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CMS & TJC Compliance Responsibilities for the Case Manager: Part I

Making the Two-Midnight Rule Work for You

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FACULTY

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and

Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in clinical management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a Fellow with the Advisory Board.

Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor

OBJECTIVES

1. Explain the requirements for billing two-midnight rule patients.

2. Compare the two-midnight requirements and exceptions.

3. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.

4. Evaluate case management protocols and penalties.

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Series Goals

Understand regulations and standards that impact the case management department

Identify and implement strategies to meet regulation and standards expectations

Recognize the compliance role of each case management team member

Develop a process to audit compliance to standards and regulations

Create a compliance dashboard for case management

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Medicare 2014 IPPS Final Rule – Two Midnight Rule

Final IPPS Rule (CMS-1599-F) (August 19, 2013) introduced the "Two Midnight Rule" as the new Medicare inpatient payment standard: Surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital payment under Medicare Part A only when:

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.

Scope of Rule: Acute Care Hospitals, CAHs, LTCHs, Inpatient Psychiatric Hospitals; Traditional Medicare only

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Medicare Law and Guidance for Admitted Patients

Medicare Benefits Policy Manual, Chapter 1, Section 10 – Definition of "Inpatient"

"An Inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient **with the expectation that he or she will remain at least overnight and occupy a bed** even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. . . . The physician or other practitioner responsible for a patient's care is responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a **24-hour period as a benchmark**. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."

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24 hour benchmark changed
Documentation critical
Inpatient admission defined by time
Observation basically unchanged
Severity of illness secondary to time
Admission orders must be specific
Major Changes With 2 Midnight Rule
7


Time-based Inpatient Admission
Inpatient admission is defined by a patient requiring a hospitalization encompassing 2 midnights
8


24 Hour Benchmark
Applies to the 24 hours that start at midnight of first calendar day patient is in a hospital bed—to the second midnight
9

Start Clock for Presumption

Two-Midnight **Presumption** starts with the inpatient order and formal admission

"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 2 or more midnights), the inpatient admission does not begin until the inpatient order and formal admission occur."

MLN Connects January 14, 2014 Presentation

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Inpatient Admission Order and Certification

Medicare 2014 IPPS Final Rule

- New regulation, 42 CFR 412.3, requiring a written inpatient admission order
- Amends Inpatient Conditions of Payment regulation, 42 CFR 424.13, to require a physician inpatient certification in accordance with 42 CFR 412.3
- Both requirements are conditions of payment

From CMS Guidance: Hospital Inpatient Admission Order and Certification issued on September 5, 2013 and updated on January 30, 2014

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Who Can Furnish an Admission Order

Admission Order must be written by a qualified physician/practitioner with "sufficient knowledge" of the patient's condition--

- Licensed by the state to admit inpatients
- Granted privileges by the hospital to admit patients
- Knowledgeable about the patient
- Not required to be the certifying practitioner
- May include medical residents and other non-physician practitioners who (i) are exercising independent judgment, (ii) are authorized by law to admit patients and (iii) have admitting privileges (no countersignature required)
- Medical residents, physician assistants, nurse practitioners, other non-physician practitioners or physicians ***without*** admitting privileges may act as a proxy if
  - authorized under state law, and
  - admitting physician approves decision and countersigns order prior to patient discharge
  - Example: ED physician without admitting privileges must have order countersigned by admitting physician prior to patient discharge

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Verbal Admission Orders

Practitioners **without admitting** authority, such as nurses, may be permitted to accept and record verbal orders at their hospital

Verbal order must identify the qualified ordering practitioner

Qualified ordering practitioner must directly communicate the order

Qualified ordering practitioner must countersign the order as written to authenticate the order

Inpatient time starts with the verbal order, if authenticated prior to discharge

State laws, hospital policies and bylaws, rules and regulations governing verbal orders must be met (See 42 CFR 482.24(c)(2))

Note: If a verbal order is not authenticated then the "hospital stay may be billed to Part B as a hospital ***outpatient*** encounter," because patient was never an inpatient.

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Standing Orders and Protocols

A standing order may not serve as an order for inpatient admission

A protocol or algorithm may be used in considering inpatient admission (See 42 CFR 482.24(c)(3))

Only the ordering practitioner or practitioner acting on the ordering practitioner's behalf (e.g., resident) may make and take responsibility for an admission decision

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Transfers

- Pre-transfer time and care provided to beneficiary at the initial hospital may be taken into account to determine whether the two midnight benchmark was met

Clock starts for transfers when the care begins at the initial hospital

Excessive wait times or time spent in the hospital for non-medically necessary services must be excluded

- Records may be required from the initial hospital to support the medical necessity of the services provided and to verify when the treatment commenced

Claim submissions for transfer cases will be monitored and any billing aberrancy identified by CMS or review contractors may be subject to targeted review

CMS contractors to ensure compliance, deter gaming or abuse

- The initial hospital should continue to apply the two midnight benchmark based on the expected length of stay within the initial hospital's facility

CMS 2 Midnight Rule FAQ 2.2

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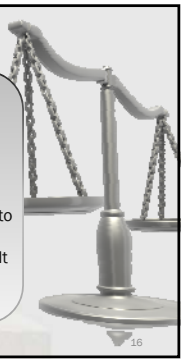
Physician Order

For payment of hospital inpatient services under Medicare Part A, the order must specify "admit to inpatient", "admit as an inpatient", "admit for inpatient services" or similar language

"Admit to ICU" or "Admit to PCU" are no longer acceptable – must default to outpatient billing



Page 50949 IPPS Final Rule for 2014

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Content of Certification

- Authentication of admission order, including certifying that services were reasonable and necessary
- Medical reason for inpatient admission
- Expected length of stay
- Plans for inpatient care and services
- Plans for post-hospital care

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Timing of Certification

- Certification begins with inpatient admission order
- Certification must be completed, signed, dated and documented **prior to patient discharge**
- CMS noted that "generally good medical record documentation ***may*** fulfill components required for certification"

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Certification Format

No specific procedure or format is required or provided by CMS

CMS indicates that the components of certification may be found in various parts of the medical record

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CMS DISCUSSION OF MEDICAL NECESSITY

CMS assumes that a hospital stay of at least 2 midnights qualifies as an inpatient stay however…

…auditors were told by CMS to watch for hospitals and physicians who are gaming the system to generate inpatient stays

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Medical Necessity

What criteria should be used?

- CMS states "the 2-midnight rule will apply even if an admission failed InterQual or Milliman"
- The question is if "there was a medical reason that required the patient to be in the hospital for 2 days….even if that reason is that the patient must remain under observation for at least 2 days"
- CMS and its auditors seem to contradict themselves about observation stays of more than one day
- Physician order and physician certification "are not considered by CMS to be conclusive evidence that an inpatient hospital admission or service was medically necessary"

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Observation Changes

Observation still <24 hours

- After 1 midnight all observation patients should be discharged or advanced to inpatient
- An observation midnight counts towards inpatient
- There should rarely be any 2 midnight (or longer) observation stays

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Role of Medical Necessity Criteria

CMS Guidance at time of final rule: "We are anticipating that most hospitals will choose not to use Interqual or Milliman to make the decision about whether or not to write the inpatient order. Instead, we're expecting that most hospitals are going to look to the guidance in this rule about the physician's expectation of a 2-midnight or more stay in the hospital requiring the hospital-level of care."

CMS FAQ ("*2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after 10/1/2013*") Q4.1—What documentation will Medicare contractors expect to support expectation of 2-midnights? A4.1: Expected LOS and underlying medical necessity of care at hospital must be supported by complex medical factors such as history and comorbidities, severity of signs and symptoms, current medical needs and risk of adverse event.

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Under the 2 Midnight Rule

1 ER midnight + 1 inpatient midnight = inpatient admission

1 observation midnight + 1 inpatient midnight = inpatient admission

2 inpatient midnights = inpatient admission

2 observation midnights = observation service

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Exceptions to 2 Midnight Rule

Exceptions to the Two Midnight Requirement for Inpatient Admission – **Unforeseen Circumstances**

- Unforeseen circumstances may result in a shorter beneficiary stay than the physician's expectation (that the beneficiary would require a stay greater than two midnights)
  - Death
  - Transfer
  - Departure against medical advice (AMA)
  - Unforeseen recovery
  - Election of hospice care
- Such claims ***may*** be considered appropriate for hospital inpatient payment

The physician's expectation and any unforeseen interruptions in care must be documented in the medical record

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Inpatient-Only Surgery

Inpatient-only surgeries do not require 2 midnights in the hospital

There are no time specifications for inpatient-only surgeries

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SNF Placement

SNF placement still requires 3 inpatient midnights

ED or observation midnights do NOT count toward meeting CMS SNF regulation

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Hospital Obligation To Self Audit Inpatient Claims

Patient Protection and Affordable Care Act, P.L. 111-148, Section 6402, 42 U.S.C. 1320a-7k(d)

Reporting and Returning of Overpayments—

In general. If a person has received an overpayment, the person shall—

(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

The term "**overpayment**" means any **funds** that a person receives or retains under title XVIII (i.e. Medicare) or XIX (i.e. Medicaid) to which the person, after applicable reconciliation, is **not entitled** under such title.

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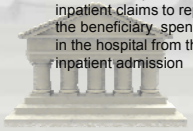
Occurrence Span Code 72 For 2 Midnight Rule

1. Effective 12/1/2013, Occurrence Span Code 72 may be used to designate "Contiguous outpatient hospital services that preceded the inpatient admission"
2. Voluntary code, but CMS encourages hospital use
3. Hospitals may use Occurrence Span Code 72 on inpatient claims to report the number of midnights the beneficiary spent receiving outpatient services in the hospital from the start of care until formal inpatient admission



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Condition Code (CC) 44: Criteria for Changing Patient Status

CC 44 may be used only if all the following requirements are met:

- The UR committee determines that a patient was admitted erroneously
- The patient status change is made prior to patient discharge
- The hospital has not submitted a claim to Medicare for the inpatient admission
- A physician responsible for the care of the patient concurs with the UR committee's decision
- The physician's concurrence is documented in the patient's record
- The patient must be notified in writing of the change in status

One physician member of the UR committee may make the determination for the committee that the inpatient admission was not medically necessary if that physician is different from the "concurring" physician.

If hospital changes patient status, then the patient's treating physician should make a similar change to make hospital and physician claim submission consistent.

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Condition Code 44: Changing Patient Status

CMS FAQ

Q: May a hospital change a patient's status using Condition Code 44 when a physician changes the patient's status without utilization review (UR) committee involvement?

A:

- No--policy for changing a patient's status using Condition Code 44 requires that determination to change patient's status be made by the UR committee with physician concurrence
- Hospital may not change patient's status from inpatient to outpatient without UR committee involvement
- Conditions for the use of CC 44 require physician concurrence with UR committee decision
- CMS guidance, in accordance with 42 C.F.R. 482.30(d)(1), is that one physician member of the UR committee may make the determination for the committee that inpatient admission is not medically necessary; physician member of UR committee must be different person from physician responsible for the care of the patient

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Scope of Part B Inpatient Billing

Per 42 CFR 414.5(a), CMS will allow Part B payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient rather than admitted as an inpatient—

- Services paid under Hospital Outpatient PPS that do not require outpatient status
- PT/OT/Speech Language Pathology Services
- Ambulance Services
- Non-implantable DME and prosthetics and orthotics
- Clinical Diagnostic Laboratory Services
- Screening and Diagnostic Mammography Services
- Annual Wellness Visit

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Two Midnight Rule Impact on the Medicare Beneficiary

- Potential Increased Beneficiary Liability for 20% Part B Copay and 100% of the cost for self-administered drugs
- CMS has indicated that even patients receiving ICU services are not considered appropriate for inpatient admission unless physician expects stay to last two midnights→could lead to very large copays
- Qualifying stay for SNF Part A coverage: Time spent in hospital receiving outpatient services (e.g., observation) counts towards the Two-Midnight Benchmark for admission purposes, but does not count towards required 3-day inpatient stay for SNF coverage
- General beneficiary confusion as to patient status and payment obligations (especially with regard to rebilling Part A to Part B)

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Impact on Beneficiaries: Co-Insurance and Deductibles

Any Co-Insurance or Deductible collected for the Part A claim must be refunded to the beneficiary

CMS in the preamble to the Final Rule refused to provide authority for hospitals to

- Offset Part B beneficiary liability against Part A deductible, or
- Waive Part B beneficiary liability for copayments and non-covered items and services

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CMS Directed Audit Contractors to Provide Probe and Educate Process

Prepayment review of a small sample of inpatient claims for admissions of less than two midnights beginning with admissions on October 1, 2013 (10 claims for smaller hospitals; 25 for larger facilities)

Contractors to use probe review as educational tool; but inpatient admissions not meeting 2 midnight rule guidelines were denied Part A payment

CMS has extended prepayment "probe and educate" period through September 30, 2015

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Probe and Educate Reviews

Results of the initial probe audit may lead to increased prepayment review, based on error rate:

Minor Concern: A provider with a low error rate and no pattern of errors, defined as 0-1 errors out of 10 claims or 0-2 errors out of 25 claims. MACs will educate the provider via the results letter indicating the reasons for denial of the inpatient claim, but will not conduct further review.

Moderate-Significant Concern: A provider with a moderate error rate, defined as 2-6 errors out of 10 claims or 3-13 errors out of 25 claims. MACs will offer 1:1 telephonic provider education in addition to the written review results letters, and will continue further probe reviews.

Major Concern: A provider with a high error, defined as 7+ errors out of 10 claims or 14+ errors out of 25 claims. MACs will offer 1:1 telephonic provider education in addition to the written review results letters, and will continue further probe reviews, with potential of another probe of between 100-250 claims for continuing non-compliance

MLN Matters Number: SE1403

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Probe and Educate Process (continued)

- Denied claims may be appealed or rebilled outpatient Part B claims
- Audit contractors were to wait 45 days after educating hospitals on compliance with two-midnight rule before making additional documentation requests, to give hospitals additional time to implement compliance strategies before next audit
- If "probe and educate" audit turns up zero errors or only one error, the hospital will not be subject to any more prepayment reviews under the two-midnight rule for claims (during probe and education time frame)

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CMS Examples of Common Denials From Probe and Educate Reviews

- Missing or flawed inpatient admission order—Admission order did not clearly express intent to admit as inpatient
- Short-stay procedures not on the inpatient-only list—patient underwent procedure with average LOS of less than two midnights, and no physician documentation to support greater than 2 midnight stay
- Short stays for medical conditions when the record fails to support an expectation of two midnights—patient presented with dizziness and physician's notes indicate that the physician intended to observe the patient overnight to monitor the effects of a medication change
- Physician attestation statements without supporting medical record documentation—preprinted statement that patient expected to require two midnights of hospital care was not supported by medical record entry, for example progress note stating discharge in morning if stable

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Audit Contractor Reviews Not Impacted by 2 Midnight Rule

Audit contractors were approved by CMS to continue other types of inpatient hospital reviews including:

- Coding reviews
- Reviews for the medical necessity of a surgical procedure provided to the hospitalized beneficiary
- Inpatient hospital patient status reviews for dates of admission prior to October 1, 2013 (based upon prior guidelines)

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2 Midnight Rule Compliance Strategies

Re-educate your hospital

- Physicians
  - High volume admitters
  - ED Physicians
  - Hospitalists
  - Intensivists
  - CMO
  - Physician advisors
- Case managers
- Nursing supervisors
- Bed board nurses
- Key nursing staff
- UR Committee members
- CDI staff
- Transfer center nursing staff
- UR Committee

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2 Midnight Rule Compliance Strategies, cont'd

- Develop/review written procedures for implementation of 2 midnight rule (and Condition Code 44)
- Place hardwired stops in computerized physician order entry (CPOE) system to assure requirement of admission order and discussion of expected stay
- If CPOE not fully developed, encourage physicians to use the term "admit" only when admitting a patient as inpatient
  - Admit to inpatient
  - Admit as inpatient
  - Admit for inpatient services
- Implement a case management process to assist physicians in managing patient status to effectively transition patients to either inpatient status or discharge when admitted for observation
- Re-educate case management staff, finance, and UR Committee, and physicians on Condition Code 44 requirements

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2 Midnight Rule Compliance Strategies, cont'd

- Review all inpatient admissions for with average LOS of less than two midnights by DRG—to understand trends in short stays (by both DRG and physician)
- Assure all Hospital/Medical Staff policies on admitting privileges and verbal orders match the requirements of the 2 midnight rule
- Assure optimal use of physician advisors
- Monitor changes in Medicare guidance regarding inpatient status and medical necessity
- Assure optimal role of appeal coordinator to work with Finance/Revenue Integrity Department

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2 Midnight Rule Compliance Strategies, cont'd

- Develop a pre-bill edit to hold Medicare inpatient claims that are one-day stays (may also want to review two-day stays)
- Implement self audit process for all one and two day stays for traditional Medical patients
- Provide feedback to physicians and case managers regarding deficiencies in documentation and length of stay
- Consider key case management roles, such as perioperative case manager, ED case manager, admissions case manager, transfer center case manager

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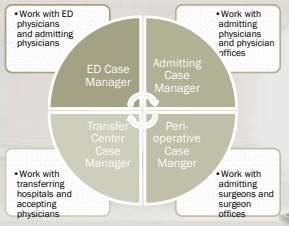
Role of Specialized Case Managers in 2 Midnight Rule Implementation



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Self Audits of All One and Two Day Stays for Traditional Medicare Patients

1. Accurate admission order
2. Expected duration of stay
3. Reason for inpatient treatment (medical necessity), including severity or exacerbation of any chronic symptoms, clinical evidence, risk of negative outcome
4. Detailed plan of care
5. Anticipated plans for post-discharge care

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Sample Self Audit: 1-2 day stays

Audit Metric	Patient 1	Patient 2	Patient 3	Patient 4
Physician order accurate				
Expected duration of stay documented				
Reason for inpatient stay documented				
Plan for inpatient care				
Plan for post-hospital care				
Physician order certification prior to patient discharge				

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PLANS AFTER RAC PROHIBITION PERIOD

After prohibition expires September 30, 2015, audit contractors have 6 months to review a claim for patient status when the hospital bills within 3 months of the date of service

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American Hospital Association (AHA) Letter to CMS With Suggested Potential Solutions

- Requested extension of policy until either October 1, 2015 or implementation of a short stay payment policy
- RAC reform: realign financial RAC incentives so they cannot deny claims "inappropriately an excessively"
- Short stay payment policies
- Evaluation of payment for observation care, which does not cover hospital costs

Sent February 2015

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AHA Short Stay Payment (SSP) Policy Models

- Considered transfer policy-based SSP, but decided it was not an option for reimbursing short inpatient hospital stays
- 5 additional SSP policy models
- Creation of new short-stay DRGs for IP hospital stays spanning less than 2 midnights
- Budget neutral to CMS
- Uses current weigh-setting methodology
- Had to use most recent MedPAR data, which was from FY 2013 (before 2 midnight rule implemented in FY 2014)
- Does not include behavior changes that might be made by hospitals

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AHA Short Stay Payment (SSP) Policy Models

MODEL	DESCRIPTION	SHORT-STAY DRGS
MDC (Major diagnostic category)	1 short-stay DRG for each MCD	26
MDC M/S (medical/surgical)	One short-stay DRG for all of the medical DRGs within an MDC and another short-stay DRG for all of the surgical DRGs within an MDC	49
Targeted DRGs	One short-stay and one non-short-stay DRG for the DRGs with the most short stays or RAC denials	61
Base DRG	One short-stay DRG for each base DRG	333
DRG Refinement	One short-stay DRG for each DRG	739

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Sample Targeted DRGs

Carotid artery stent
Extracranial procedures
Intracranial hemorrhage or cerebral infarction
TIA
Intraocular procedures
Sinus and mastoid procedures
Salivary gland procedures
Disequilibrium
COPD
Simple pneumonia & pleurisy
Respiratory signs & symptoms
Major cardiovascular procedures
Drug-eluding stents
Other vascular procedures

Acute MI expired
Heart failure and shock
Cardiac arrest, unexplained
Atherosclerosis
Hypertension
Cardiac arrhythmias
Syncope & collapse
Chest pain
Appendectomy
GI hemorrhage
Esophagitis, gastroent & miscellaneous digestive disorders
Laparoscopic cholecystectomy
Cervical spinal fusion
TURP

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2 MIDNIGHT RULE DASHBOARD

Metric	EPL	Month 1 Results	Month 2 Results	Month 3 Results	YTD Results
% Accurate Orders					
% Documented Expected LOS					
% Documented medical necessity					
% Documented discharge plan					
% Order authenticated before discharge					
% Accounts with Condition Code 44 billed					
% of Condition Code 44 accounts billed that have accurate supporting documentation					
% of 1 day stay self denials					
% of 2 day stay self denials					
% of 1 and 2 day stay self denials					

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Coming This Summer

2015 OPPS
Proposed Rule

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RESOURCES

- Final 2 midnight rule CMS-1599 (August 2013)
- Medicare Benefits Policy, Chapter 1, Section 10
- MLN Connects, January 14, 2014 Presentation: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2014-01-14-midnight.html
- 42 CFR 412.3 (Final rule regarding physician certification): http://www.ecfr.gov/cgi-bin/text-idx?SID=6153f6aa2d7cd17640867c003e18e2e2&node=se42.2.412_13&rgn=div8%20%3E
- CMS Guidance: Hospital Inpatient Admission Order and Certification issued on September 5, 2013 and updated on January 30, 2014
- Condition Code 44: CMS Transmittal 299 (September 10, 2004) and Medicare Claims Processing Manual, Chapter 1, Section 50.3, and 42 C.F.R. 482.30(d)(1)

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RESOURCES

- Probe and educate process: MLN Matters Number: SE1403
- CMS IOM-002 Medicare Benefit Policy Manual, Chapter 6, Section 20.6B, "Coverage of Outpatient Observation Services"
- Social Security Act 1862 (a) (1) (A)
- MLN Matters SE 1333, Revised: Part A to Part B Billing of Denied Hospital Inpatient Claims: http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1403.pdf
- Verbal orders, 42 CFR 482.2(c)(2): https://www.law.cornell.edu/cfr/text/42/482.24

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RESOURCES

- CMS Guidance: Hospital Inpatient Admission Order and Certification issued on September 5, 2013 and updated on January 30, 2014
- Society for Hospital Medicine, July 2014, "The Observation Status Problem—Impacts and Recommendations for Change"
- Probe and educate updates, appeals processes: www.cms.gov/research-statistics-data-and-systems/monitoring-programs/Medicare
- Transfers: CMS 2 Midnight Rule FAQ 2.2: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf

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IT'S TIME FOR QUESTIONS!
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