision would change the way CMS litigates cases before the HHS Provider Reimbursement Review Board (PRRB), which hears cost-report appeals.

continued
Hospitals file cost reports to capture “pass-through” payment not reflected in Medicare prospective payment systems, including those related to bad debt, graduate medical education, indirect medical education, disproportionate share hospital (DSH) payments, organ acquisition cost reimbursement and allied health programs.

Cost reports don’t play as big of a reimbursement role as they used to, but they represent millions of dollars annually to many hospitals, Harris says.

Every year, hospitals submit cost reports to their Medicare administrative contractors five months after the end of the cost-report year. Cost reports reconcile payments that Medicare pays hospitals during the year. As hospitals receive additional information about their allowable reimbursement, such as Medicaid eligible inpatient days that figure into DSH calculations, they can file amended cost reports with their MACs, Harris says. Usually MACs accept amended cost reports, but acceptance of amended cost reports is at the MACs’ discretion according to Medicare regulations. After MACs audit them, they send hospitals a notice of program reimbursement and allied health programs.

Cost reports don’t play as big of a reimbursement role as Medicare administrative contractors five months after the end of the cost-report year. Cost reports reconcile payments that Medicare pays hospitals during the year. As hospitals receive additional information about their allowable reimbursement, such as Medicaid eligible inpatient days that figure into DSH calculations, they can file amended cost reports with their MACs, Harris says. Usually MACs accept amended cost reports, but acceptance of amended cost reports is at the MACs’ discretion according to Medicare regulations. After MACs audit them, they send hospitals a notice of program reimbursement and allied health programs.

CMS Has the Authority to Act

CMS says that it plainly has the statutory authority to make this change. More importantly, the proposed rule states, there are “sound policy reasons for requiring a provider to include an appropriate claim for an item in its cost report by either claiming payment for the item” or “self-disallowing the item,” which means seeking payment for something that the provider acknowledges may not be covered. Mainly, providers should get everything resolved during cost-report reconciliation with MACs and not bring things up after the fact at the PRRB, CMS contends.

A cost report claim for full payment of the cost enables the contractor to review the claim, make any adjustments that seem appropriate, and include final payment for the cost as part of the NPR, the proposed rule states. “Requiring a cost report claim for full payment of allowable costs (where the provider does not disagree with how Medicare determines payment for the cost) facilitates the contractor’s discharge of some of its principal responsibilities, which include using the contractor’s expertise and experience to review and audit payment claims.” The new policy would take effect for cost report years that begin Oct. 1, 2014.

On a more practical note, CMS says there are 12 MACs with large audit staffs that have “expertise,” compared to a five-member PRRB with a relatively small staff. “We believe it is a waste of scarce resources and very inefficient for a provider to first raise a clearly allowable cost in an appeal to the Board when the contractor could have reviewed and finally determined payment for such an allowable cost in the NPR, if the provider had simply made a timely cost report claim for full payment of the allowable cost. As indicated by the very name of the Provider Reimbursement Review Board, it is a ‘Re-

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view Board’ or administrative appeals tribunal, not the Medicare program’s front line auditors charged with making the initial determination of program reimbursement for such allowable costs.”

But Harris says CMS is disregarding the way the real world works. Cost reporting is by definition a fluid process. For example, Medicare DSH payments are driven largely by a hospital’s number of Medicaid eligible days, but the hospital is dependent on the state for that information. While the state is busy verifying Medicaid eligibility and the hospital is identifying eligible Medicaid recipients, it is continually updating its numbers, long after the cost-report year has ended, Harris says. Or hospitals may fail to include all of their Medicare bad debt accounts because they weren’t known at the time their initial cost reports were filed. And sometimes hospitals make mistakes in the cost-report software that may not be caught until much later, Harris says.

It’s true that CMS allows MACs to accept amended cost reports, and they usually do but it’s at their discretion. “Under the new rules, if they don’t accept amended cost reports or allow hospitals to reopen a cost report, hospitals can never appeal anything they could not quantify and explain at the time they file the original cost report,” he says. “Although it is my understanding the majority of MACs accept amended cost reports, history is no indicator of the future.”

Contact Harris at sharris@tgh.org. Submit comments on the rule electronically at www.regulations.gov or by regular mail to Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1607–P, P.O. Box 8011, Baltimore, MD 21244–1850.

**Modifier Use for Global Surgery, ER Procedures Is Prone to Error**

As hospitals and physicians face Medicare reviews of modifiers and navigate conflicting payer rules in this area, they often have to go slowly with their use of modifiers, including -25. It’s not always clear when to apply modifier -25, which signifies the provider performed a significant, separately identifiable evaluation and management service on the same day as a procedure or other service. There’s confusion partly because modifier -25 is used only with minor procedures during the global surgery period, but more major procedures are being reclassified as minor.

Even as providers struggle with the definition of “significant and separately identifiable,” their use of modifier -25 is rising, experts say. “They can put organizations at risk,” certified coder Elin Baklid-Kunz said at a recent webinar sponsored by the American Academy of Professional Coders. Medicare administrative contractors are doing prepayment reviews of modifier -25 and all four recovery audit contractors have had it on their hit list, she says.

Modifiers are reported with CPT codes and convey to payers that a procedure or service had special circumstances and may generate additional payment. They are often misused, sometimes because modifier descriptions are precise and the distinctions between them may be subtle. While modifier -25 allows separate payment for a significant and separately identifiable E/M service performed by the same physician on the same day as long as there is supporting documentation, a separate diagnosis is not required, said Baklid-Kunz, who is director of physician services at Halifax Health in Florida. There are exceptions, of course. For example, providers cannot use modifier -25 for:

◆ **Inpatient dialysis services**, unless they are unrelated to the treatment of end-stage renal disease or could not be furnished during dialysis.

◆ **Critical care visits except when the patient requires constant attention unrelated to the specific injury.** “Critical care and modifier -25 are often misunderstood so be careful,” she said. “Some MACs are performing prepayment reviews on critical care — CPT code 99291 — because it’s at high risk of payment errors.”

Some types of surgery are a popular spot for modifier errors. Medicare and private payers package payments for surgery, which means they pay a soup-to-nuts price for the procedure and the pre-procedure and post-procedure E/M services. Whether the patient also requires critical care and modifier -25 are often misunderstood so be careful. The three types of global surgery packages based on the number of post-op days — major, minor and zero-day procedures — have implications for the compliant use of modifier -25:

◆ **Major procedures**: They have a 90-day post-op period, but the total global period is 92 days because there’s one-day pre-op and the day of the procedure is generally

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not payable as a separate service, she said. Providers sometimes mistakenly use modifier -25 to represent the decision making during the global period that surgery is necessary when they should use modifier -57, which indicates a separately payable E/M service performed on the day of or day before a procedure, Baklid-Kunz said. “You indicate to the payer that the service is not a typical pre-surgery E/M visit, but that the evaluation itself determined the need for surgery,” she said.

♦ Minor procedures: There’s no pre-op period, and the E/M visit on the day of the procedure is not separately payable, she said. The total global period is 11 days. In terms of modifier -25, billing an injection E/M for patients scheduled for minor procedures is “one of the highest areas of scrutiny,” she said.

♦ Zero-day procedures: Endoscopies and other very minor procedures have no pre-op or post-op days. “A visit on the day of the procedure is not payable as a separate service,” she said.

This sounds clear cut, but physicians and hospitals get into gray areas. “One of the hardest things to do is define ‘significant and separately identifiable’ for using modifier -25,” she said. “One helpful question to ask physicians is whether the E/M service is part of the standard of care. When it’s part of the standard of care for the procedure, you can’t separately bill for the E/M.” But there could be room to bill for a separate E/M using modifier -25 if the physician documented a complete exam of an area that’s unrelated to the procedure, Baklid-Kunz said. To hash it over with physicians, use examples from their own practices. Remember, though, even when compliance officers and physicians see eye-to-eye on defining “significant and separately identifiable services,” they may not be billable. If the documentation for the procedure is removed, there may not be enough left over in the medical record to charge separately for an E/M service. “You have to define it and then you have to see if you have the documentation to support that,” she says.

**Modifier -25 Is Sometimes the Answer**

Sometimes circumstances favor using modifier -25, such as preventive services with a problem-oriented E/M service, Baklid-Kunz says. It’s appropriate to bill an E/M service above and beyond the preventive E/M service when the additional service is for a nonpreventable clinical reason. “To demonstrate medical necessity, use an ICD-9 code to clearly indicate it was a nonpreventive service,” she said. “You will append -25 for an issue separate from the presenting issue.” Suppose the patient complains of a chronic problem during the preventive visit. Make sure the documentation supports the additional work, such as ordering lab tests or consulting with an endocrinologist. “If your documentation says only that ‘it’s a diabetes follow-up and prescription refills were given,’ that’s not enough to support an additional E/M,” Baklid-Kunz said.

But modifier -25 won’t go over well with auditors for two same-specialty visits on the same day. Maybe a cardiologist sees the patient in the morning, documenting history, exam and medical decision making. In the afternoon, a different cardiologist from the same practice sees the patient because his condition worsened, and also documents history, exam and medical decision making. “When they are two separate E/M services for the same condition, Medicare will not allow the second visit to be billed with modifier -25,” Baklid-Kunz said, unless perhaps the second visit is for critical care.

She also cautioned hospitals to be mindful of Medicare guidance on the use of modifier -25 in emergency room settings that was updated in July 2013. In an answer to a frequently asked question on the use of the modifier for small laceration repairs and other services provided in the ER, CMS said “modifier -25 should be used to indicate that, on the day a procedure or service was performed, the patient’s condition required a significantly separate and identifiable service above and beyond the other service provided by the same physician on the same day of the procedure or other service.” That may require a change in hospital modus operandi. “It used to be that in the ER it was assumed that you could always report an E/M service and
modified -25 when a minor procedure was done,” Baklid-Kunz said. And while that’s still allowable, “CMS in this FAQ makes it clear than you cannot always do this.

Also, providers have to adapt to different payer approaches to modifier use. “Not all insurers will pay you for the separate E/M service even if you code in compliance with CPT rules,” Baklid-Kunz said. In fact, private payers reject claims with modifier -25, so providers should appeal them when denials are unreasonable.

Contact Baklid-Kunz at ekunz@bellsouth.net.

**CMS Has Calif. Nursing Home Quality Worries Despite State Surveys**

Even though the state of California surveys nursing homes every two years, CMS can’t necessarily count on that to ensure the quality of care provided to Medicare and Medicaid beneficiaries, the HHS Office of Inspector General says in a report posted June 10.

“We found that nursing homes did not always meet certain State requirements for employee health examinations and optional service units,” OIG says.

Its previous reviews found problems with quality-of-care oversight in California nursing and skilled nursing facilities, which is troublesome because CMS relies on state licensing surveys to help ensure quality of care, OIG says. It’s also now performing similar reviews in other states involving other provider types.

Nursing home employees, such as nurses, who furnish professional services must be licensed or certified under state law and undergo initial and annual health examinations. The exams consist of a physical evaluation, medical history evaluation, and tuberculosis screening. Nursing homes also have to get state approval to operate optional service units, such as physical therapy units.

For its review, OIG zeroed in on eight of 1,117 nursing homes and randomly selected 30 health care employees at each of them. All 240 sampled employees were licensed or certified. But health exams were not conducted on 59 employees, and at least one mandatory component of a health exam was not done for 73 employees, OIG says.

“Using our sample results, we estimated that during CYs 2010 and 2011, health examinations were not conducted for 30 percent of employees statewide, and at least one required component of health examinations was not conducted for 26 percent of employees statewide,” OIG concluded. This could create a hazard for Medicare and Medicaid beneficiaries, OIG said.

Apparentely, health exam policies and procedures were not always followed at the nursing homes or they were insufficient, OIG said. Also, “the State agency did not always conduct the required licensing surveys, and the State agency’s procedures for reviewing health examination records did not specify all required components.”

Also, OIG said the nursing homes in the review didn’t always get state approval for optional service units, but services were provided in these units anyway, OIG says. “The nursing homes and State agency districts didn’t always follow the requirement to obtain approval for optional service units. Also, the State agency’s licensing survey procedures for reviewing optional service units did not require surveyors to determine whether the nursing homes had approval to operate them,” the report notes.

Read the report at http://go.usa.gov/8eE4.

**Hospitals Re-engineer Processes**

*continued from p. 1*

figure out the most efficient way to conduct reviews and get it right the first time.”

One major focus: the reduction of what Gillis calls “the inconsistent application of the Medicare inpatient-only list.” As long as procedures are medically necessary and there’s an inpatient order, Medicare guarantees Part A payment for the inpatient-only list, even if patients don’t stay in the hospital two midnights. But inpatient-only procedures often trigger claim denials anyway. Sometimes this happens when there’s no admission order because physicians don’t realize the procedure is on the inpatient-only list and the case is booked as an outpatient procedure. Or hospital schedulers don’t always check the inpatient-only list when scheduling procedures at the request of the physician’s office. There’s also ambiguity in the coding of inpatient-only procedures.

Partners HealthCare is clearing a way through the morass of inpatient-only procedure compliance. When booking elective procedures, hospitals are trying to require the CPT code — with a twist. Instead of just checking the short descriptors listed on Addendum E, the inpatient-only list updated annually in the outpatient prospective payment system regulation, the hospitals will ask ordering physicians to examine the long descriptors in Addendum B, which identifies all procedure codes, not just inpatient-only procedures.

“You need the full Addendum B when booking procedures so you are not just focusing on inpatient-only procedures. You need to look at the long descriptors to know what you are booking. You are actually getting the correct CPT code,” he says. Addendum B also has “T” and “C” status indicators, which help determine whether procedures are payable as inpatient vs. outpatient and therefore are a roadmap for the inpatient-only list. Because there is no Medicare payment for status “C”
procedures when they’re performed in an outpatient setting, they serve as a double check on inpatient-only procedure compliance.

Partners is in the process of sending physician offices excerpts from Addendum B that pertain to procedures they routinely perform. Without this detailed information, physicians may admit the patient for procedures that may not be on the inpatient-only list. For example, “reconstruct lower jaw bone” is the short descriptor for both CPT codes 21247 and 21255, but their long descriptors are different. CPT code 21247 is reconstruction of mandibular condyle with bone and cartilage autografts (which includes obtaining grafts, e.g., for hemifacial microsomia) and 21255 is reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (which includes obtaining autografts). They both have “C” status indicators, which flag them as inpatient-only procedures. Meanwhile, the short descriptor for a similar-sounding procedure, “reconstruction of jaw” (CPT 21248 and 21249) has status indicator “T,” which means it could be inpatient or outpatient. The long descriptor for CPT 21248 is reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder), partial and 21249 is the same, but it’s for the complete version.

### Using Long, Short CPT Descriptors Helps Compliance With Admissions

Here are two examples of a series of CPT codes that appear to be the same based on the short description, but are clearly different based on the long description.

“The Status Indicator ‘T’ indicates that this service can be performed in an outpatient setting while Status Indicator ‘C’ is indicative of an inpatient only procedure. No reimbursement will be made by Medicare if a Status C CPT code is billed on an outpatient claim,” says Stephen Gillis, director of compliance coding, billing and audit for Partners HealthCare in Boston. He asks physicians to look at both before writing admission orders to ensure the hospital admits patients for Medicare inpatient-only procedures, while decisions are made on a case-by-case basis for patients whose procedures are not on the inpatient-only list. “If you rely solely on the short descriptors, there is a chance of error,” Gillis says. Contact Gillis at sigillis@partners.org.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>19357</td>
<td>Breast reconstruction</td>
<td>BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION</td>
<td>T</td>
</tr>
<tr>
<td>19361</td>
<td>Breast reconstr w/lat flap</td>
<td>BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP WITHOUT PROSTHETIC IMPLANT</td>
<td>C</td>
</tr>
<tr>
<td>19364</td>
<td>Breast reconstruction</td>
<td>BREAST RECONSTRUCTION WITH FREE FLAP</td>
<td>C</td>
</tr>
<tr>
<td>19366</td>
<td>Breast reconstruction</td>
<td>BREAST RECONSTRUCTION WITH OTHER TECHNIQUE</td>
<td>T</td>
</tr>
<tr>
<td>19367</td>
<td>Breast reconstruction</td>
<td>BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICILE, INCLUDING CLOSURE OF DONOR SITE;</td>
<td>C</td>
</tr>
<tr>
<td>19368</td>
<td>Breast reconstruction</td>
<td>BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICILE, INCLUDING CLOSURE OF DONOR SITE; WITH MICROVASCULAR ANASTOMOSIS (SUPERCHARGING)</td>
<td>C</td>
</tr>
<tr>
<td>19369</td>
<td>Breast reconstruction</td>
<td>BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), DOUBLE PEDICILE, INCLUDING CLOSURE OF DONOR SITE</td>
<td>C</td>
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<td>21240</td>
<td>Reconstruction of jaw joint</td>
<td>ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH OR WITHOUT AUTOGRFT (INCLUDES OBTAINING GRAFT)</td>
<td>T</td>
</tr>
<tr>
<td>21242</td>
<td>Reconstruction of jaw joint</td>
<td>ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH ALLOGRAFT</td>
<td>T</td>
</tr>
<tr>
<td>21243</td>
<td>Reconstruction of jaw joint</td>
<td>ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC JOINT REPLACEMENT</td>
<td>T</td>
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<tr>
<td>21244</td>
<td>Reconstruction of lower jaw</td>
<td>RECONSTRUCTION OF MANDIBLE, EXTRAORAL, WITH TRANSOSTEAL BONE PLATE (EG, MANDIBULAR STAPLE BONE PLATE)</td>
<td>T</td>
</tr>
<tr>
<td>21245</td>
<td>Reconstruction of jaw</td>
<td>RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; PARTIAL</td>
<td>T</td>
</tr>
<tr>
<td>21246</td>
<td>Reconstruction of jaw</td>
<td>RECONSTRUCTION OF MANDIBLE OR MAXILLA, SUBPERIOSTEAL IMPLANT; COMPLETE</td>
<td>T</td>
</tr>
<tr>
<td>21247</td>
<td>Reconstruct lower jaw bone</td>
<td>RECONSTRUCTION OF MANDIBULAR CONDYLE WITH BONE AND CARTILAGE AUTOGRFTS (INCLUDES OBTAINING GRAFTS) (EG, FOR HEMIFACIAL MICROsomIA)</td>
<td>C</td>
</tr>
<tr>
<td>21248</td>
<td>Reconstruction of jaw</td>
<td>RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); PARTIAL</td>
<td>T</td>
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<tr>
<td>21249</td>
<td>Reconstruction of jaw</td>
<td>RECONSTRUCTION OF MANDIBLE OR MAXILLA, ENDOSTEAL IMPLANT (EG, BLADE, CYLINDER); COMPLETE</td>
<td>T</td>
</tr>
<tr>
<td>21255</td>
<td>Reconstruct lower jaw bone</td>
<td>RECONSTRUCTION OF ZYGOMATIC ARCH AND GLENOID FOSSA WITH BONE AND CARTILAGE (INCLUDES OBTAINING AUTOGRFTS)</td>
<td>C</td>
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two-midnight benchmark

contiguous to inpatient admissions and may support the claim form means outpatient services were provided Gillis says. Putting occurrence code 72 on the hospital occurrence code 72 if they conduct their own reviews, hospital,” the website states for transfers begins when the care begins in the initial beneficiary at the initial hospital. That is, the start clock count the pre-transfer time and care provided to the rule. “The receiving hospital is allowed to take into ac

ers are incorporated into the timing of the two-midnight and answers on patient status reviews, CMS said trans

partures against medical advice, patients electing hospice discharges against medical advice, patients electing hospice and patients who expire.” In March 12, 2014, questions and answers on patient status reviews, CMS said trans

ment post-discharge self-audit rebilling program to look at zero- to one-day Medicare fee-for-service inpatient stays on a daily to weekly basis, using case management software. “It is not in real time but it is within five to 10 working days,” he says. When Community Health Network pulled the trigger on the program, “525 cases fell under the criteria and needed to be looked at,” Knuth says. “It took us a while to get through all those. We are caught up and now it is more real time,” which means cases are deemed appropriate for Part A payment or should be rebilled, although sometimes the hospital acts fast enough to get the bill out before it’s dropped, making rebilling moot. As a result of Community Health Network’s efforts, “we are probably seeing an equal reduc

status codes, the less likely the claim will be audited because there is an exemption for transfers, departures against medical advice, patients electing hospice and patients who expire.” In March 12, 2014, questions and answers on patient status reviews, CMS said trans

But hospitals also will check whether discharge status codes are correct (e.g., from acute care hospital to skilled nursing facility). “The more accurate you are with discharge status codes, the less likely the claim will be audited because there is an exemption for transfers, departures against medical advice, patients electing hospice and patients who expire.” In March 12, 2014, questions and answers on patient status reviews, CMS said trans

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Coupling Case Management and CDI Can Help

The health system also has brought case management and clinical documentation improvement under the same leadership, Knuth says. Case managers, coders, utilization reviewers and CDI nurses “collaborate and communicate...in an effort to improve compliance with these regulations and coding and documentation requirements” and hopefully reduce claim denials, he says. Through daily or weekly rounding together, he sees benefits in more accuracy in diagnosis coding; managing the length of stay; better documentation; and optimization of MS-DRG assignment. “One premise of collaboration is to help provide a more accurate picture of the type of patients we care for — their severity of illness and risk of mortality,” which plays into the medical necessity of admissions, Knuth says.

Partners is also ripe for re-engineering of case management, Gillis says. In the emergency rooms, for example, are case managers spending the bulk of their time

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on discharge planning or evaluating whether patients are appropriate for admission under the two-midnight rule? Both are important, so how do you favor one? And if they have time to review only a handful of patient status cases per shift, case managers should be able to identify and set aside inpatient-only procedures and focus on more gray-area cases.

Also, Gillis says, “the segregation of duties is being evaluated.” If hospitals have case management coverage in the ER on nights and weekends, but the case managers on duty then focus exclusively on discharge planning during their shifts, leaving admission decision making neglected at that time, then the hospitals are fooling themselves. “If you are under the belief you have case managers working on nights and weekends, but they are not reviewing physician status assignments, why not?”

Partners also is monitoring the number of observation cases that are greater than 20 hours, especially if they stayed two days. “When we look at the data, we still see a lot of cases where patients are not admitted although they crossed the two midnights,” he says. “It could be a social admission or we didn’t get case management involved to work with physicians prior to the second midnight.”

Contact Gillis at sigillis@partners.org and Knuth at kknuth@ecommunity.com.

**NEWS BRIEFS**

♦ CMS settled several more cases recently under its self-referral disclosure protocol. The details posted on the website are vague, as usual, with no names revealed. But CMS says that a Maryland hospital agreed to pay $100,749 on May 19 to resolve potential violations of the Stark self-referral law in connection with an arrangement with a physician group that didn’t satisfy the requirements of the personal service arrangements exception. In another case, a Connecticut hospital agreed on April 28 to pay $463,473 after self-disclosing potential Stark violations in connection with “arrangements with multiple physicians that failed to satisfy the requirements of the rental of office space exception,” CMS says. Visit http://tinyurl.com/bt6sy9z.

♦ In June, CMS will put out comparative billing reports on electrodiagnostic testing. The comparative billing reports will compare providers’ billing and payment patterns to their peers in the state and across the nation, and will include data-driven tables and graphs. CMS publishes these tools to help providers improve their compliance with Medicare billing rules. CMS has produced comparative billing reports in other areas, such as pain management, home oxygen supplies, evaluation and management services and physical therapy. Interested providers should email the contractor that will produce the electrodiagnostic testing reports at CBRSupport@eglobaltech.com.

♦ Physician Maryam Jafari was sentenced to 21 months in prison after being convicted of receiving cash kickbacks for diagnostic testing referrals, the U.S. Attorney for the District of New Jersey said June 11. After a three-week trial in U.S. District Court in Newark, Jafari was convicted on Feb. 4, 2014, of one count of conspiracy and two counts of violating the anti-kickback statute. The U.S. attorney’s office alleged that Jafari, an internist in Newark, took cash kickbacks from Orange Community MRI LLC (OCM) in exchange for her referrals for MRIs and CAT scans. “At the end of each month, OCM printed patient reports that included information such as dates of service, patient name, referring health care practitioner and medical insurance to be billed. The reports were used to tally the number of tests referred by each doctor and determine the amount of kickback payment paid to the referring healthcare provider,” the U.S. attorney’s office says. For more information, visit www.justice.gov/usao/nj.

♦ Providers must report a clinical trial number on claims for items and services provided in clinical trials that qualify for Medicare coverage, CMS says in MLN Matters MM8401 (change request 8401). It became mandatory on Jan. 1, 2014, to report a clinical trial number. CMS “uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population,” CMS says.

♦ The HHS Office for Civil Rights said on June 11 that it has presented a report to Congress on “HIPAA Privacy, Security, and Breach Notification Rule Compliance,” and a second report on “Breaches of Unsecured Protected Health Information.” The reports are required by the HITECH Act. They address activity from 2011 and 2012. Visit www.hhs.gov/ocr/privacy/hitechrepts.html.
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