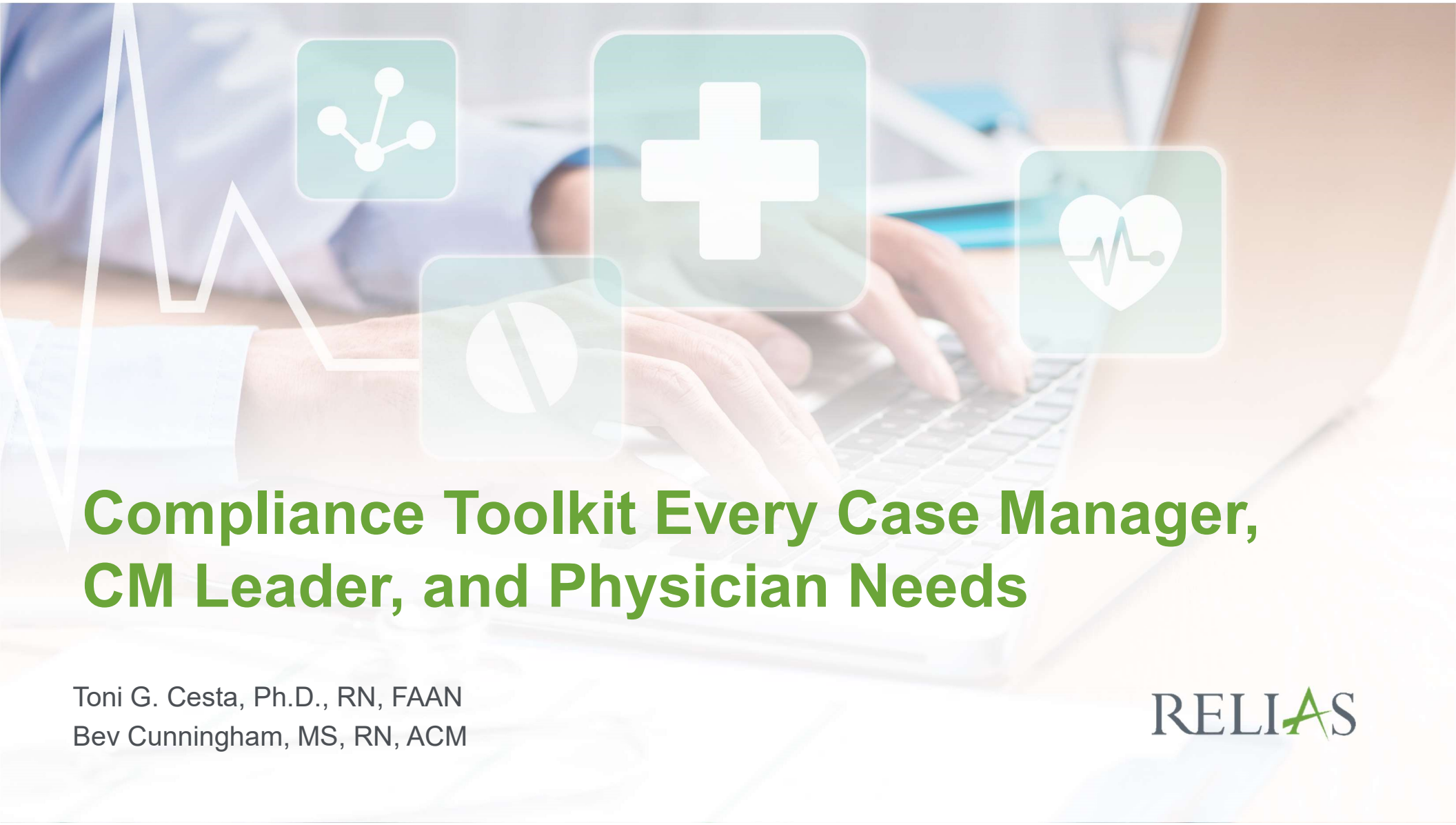


Compliance Toolkit Every Case Manager, CM Leader, and Physician Needs

Toni G. Cesta, Ph.D., RN, FAAN
Bev Cunningham, MS, RN, ACM

RELIAS

SPEAKERS

Toni Cesta, PhD, RN, FAAN

Founding partner of Case Management Concepts, LLC. 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. She has been active in the research and development of Case Management for over 20 years.

Beverly Cunningham, MS, RN, ACM

Founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials 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 the former Vice President of Resource Management at Medical City Dallas Hospital.

OBJECTIVES

- Discuss compliance elements that affect the daily practice of a case manager.
- Describe the CMS compliance requirements for case managers.
- Identify compliance gaps in your daily practice.

THE BALANCE OF COMPLIANCE: FINANCIAL AND CLINICAL

RN Case Managers

Case Management Leaders

SW Case Managers

Physicians

RELIAS

COMPLIANCE

In general, **compliance** means conforming to a rule, such as a specification, policy, standard or law. **Regulatory compliance** describes the goal that corporations or public agencies aspire to achieve in their efforts to ensure that personnel are aware of and take steps to comply with relevant laws and regulations.

Wikipedia

Cooperation or obedience: Compliance with the law is expected of all.

Dictionary.com

FRAUD

- In the law: deliberate deception to secure unfair or unlawful gain
- In the government: defrauding the Federal government and its programs is illegal; practices that either directly or indirectly result in unnecessary costs to the Medicare program
  - Mistake
  - Inefficiencies
  - Bending of rules
  - Intentional deception

LACK OF COMPLIANCE

=

LACK OF REIMBURSEMENT

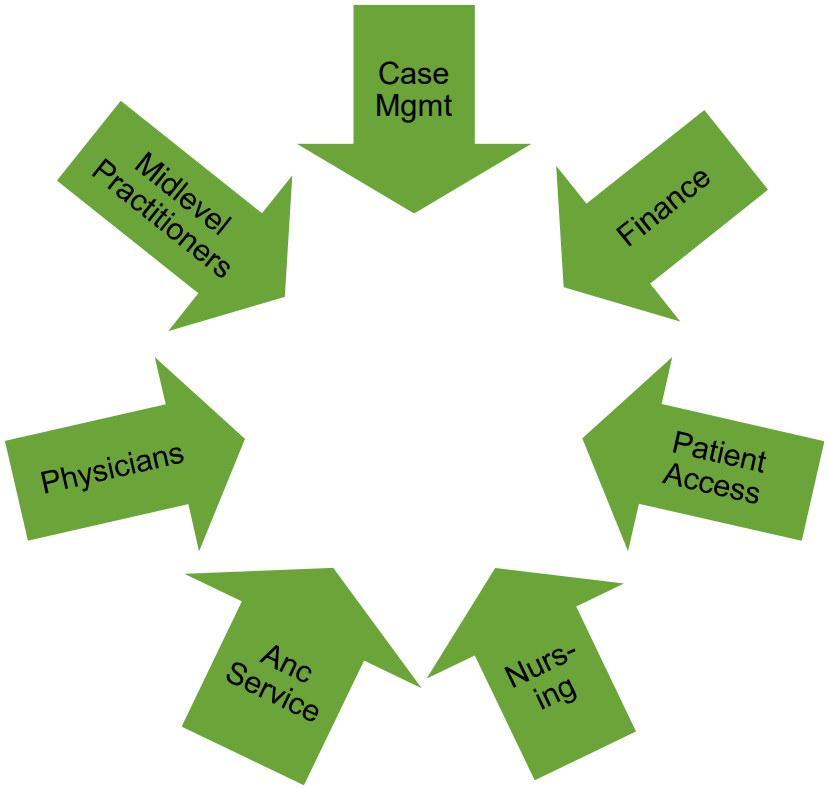
But……..can also result in penalties and imprisonment

WHO REQUIRES COMPLIANCE?

- CMS Conditions of Participation
- The government
- National and state agencies
- Hospital accreditation bodies
- Payers
- Your hospital
- Your patients

COMPLIANCE SHARED RESPONSIBLITIES

Compliance Is Not Just A Case Management Process

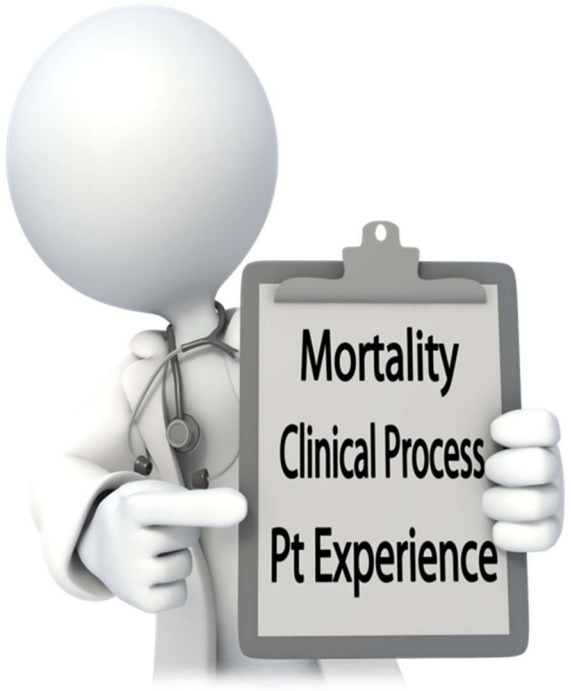


RELIAS

HOSPITAL PROCESSES RELATED TO PENALTIES

- Core measures
- Hospital acquired conditions
- Patient safety indicators
- Readmissions
- Mortality
- Spending per Medicare beneficiary
- HCAHPS scores
- Hospital associate infections
- Delays in care

It's more than rules and regulations!



CASE MANAGEMENT PROCESSES RELATED TO BILLING

- Medical necessity
- 2 midnight rule
- Appropriate order
- Billing codes
  - Condition code 44
  - Provider liable
- Physician advisor role
- Discharge planning
- 3 day qualifying stay for skilled nursing facility transfer

MORE CASE MANAGEMENT PROCESSES RELATED TO BILLING

- HINNs (Hospital Issued Notice of Noncoverage)
- ABNs (Advanced Beneficiary Notice)
- Utilization Review Plan
- Utilization Review Committee
- Physician documentation to support billing
- Designation of appropriate discharge code (for transfer DRGs)

GETTING PAID WHAT WE DESERVE TO BE PAID — A BIG CHALLENGE

- Transfer DRGs
- Appealing denials
- Outlier patients
- Commercial payers meeting contract requirements
- Following value-based reimbursement guidelines: quality outcomes now impact our reimbursement
- Billing the correct status, especially on readmissions

MEDICAL NECESSITY: LEVELS OF CARE, STATUS, ADMISSION AND CONTINUED STAY: THE RULES

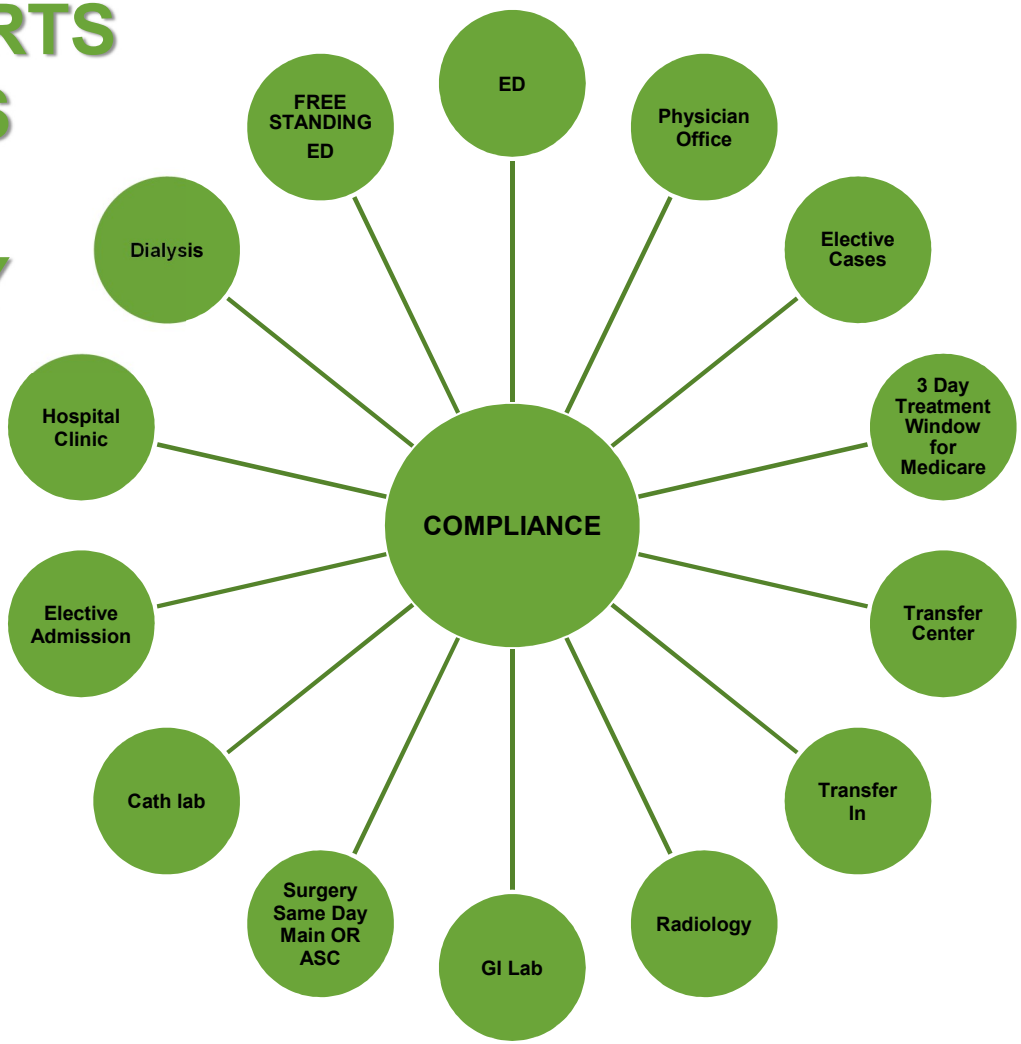
- Medical necessity is guided by medical necessity criteria
- When the record does not meet criteria, discuss with attending physician to determine if there is more documentation
- If that conversation does not result in the record meeting medical necessity, refer to your physician advisor
  - Outpatient in a bed
  - Observation service
  - Inpatient admission
    - Medical-surgical
    - Intermediate
    - Critical care
    - NICU

RELIAS

MEDICAL NECESSITY: LEVELS OF CARE, STATUS, ADMISSION AND CONTINUED STAY: THE BILLING RULES

- All payers demand that we only bill for the level of care provided—not billing for where patient is placed
- Telemetry placement does not always mean an intermediate level of care
- Conditions of Participation require that we review medical necessity: We are our own UM for traditional Medicare patients
- We are also our own UM for some DRG-paid insurance companies

COMPLIANCE STARTS AT THE ACCESS POINTS FOR YOUR FACILITY



RELIAS

CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS) CONDITIONS OF PARTICIPATION (CoP) FOR HOSPITALS: 42 C.F.R. PART 428

Rules from CMS by which Medicare and Medicaid enrolled hospitals must abide as a condition of participation in federal health care programs

Any state regulation that is more restrictive than the CoP will "trump" the CoP

42 C.F.R. PART 482 — CONDITIONS OF PARTICIPATION (CoP) FOR HOSPITALS

Subpart C: Basic hospital functions relating to case management

- § 482.30 Condition of participation: Utilization review
- § 482.43 Condition of participation: Discharge planning

RELIAS

CoP
UTILIZATION REVIEW REQUIREMENTS
482.30

Attachment 1
Medicare Claims Processing Manual: Attachment 2

MEDICARE CONDITIONS OF PARTICIPATION

Requirement for a Utilization Review (UR) Committee

Medicare Conditions of Participation, Section 482.30 for Inpatient Prospective Payment System (IPPS) and 485.66 for Critical Access Hospitals (CAH)

CAH State Operations Manual, Appendix W

Medicare Claims Processing Manual, Chapter 1, 50.3

MEDICARE CONDITIONS OF PARTICIPATION (CoP)

- All hospitals must have a UR plan: Must have a plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs
- Some states have specific requirements for a hospital's UR plan
- All hospitals must have a UR committee
- Hospital must ensure that all UR activities, including review of medical necessity of hospital admissions and continued stays are fulfilled as described in 42 CFR 482.30

UTILIZATION REVIEW PLAN AND COMMITTEE: THE RULES

- Must be committee of the medical staff
- Reviews must be conducted for
  - Duration of stay in cases reasonably assumed to be outlier cases
  - Professional services in cases reasonably assumed to be outlier cases
- Reviews may not be conducted by any individual who
  - Has direct financial interest
  - Was professionally involved in the care of the patient whose case is reviewed

UTILIZATION REVIEW PLAN ANDCOMMITTEE: THE BILLING RULES

- No specific billing rules for this
- CMS does expect Conditions of Participation to be followed for all Medicare and Medicaid patients—could view this as “fraud”, if not followed

2 VERY IMPORTANT CoP BILLING PROCESSES

- Condition Code 44
  - Ability to bill Medicare Part B if patient has IP order, but does not meet medical necessity and HAS NOT been discharged
  - Requirements to meet C0P guidelines for this billing to occur
  - Increased payment for hospital (more payment than with provider liable process below)
  - Must have UR Committee agreement that patient does not meet medical necessity
  - Patient must receive observation letter within 2 days

2 VERY IMPORTANT CoP BILLING PROCESSES

- Provider liable
  - Ability to bill Medicare Part B if patient has IP order, but does not meet medical necessity and has already been discharged
  - Less payment to hospital with this process
  - Must have physician advisor agreement that patient does not meet medical necessity

PATIENT BILLING MUST BE ACCURATE REGARDLESS OF PATIENT LOCATION

- Status assignment (for billing)
  - Outpatient
  - Observation service
  - Inpatient
- Level of care (for billing)
  - Medical/surgical
  - Intermediate
  - Critical care
  - NICU levels of care

THE 2 MIDNIGHT RULE (Traditional Medicare)

- Defined physician documentation and made payment contingent on such documentation
- Document
  - Expectation of patient stay to be greater or less than 2 midnights, with accompanying appropriate order
  - Reason for inpatient discharge if patient discharged after only 1 midnight
  - Reason for hospital services for any inpatient stay expected longer >1 midnight must support medically reasonable and necessary care
- Reassess after 1 midnight, if placed in observation service, and reason for continued stay, if staying a 2nd midnight as inpatient
- Authentication of admission order before patient discharged
- IP only procedures are exception

EXCEPTIONS TO 2 MIDNIGHT RULE

- Unforeseen circumstances may result in a shorter beneficiary stay than the physician's expectation that patient would stay at least 2 midnights
  - Death
  - Transfer
  - Departure against medical advice
  - Unforeseen recovery
  - Election of hospice care
- Such claims "may" be considered appropriate for IP hospital payment
- Physician expectation and any unforeseen interruptions in care must be clearly documented in the medical record

2 MIDNIGHT RULE: THE BILLING RULES

- Do not bill unless all components of the rules are in place
- Self audits per Medicare requirements: Medline Matters SE 1333 (Attachment 3)

2016 FINAL RULE FOR 2 MIDNIGHT RULE

- 2 midnight rule transitioned from Inpatient Prospective Payment System to Outpatient Prospective Payment System final rule
- 2 midnight rule essentially did not change
- Expanded inpatient admissions for less than 2 midnights: admission would be accepted on case-by-case basis
- Enforcement of 2 midnight rule shifted to Beneficiary and Family Centered Quality Improvement Organizations (BFCC-QIO)
- CMS invited comments on specific medical criteria to be used with 2 midnight rule

ACCEPTABLE ONE DAY STAYS

- Depends on physician judgement
- Depends on documentation to justify stay
- CMS expected these to be rare
- These types of admissions will be monitored and reviewed, if appropriate

OBSERVATION HAS BECOME A KEY COMPLIANCE CONCEPT

OBSERVATION CARE

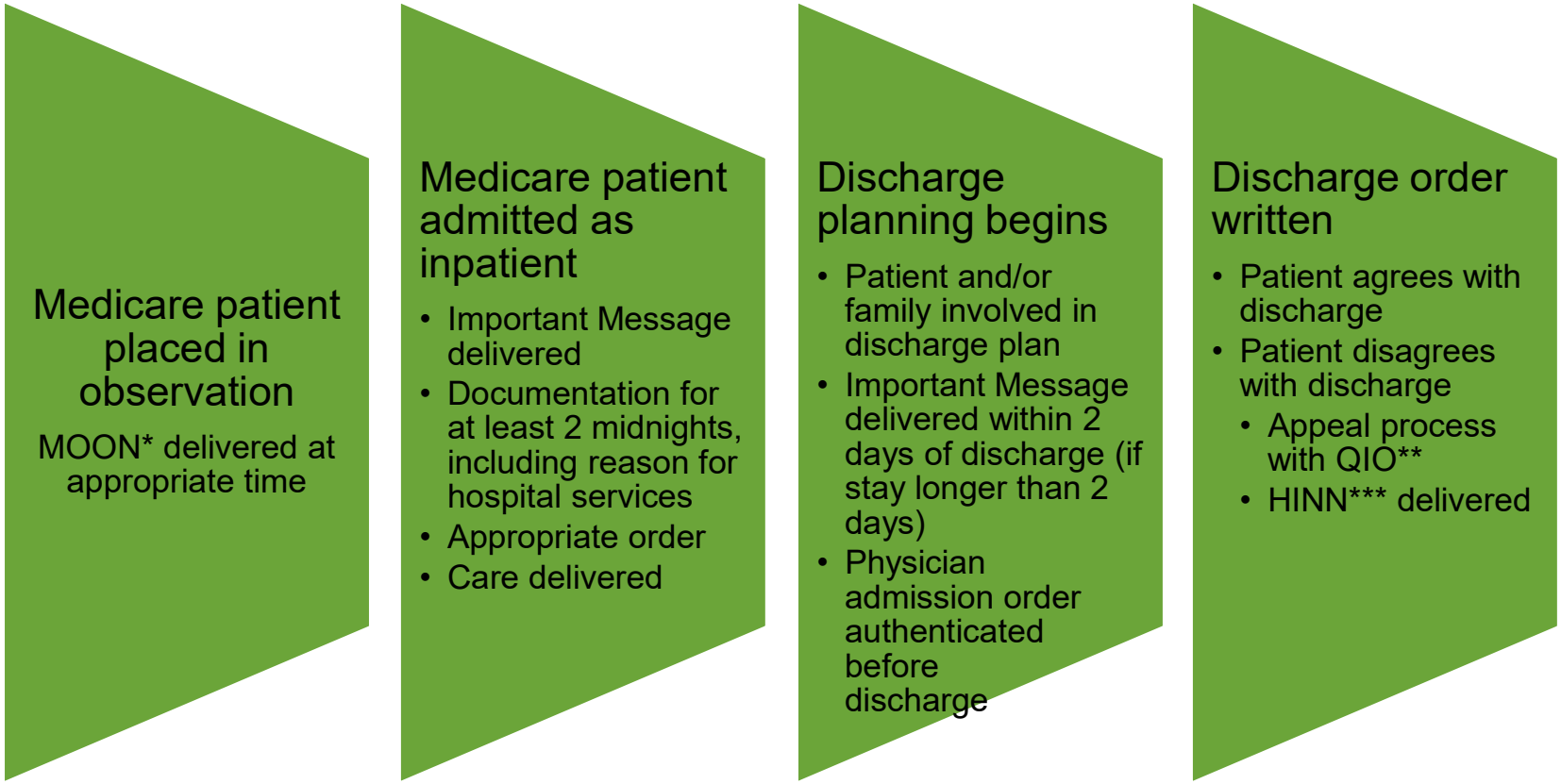
- Well-defined set of specific, clinically appropriate services
- Includes
  - Ongoing short term treatment
  - Assessment
  - Reassessment
- Furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital

Internet-Only Manual (IOM), Publication 100-04,
Chapter 4, Section 290

CHALLENGES OF OBSERVATION SERVICE

- Physician understanding of observation service designation
- Written designation of “place” in observation service (not admit to observation)
- 2 midnight rule effect
- Media suggestions to patient to “demand” that patient be admitted as inpatient, rather than observation
- No observation orders to be written before surgical procedure
- Conditions of Participation regulations for observation order when patient already admitted as inpatient

KNOW UTILIZATION MANAGEMENT RULES AND REGULATIONS



RELIAS

*Medicare Outpatient Observation Notice **Quality Improvement Organization ***Hospital Issued Notice of Noncoverage

IMPORTANT MESSAGE: THE PATIENT'S RIGHT TO APPEAL

- 1st important message given on admission
- 2nd important message give within 2 days of discharge

HOSPITAL ISSUED NOTICE OF NONCOVERAGE: HINN

- Hospitals "may" issue HINNs to Medicare fee-for- service patients if they plan to hold patient financially liable
- Reason for HINN: Care patient receiving, or about to receive not covered because it is:
  - Not medically necessary
  - Not delivered in the most appropriate setting
  - Custodial in nature
- Ensure you have contacted physician for additional information regarding patient's case, and escalated to physician advisor before issuing HINN

HOSPITAL ISSUED NOTICE OF NONCOVERAGE: HINN

- Patient must be able to comprehend the HINN and it may not be issued where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies
- Patient billing must meet CMS requirements: if proper HINN not obtained, patient cannot be held financially liable

HINN: THE RULES

- Preadmission/Admission HINN
  - Admission not meeting medical necessity (patient demanding inpatient admission, rather than observation service)
  - Pre-op days not meeting medical necessity
  - Admission not meeting requirements of National or Local Coverage Determination (NCD or LCD) or level of care inappropriate

HINN: THE RULES

- HINN 10: Notice of Hospital Requested Review
  - Request a Quality Improvement Organization (QIO) review/decision when hospital determines patient no longer needs inpatient care, but is unable to obtain agreement of physician

HINN: THE RULES

- HINN 11
  - When diagnostic or therapeutic item of service that is not medically necessary will be provided during an otherwise covered inpatient stay
  - May only be used when published Medicare coverage policy (NCD or LCD) confirms that item or service not medically necessary

HINN: THE RULES

- HINN-12
  - When patient initially met inpatient level of care, but the hospital, with the concurrence of physician or QIO, determines patient no longer needs inpatient care and has made decision to discharge patient

ADVANCE BENEFICIARY NOTICE (ABN): THE RULES

- Outpatient notices of potential noncoverage when provider believes that Medicare may not cover service
- Also known as waiver of liability
- For traditional Medicare patients only
- Usually delivered by Patient Access for outpatient testing or treatment
- Can be used for observation patients
- ABN not required for services that Medicare never covers, but are given if Medicare only covers service annually (for example labs)

ABN: THE BILLING RULES

- Must have reason to believe that Medicare may not, or will not, cover service

CURRENT CoP DISCHARGE PLANNING REQUIREMENTS 482.43

Attachment 4
Hospital Discharge Planning Worksheet: Attachment 5

CMS CONDITIONS OF PARTICIPATION: DISCHARGE PLANNING 482.43

- Discharge planning process that applies to all patients
- Policies and procedures must be in writing
- Must identify at early stage of hospitalization all patients likely to suffer adverse health consequences upon discharge if no adequate discharge planning
- Must provide discharge planning evaluation to patients identified in this section, and to other patients upon patient's request, request of person acting on patient's behalf, or request of the physician
- RN, social worker, or other appropriately qualified personnel must develop, or supervise development of evaluation

CONDITIONS OF PARTICIPATION DISCHARGE PLANNING

- Must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care
- Must reassess discharge planning process on an on-going basis; reassessment must include review of discharge plans to ensure that they are responsive to discharge needs

CONDITIONS OF PARTICIPATION AND PATIENT CHOICE

Include in discharge plan list of HHAs or SNFs available to patient, that participate in the Medicare program, and that serve geographic area (as defined by the HHA) in which patient resides, or in case of a SNF, in geographic area requested by patient; HHAs must request to be listed by hospital as available

- List must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by discharge planning evaluation
- For patients enrolled in managed care organizations, hospital must indicate availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations
- Must document in the patient's medical record that list was presented to patient or individual acting on patient's behalf

CONDITIONS OF PARTICIPATION AND PATIENT CHOICE

- Must inform patient or patient's family of freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when expressed; hospital must not specify or otherwise limit the qualified providers that available to the patient
- Must identify any Home Health Agency (HHA) or Skilled Nursing Facility (SNF) to which patient is referred in which hospital has disclosable financial interest, and any HHA or SNF that has disclosable financial interest in a hospital under Medicare

3-DAY QUALIFYING INPATIENT STAY FOR SKILLED NURSING FACILITY TRANSFER: THE RULES

- Traditional Medicare patient should have 3 inpatient midnights to qualify for a transition to a skilled nursing facility
- Exceptions
  - Accountable care organization may allow for elimination of this requirement
  - Mandatory bundled payment for total hips and knees may allow for elimination of this requirement
- Patient who comes to ED, but was discharged within 30 days (with 3 day qualifying inpatient stay), may be transferred directly to SNF without additional qualifying inpatient days

3-DAY QUALIFYING INPATIENT STAY FOR SKILLED NURSING FACILITY TRANSFER: THE BILLING RULES

- If inpatient stay is denied by Medicare, skilled nursing facility will not be paid
- Some skilled nursing facilities are billing patients if they are not paid

RELIAS

A PAYER'S COMPLIANCE EXPECTATIONS

- Follow contract language
- Case manager should be aware of
  - Utilization management portion of contract
    - Criteria payer used by payer
    - Time for calls for medical necessity
    - Frequency of calls
    - On-site case management
    - Appeal processes
  - Discharge planning resources provided by payer
- Billing contract regulations

THE NOTICE ACT

Notice of Observation Treatment and Implication for Care Eligibility Act

Provide notification to each Medicare beneficiary who receives observation services as an outpatient for more than 24 hours

Includes both traditional Medicare and Medicare Advantage plans

NOTICE ACT

- President Obama signed August 7, 2015
- Effective August 6, 2016
- Includes critical access hospitals
- Explains individual's status as outpatient observation, and not inpatient, and reason(s) why
- Explains implication of that status on services furnished (including those furnished as an inpatient), in particular
  - Implications for cost-sharing requirements
  - Subsequent coverage eligibility for services furnished by a skilled nursing facility

NOTICE ACT: PATIENT NOTIFICATION

- Includes appropriate additional information
- Is written and formatted using plain language and made available in appropriate languages
- Is signed by patient or representative acting on the patient's behalf to acknowledge receipt of the notification
- If patient or representative refuses to sign, the written notification must be signed by the hospital staff member who presented it

COMPLIANCE = REIMBURSEMENT

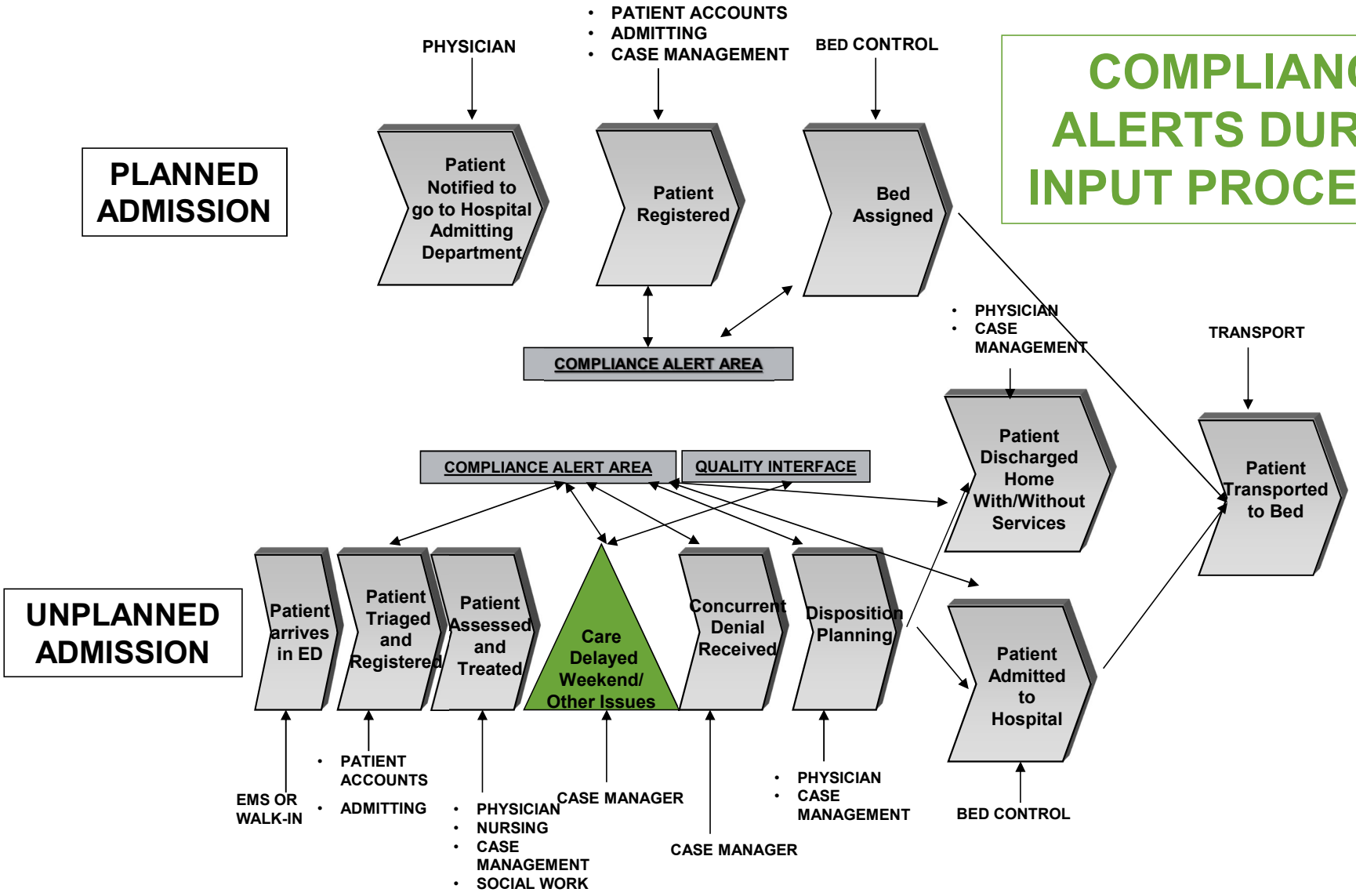
Transition from pay for volume to pay for performance requires compliance to evidence-based practices

- Efficiency
- Mortality
- Readmissions
- Complications, including hospital-acquired infections
- Core measures
- Patient experience
- Patient safety indicators

RELIAS

CASE MANAGEMENT COMPLIANCE STRATEGIES

COMPLIANCE ALERTS DURING INPUT PROCESSES



COMPLIANCE AND THE INTERDISCIPLINARY TEAM

- Know your team
- Collaborate with team
- Educate team for basic understanding of compliance rules and regulations
  - Case management staff
  - Physicians: ED, hospitalists, intensivists, high volume admitters
  - Physician advisor(s)
  - Midlevel providers
  - Nursing
  - Ancillary providers

RELIAS

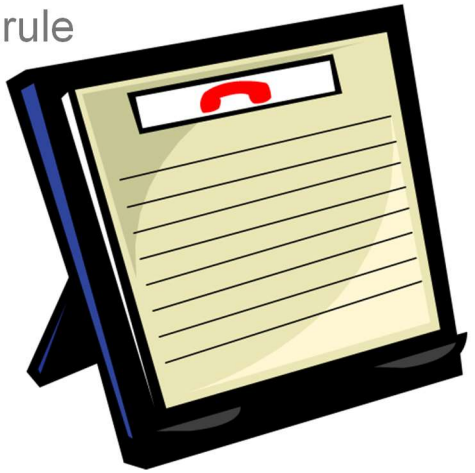
COMPLIANCE STRATGIES ARE NOT INTUITIVE TO PHYSICIANS!

PHYSICIAN COMPLIANCE EDUCATION

- Physician advisor: Internal and/or external
- ED physicians
- Hospitalists
- Surgeons
- Physician offices
- High volume admitters

PHYSICIAN DOCUMENTATION TO SUPPORT BILLING: THE RULES

- Order to admit
  - Order must be present
  - Order must indicate inpatient, observation services, outpatient
  - Order must be authenticated before discharge, per 2 midnight rule
  - Cannot bill if order not present
- 2 midnight rule documentation
  - Expectation of length of stay
  - Reason for hospital services
  - Discussion of discharge plan
  - Authentication of order before discharge
  - Self auditing with feedback to physicians not in compliance (Self auditing mandated; Feedback to physicians not mandated)



PHYSICIAN DOCUMENTATION TO SUPPORT BILLING: THE RULES

- Medical necessity: Support for admission and continued stay
- Condition code 44 process
  - Physician must agree with UR committee member that status should be changed from inpatient to observation services
  - Documentation must occur in the medical record that physician agrees with UM Committee
- Commercial denials:
  - Peer to peer conversation with payer Medical Director to appeal denial
  - Often denial will stand if no peer to peer discussion
  - If payer contract allows, concurrent appeals are more convenient for physicians

PHYSICIAN ADVISOR ROLE: THE RULES

In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate

CMS Interpretive Guidelines 482.30(d) for surveyors of Conditions of Participation for Utilization Management

PHYSICIAN ADVISOR ROLE: THE BILLING RULES

- No particular billing rules regarding physician advisor roles
- Physician advisor, either outsourced or in-hospital should understand the billing guidelines and regulations related to case management processes

PHYSICIAN ADVISOR ROLE IN COMPLIANCE

- Education
- Physician advisor societies
- Physician advisor conferences
- Role with patient who does not meet medical necessity
  - Any patient
  - 2 midnight rule
  - Condition code 44 requirement
  - CMS mandated self assessment for short stays

IMPACT OF EACH CASE MANAGER ON COMPLIANCE

ED RN Case Manager

- 2 Midnight Rule
- Appropriate order with admission medical necessity for status/service
- Discharge plan
- 3 day qualifying inpatient stay for SNF placement (for patients needing placement and discharged within past 30 days)
- Readmissions

ED Social Worker

- Discharge plan
- 3 day qualifying inpatient stay for SNF placement (for patients needing placement and discharged within past 30 days)
- Readmissions

IMPACT OF EACH CASE MANAGER ON COMPLIANCE

Unit RN Case Manager and UR Nurse

- 2 Midnight Rule
- Appropriate order with admission medical necessity
- Continued stay medical necessity
- Prioritize observation service patients each day
- Appropriate use of condition code 44 and provider liable
- Discharge plan with patient choice
- 2nd important message
- 3 day qualifying inpatient stay for SNF placement (for patients needing placement and discharged within past 30 days)
- Readmissions
- Appropriate use of physician advisor

IMPACT OF EACH CASE MANAGER ON COMPLIANCE

Unit Social Worker

- Discharge plan with patient choice
- 3 day qualifying inpatient stay for SNF placement (for patients needing placement and discharged within past 30 days)
- Readmissions

IMPACT OF EACH CASE MANAGER ON COMPLIANCE

Appeals Coordinator

- 2 midnight rule self audit
- Appropriate orders for status/service
- Admission medical necessity for status/service
- Continued stay medical necessity
- Denial and appeal management
- Appropriate use of condition code 44 and provider liable

COMPLIANCE NOW REQUIRES CONSIDERATION OF OTHER CRITICAL CASE MANAGEMENT ROLES

- Transfer Center case manager
  - Appropriate order for level of care for patients transferred in
- Complex discharge planning social worker
  - Discharge planning for extended stay patient
  - Discharge planning for complex discharge
- Case management extender
  - Support for compliance roles with appropriate education and mentoring
- Perioperative case manager

IMPACT OF EACH CASE MANAGER ON ACCURATE BILLING

Perioperative case manager

- 2 midnight rule
- Appropriate initial order
- Admission medical necessity
- Condition code 44
- Provider liable
- Discharge planning
  - Outpatients, such as day surgery patients
  - Initial discharge planning for scheduled patients
- Inpatient only procedures

IMPACT OF CASE MANAGEMENT LEADER ON COMPLIANCE

- Optimal case management model to support compliance
- Right roles: RN case manager, social worker, case management associate support, case management leadership team
- Effective physician advisor role
- Collaborate with other departments to assure responsibilities for compliance are coordinated by the appropriate department
  - 1st important message
  - NOTICE Act requirements
  - Observation letter
  - Denial processes
  - Discharge planning proposed rule

RELIAS

IMPACT OF CASE MANAGEMENT LEADER ON COMPLIANCE

- Education: Staff, physicians, nursing
- Orientation of new staff
- Orientation of new case management leaders
- Annual staff competencies
- Audit appropriate compliance processes; share results with department and individually with each staff member
- Oversee UR Committee
- Assure UR plan annual review
- Prepare for new CMS rules, such as proposed discharge planning rule

FUTURE CMS COMPLIANCE RULES

CMS CoP PROPOSED DISCHARGE PLANNING RULES

- Published November 2015
- Comments were accepted until January 2016
- Delayed……

SAMPLE CASE MANAGEMENT COMPLIANCE GAP ANALYSIS

MEASURE	CURRENTLY IN PLACE	NEEDS TO BE IMPROVED
2 Midnight Rule process in place and successful		
2 Midnight Rule audit process in place and reported to UM Committee		
UM Committee in place and following Condition of Participation requirements		
ED Case Management in place during appropriate hours		
Access Case Management in place, if appropriate		
Physician advisor process in place and effective		
All case managers understand role of medical necessity and 2 midnight rule expectations		
All records have orders with correct order to admit		
Effective self denial process in place		
Important Message delivered appropriately with accurate appeal process in place with QIO		
HINN delivery process mirrors CMS requirements		

SAMPLE CASE MANAGEMENT COMPLIANCE GAP ANALYSIS

MEASURE	CURRENTLY IN PLACE	NEEDS TO BE IMPROVED
Preparation for proposed discharge planning proposed rules		
Discharge planning process follows Condition of Participation requirements		
Discharge plan re-evaluated at appropriate intervals (for example, after a surgical procedure, discharge plan reassessed)		
Policies in place to support compliance rules and regulations		
RN case manager and social worker documentation support CMS requirements		
Annual IRR of medical necessity criteria RN case managers		
Feedback to department and individual staff from dashboard		
Annual education of staff and physicians		
Collaboration in place for new compliance requirements: such as NOTICE Act and proposed discharge planning rules		
Education to answer questions from patients (if requested) regarding MOON		

RESOURCES

- CMS: Hospital inpatient order and certification: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf
- CMS: 2 Midnight Rule Discussion: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2014-02-27-2Midnight.html
- Discharged planning proposed rules 2015: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-10-29.html

RESOURCES

- Final 2 midnight rule CMS-1599 (August 2013)
- Medicare Benefits Policy, Chapter 1, Section 10
- 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)
- 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

RESOURCES

- 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
- Compliance Mentor; AHC Media, A Relias Learning Newsletter
- Medicare Learning Network; mlnconnects; https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2017-07-20-eNews.html

RESOURCES

- Medicare Claims Manual, Chapter 4 Part B Hospital: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
- Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries Memorandum Report: http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf
- The Hospital Observation Care Problem: Perspectives and Solutions from the Society of Hospital Medicine. White Paper. September 2017: https://www.hospitalmedicine.org/globalassets/policy-and-advocacy/advocacy-pdf/shms-observation-white-paper-2017

OBSERVATION HELP FOR MEDICARE BENEFICIARIES

- Center for Medicare Advocacy: Self Help Packet for Medicare Observation Status http://www.medicareadvocacy.org/self-help-packet-for-medicare-observation-status/
- FAQ Hospital Observation Care Can Be Costly for Medicare Patients (Kaiser Health News) http://khn.org/news/observation-care-faq/
- Medicare.gov Find Out if You're an Inpatient or an Outpatient: It Affects What You Pay https://www.medicare.gov/what-medicare-covers/part-a/inpatient-or-outpatient.html

THANK YOU

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