Medicare Advantage and the 2-Midnight Rule in 2024

Presenters:
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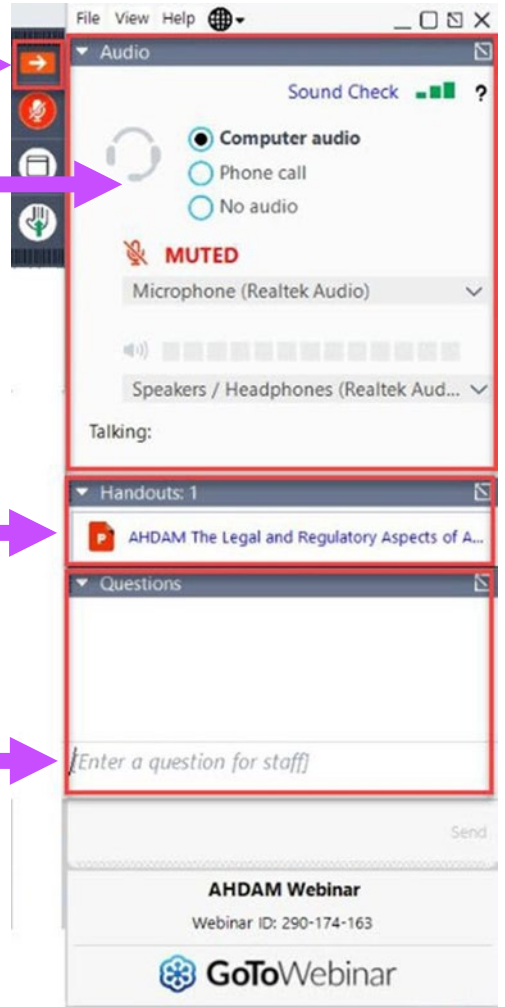

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From the survey you will be prompted to select desired CEUs:

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- American Health Information Management Association (AHIMA): Certified health information management professionals
- American Nurse Credentialing Center (ANCC): Continuing nursing education

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There are no conflicts of interest to declare for any individual in a position to control the content of this presentation.

Denise Wilson MS, RN, RRT

Senior Vice President, PayerWatch/AppealMasters; President, AHDAM

Denise has over thirty years of experience in healthcare, including clinical management, education, compliance, and appeal writing.

Denise has extensive experience as a Medical Appeals Expert and has personally managed hundreds of Medicare, Managed Medicare, and Commercial appeal cases and presented hundreds of cases at the Administrative Law Judge level. Denise is a nationally known speaker and dynamic educator on Medicare and Commercial appeals processes, payer behaviors, standards of care, appeal template development, and building a road map to drive the payer to a decision in the provider's favor. She has educated thousands of healthcare professionals around the country in successfully overturning healthcare denials.

Kendall Smith MD, SFHM

Chief Medical Officer, Chief Physician Advisor

Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Medical Officer for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems. He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

Learning Objectives

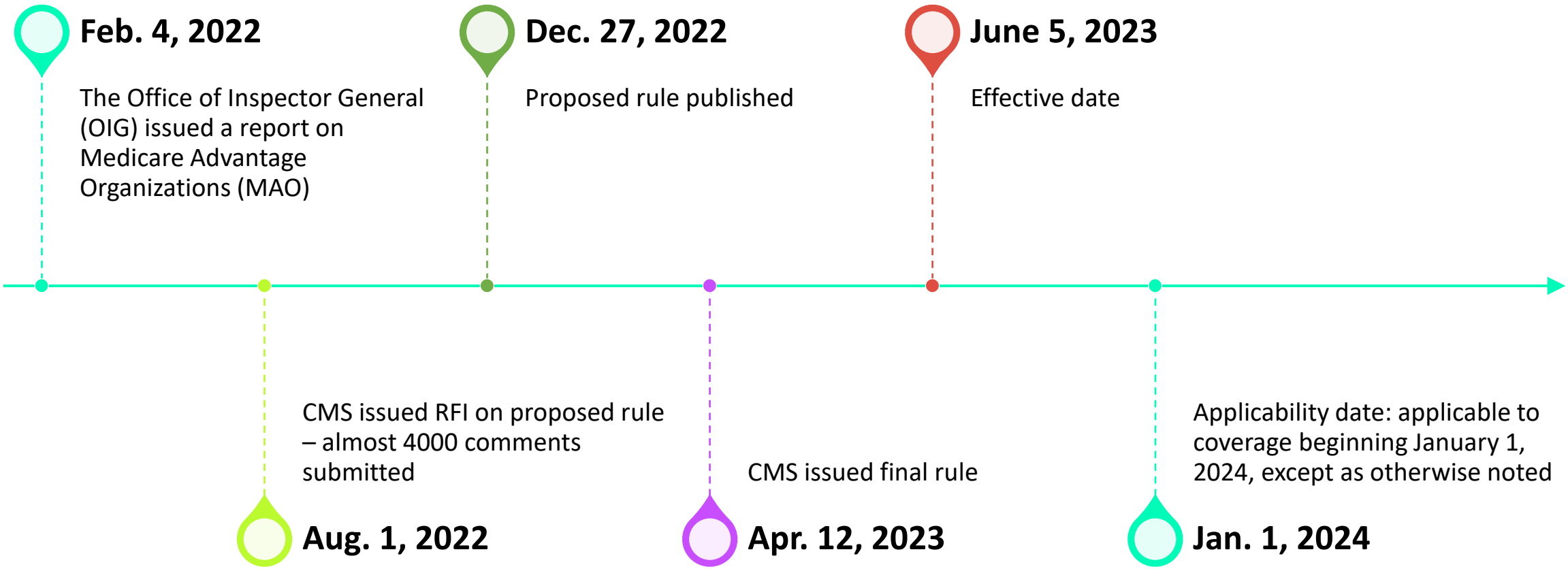
At the conclusion of the webinar, the learner will be able to:

Self-report they can summarize 2 major provisions of the 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F), how to prepare for the implementation of the final rule, and how to provide feedback regarding MAO noncompliance.

At the conclusion of the webinar, at least 90% of participants will share on the evaluation:

1. The ability to identify 2 major provisions to the CMS Final Rule (CMS-4201-F) that impact the work of denial and appeal management specialists.
2. The ability to identify 2 steps to take now to prepare for the implementation of the final rule.
3. The ability to identify 2 ways to provide feedback regarding MAO noncompliance with CMS 4201-F.

Overview of the CMS 4201-F rule



Overview of the CMS 4201-F rule

The final rule reaffirms:

- MA organizations (MAO) cannot limit or deny coverage for services that would be covered under Traditional Medicare.
- The CMS inpatient-only list applies to MAOs
- MAOs must follow the “two midnight benchmark” as well as the “case-by-case exception”

Overview of the CMS 4201-F rule

The “two midnight benchmark”

- "an inpatient admission is generally appropriate for Medicare Part A payment if the physician (or other qualified practitioner) admits the patient as an inpatient based upon the expectation that the patient will need hospital care that crosses at least 2 midnights."

The “case-by-case exception”

- "allow[s] for Medicare Part A payment on a case- by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights."

Overview of the CMS 4201-F rule

The "2-midnight presumption"

- CMS specifically states that “the ‘2-midnight presumption’ (the presumption that all inpatient claims that cross two midnights following the inpatient admission order are ‘presumed’ appropriate for payment and are not the focus of medical review absent other evidence) **does not apply to MA plans**.”
- "… this final rule does not dictate how MA organizations will decide which claims to subject to review."
- A Medicare Advantage plan does not have to presume that an inpatient stay spanning at least two midnights is medically necessary as an inpatient service, and the plan remains free to review that claim, as permitted by the **plan’s contract** with the hospital.

CMS Inpatient Defintion

Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. 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. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;

Prior Authorizations and Medical Necessity

Medicare Managed Care Manual, Section 10.16, Chapter 4

Every MA plan:

- Must have policies and procedures that allow for ***individual*** medical necessity determinations
- Make medical necessity determinations based on:
  - the medical necessity of plan-covered services
  - the enrollee's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes

Pre-service authorizations – are they considering the above?

No? Consider peer-to-peer at this point.

Prior Authorizations and Medical Necessity

42 CFR 422.138 Prior Authorization

- If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at § 405.986 of this chapter) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616.
- Replaces: "Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity." Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections10.16 – Medical Necessity

Documenting the Need for Hospital Care

How do you support the need for hospital care?

- Care that can only be provided in a hospital setting (consider hospital policies for nurse staffing, drug administration)
- It's not custodial care!
- Delay in treatment does not support hospital care.

DOCUMENT... DOCUMENT...DOCUMENT...

- Don’t document a laundry list of problems
- Do document the risks and immediate concerns regarding the holistic picture of this patient's acute and chronic medical conditions...connect those dots

What about MCG and IQ?

- MA plans must comply with general coverage and benefit conditions included in Traditional Medicare laws including payment criteria for inpatient admissions.
- MA plans may not use InterQual or MCG criteria, or similar products, to change coverage or payment criteria already established under Traditional Medicare laws – including NCDs and LCDs and other published coverage criteria.
- Use of these tools, in isolation, without compliance with requirements in this final rule is prohibited.

MCG's Views on Observation Services

MCG does not set a specific time frame for observation care. The duration of observation care is often determined by prevailing regulation (e.g., CMS' Two-Midnight rule) or payer-provider contractual agreement. When writing criteria pertaining to observation care, it is helpful to have a general duration in mind; MCG feels that the appropriate use of observation care necessitates that observation care should be finite, short, and not mandatory. This is in keeping with our understanding of the definition and purpose of observation care. Rubrics such as the Two-Midnight Rule provide a good estimation of what is meant by "short." Different payers may have different durations for observation care; however, our view is that the Two-Midnight Rule is a good rubric to have in mind. Time frames beyond this (e.g., 72 hours, 3 days) are not what MCG envisions for observation care.

What is a sincere, reasonable attempt in observation care?

Unfortunately, MCG cannot define this in all clinical scenarios other than to say that there should be a true attempt to improve the patient's condition with appropriate treatment. There cannot be delays in care that prolong the patient's length of stay to cross a specific time threshold (e.g., across a second midnight). The provider should be able to defend the treatment given as a true attempt to meet the relevant observation care discharge milestones.

What is a sincere, reasonable attempt in observation care?

Q: Does this mean every patient in observation care has to stay in that status until just after the second midnight?

A: No.

If and when the attending clinician can reasonably estimate/state/document that a patient will not meet observation care discharge criteria within the observation care time frame, the patient can be admitted to inpatient care.

Humana

- When reviewing to determine whether an admission was medically necessary, Humana's MA policy is to adhere to Original Medicare's requirements, such as the requirement for complete and valid certifications and orders of admission.
- When reviewing a claim for an inpatient admission for medical necessity, Humana MA plans will take into consideration all available relevant facts, including whether the stay crossed two midnights and whether at the time of the order of admission the ordering health care provider reasonably believed that inpatient admission was medically necessary. If an inpatient stay crossed two midnights, that fact is significant, but is not sufficient to establish medical necessity.
- Humana's policy is that an inpatient claim can be reviewed for medical necessity even if it crosses two midnights. ***Health care providers should always assume that Humana Medicare Advantage (MA) plans may review a claim for medical necessity.***

United Healthcare

Same as CMS: "Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, etc." UHC MA Policy: Hospital Services (Outpatient, Observation, and Inpatient)

PLUS

"For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant then need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis."

NOT part of CMS guidelines!

United Healthcare Policies: Inpatient Services

- For more detailed elective inpatient hospital services definitions/clinical criteria and guideline, refer to the UnitedHealthcare Commercial Medical Policy titled Elective Inpatient Services.
- For more detailed hospital services definitions/clinical criteria and guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Hospital Services: Observation and Inpatient.
- ***UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider.***

The CMS Inpatient Only (IPO) List

Where to find it

- Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for calendar year 2024
- https://www.cms.gov > Medicare > Payment > Prospective Payment Systems > Hospital Outpatient PPS > Hospital Outpatient Regulations and Notices > CMS-1786-FC > Related Links > 2024 NFRM OPPS Addenda

- Will download as a zip file
- Open/Save Addendum B

The CMS Inpatient Only (IPO) List

How to read it

SI = Status Indicator (Addendum D1)

C = Inpatient Procedures J1 = Hospital Part B Services Paid Through a Comprehensive APC

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27120	Reconstruction of hip socket		C					
27122	Reconstruction of hip socket		C					
27125	Partial hip replacement		C					
27130	Total hip arthroplasty		J1	5115	143.6551	$12,552.87		$2,510.58
27132	Total hip arthroplasty		C					
27134	Revise hip joint replacement		C					
27137	Revise hip joint replacement		C					
27138	Revise hip joint replacement		C					
27140	Transplant femur ridge		C					
27146	Incision of hip bone		C					

But I have a contract!

What does your contract say?

Noncompliance with 4201-F

AHA Urges CMS to Swiftly Correct Medicare Advantage Plan Policies that Appear to Violate CY 2024 Rule - November 20, 2023

- (10/13/2023), urged CMS to conduct rigorous oversight to monitor compliance with these policies and to ensure that appropriate action is taken in response to any violations.
- Indeed, one plan recently issued guidance to its network providers indicating that they plan to continue using internal criteria beyond the Traditional Medicare criteria to evaluate inpatient admissions.
- In other cases, it appears some plans are making changes to the terminology they use in denial letters that may be intended to circumvent recent CMS rulemaking (calling them payment reviews and not level of care reviews). *(See AHDAM June 2023 newsletter)*

Noncompliance with 4201-F

- Clarify that coverage criteria for inpatient admissions are fully established under Traditional Medicare.
- Clarify that the flexibility for MA plans to supplement Traditional Medicare rules with additional internal coverage criteria is not applicable for medical necessity reviews of inpatient admissions.
- Reinforce expectations to MAOs and confirm MAO compliance with public accessibility and evidentiary standards for internal coverage criteria.
- Take swift action to correct MA plan policies that do not comply with CMS rules, including applying intermediate sanctions where appropriate.

Noncompliance with 4201-F

Responding to non-compliance by the MAOs

Ways to respond:

- File a grievance with the plan
- Submit your inquiry to the Part C and D mailbox at https://appeals.lmi.org/dapmailbox
- File your concern with the CMS regional office: https://www.cms.gov/about-cms/where-we-are/regional-offices
- Track cases and discuss during Joint Operating Committee meetings or with the plan's medical director
- Encourage the enrollee to call 1-800-MEDICARE

Practical Takeaways

- Under the Final Rule, Medicare Advantage plans must cover any inpatient admission that falls within the two-midnight rule, the case-by-case exception or the Medicare inpatient-only list.
- Medicare Advantage plans can still audit claims for inpatient care lasting more than two midnights. The contract between the hospital and the Medicare Advantage plan will govern those audit rights. Providers should ensure that their documentation practices continue to adequately support the medical necessity of inpatient services.
- The Final Rule provides hospitals with a strong argument that inpatient care that lasts at least two midnights should be paid under Medicare Advantage, as it would have been under traditional Medicare Part A

Practical Takeaways

- Ensure your teams understand two midnight benchmark, case-by-case exception, 2-midnight presumption
- Connect the dots in documentation to support hospital care
- Don't allow MAOs to use screening tools in isolation
- Know your payer policies – review your contracts
- Ensure surgical UM is including MA payers in reviews for IP only procedures
- Incorporate the Prior Authorization language in appeals
- Report non-compliance with the final rule

Questions and Answers

OIG Report, Feb. 4, 2022:

Office of Inspector General. (2022). Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (Report No. OEI-09-18-00260), United States Department of Health and Human Services.

- https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

Request for Information on Medicare, Aug. 1, 2022:

- https://www.federalregister.gov/documents/2022/08/01/2022-16463/medicare-program-request-for-information-on-medicare

CMS Proposed Rule, Dec. 27, 2022:

- https://www.federalregister.gov/documents/2022/12/27/2022-26956/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

CMS 4201 Final Rule, Apr. 12, 2023:

- https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

Federal Register/Vol. 80, No. 219/Friday, November 13, 2015/Rules and Regulations

- https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf

Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections:

- https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

42 CFR 422.138 Prior Authorization

- https://www.ecfr.gov/current/title-42/section-422.138

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Centers for Medicare and Medicaid Services. (page last modified 5/12/2022). File a Complaint. CMS.gov.

- https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/FileaComplaint

AHA Urges CMS to Rigorously Enforce New Policies to Safeguard MA Coverage – October 13, 2023

- https://www.aha.org/lettercomment/2023-10-13-aha-urges-cms-rigorously-enforce-new-policies-safeguard-ma-coverage

AHA Urges CMS to Swiftly Correct Medicare Advantage Plan Policies that Appear to Violate CY 2024 Rule - November 20, 2023

- https://www.aha.org/news/headline/2023-11-20-aha-urges-cms-swiftly-correct-ma-polices-violate-cy-2024-rule

References

CMS Inpatient Only List

- https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices

CMS Inpatient Definition; Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A, 10 - Covered Inpatient Hospital Services Covered Under Part A

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf

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Thank you for attending today's event!

For more information, please contact:

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PayerWatch