Two-Midnight Rule, Condition Code 44 and MOON Form: Auditing Your Way to Compliance

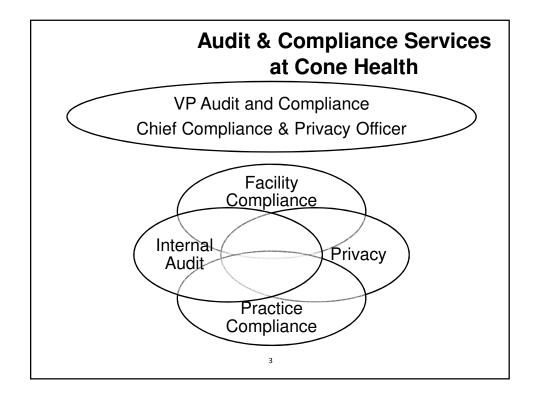
HCCA Regional Compliance Conference January 19, 2018

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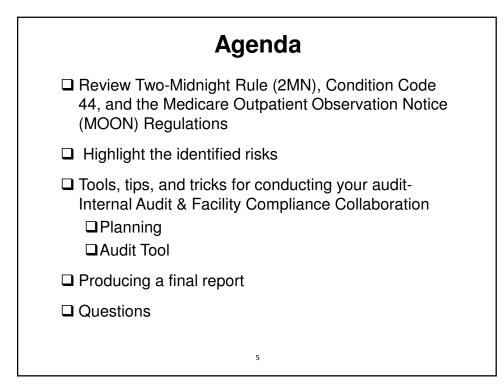
Who is Cone Health?

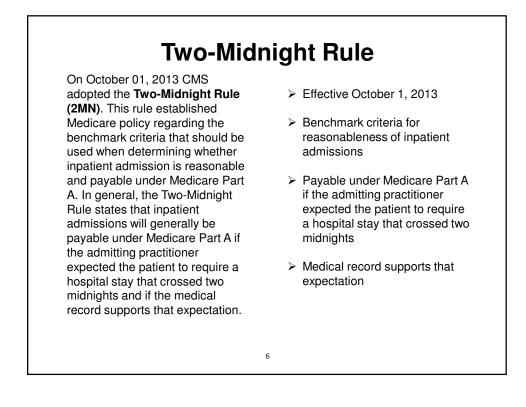
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- 6 Hospitals 1254 beds
- 149 Outpatient locations, including physician practices
- 3 Outpatient Surgical Centers
- 5 Emergency Departments
- 4 Urgent Care Centers
- 12,000 Employees
- 1,500 Physicians
- 1,200 Volunteers









MOON Form

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) was enacted on August 6, 2015 and implemented on March 08, 2017. The NOTICE Act requires "hospitals and Critical Access Hospitals to provide notification to individuals receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status." Notification is accomplished and documented by utilization of the Medicare **Outpatient Observation Notice** (MOON) form created and provided by CMS.

≻Mandated by NOTICE Act

≻Effective March 08, 2017

Provides oral and written notification to observation patient with stay > 24 hours

>Delivery required by hour 36 of stay

➤Explains the implication of status

≻Edits to CMS MOON form limited

≻Signature required

	MOON Form (Hospitals may include contact information or logo here)	7
	Medicare Outpatient Observation Notice	
MOON form is available at https://www.cms.gov	Patient name: Patient number: You're a hospital outpatient receiving observation services. You are not an inpatient because:	
	Being an outpatient may affect what you pay in a hospital: When you're a hospital outpatient, your observation stay is covered under Medicare Part B. For Part B services, you generally pay: O A copyments to reach outpatient hospital service you get. Part B copyments may vary by type of service. O Soft of the Medicare-approved amount for most doctor services, after the Part B dedictible. Observations services may affect coverage and payment of your care after you leave	
	The hospital: If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stary for a related lines or ispury. An apalent hospital stary begins the day the hourse discharged as in publient based on a doctor's order and desert houte the day you're discharged. If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the	
	plain may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan. NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stary, However, Part A will generally cover medically necessary inpatient and plant and the service of the service of the services of the services for the first 60 days you'r pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.	

7

Condition Code 44

CMS implemented a new condition code, issued by the National Uniform Billing Committee, in 2004. Condition Code 44 (CC 44) is for use on outpatient claims, when the physician ordered inpatient services, but upon internal review, the hospital determined the services did not meet inpatient criteria. When the hospital has determined that it has met the requirements for CC 44 the entire episode of care should be treated as though the inpatient admission never occurred. Submission of an outpatient claim for medically necessary Medicare Part B services is allowed.

≻Condition Code 44 effective April 1, 2004

>Inpatient status changed to Observation because it did not meet inpatient admissions criteria

>Only submit medically necessary Part B services for payment

>Entire episode of care treated as if the inpatient admission never occurred

➢Condition Code 44 should "become increasingly rare" (MLN Matters SE0622)

2MN Rule, CC44, MOON Compliance Risks

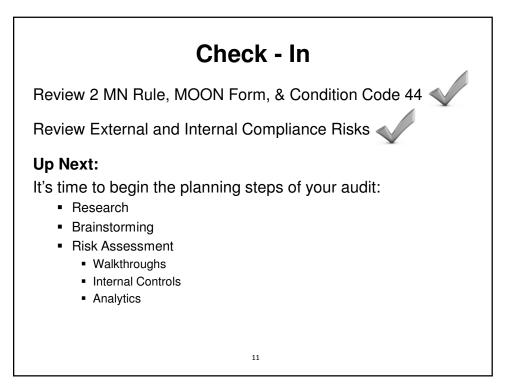
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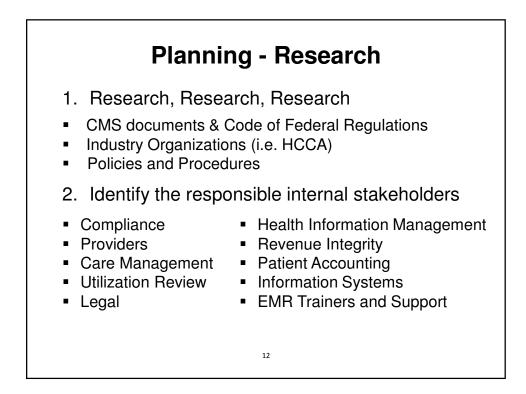
External

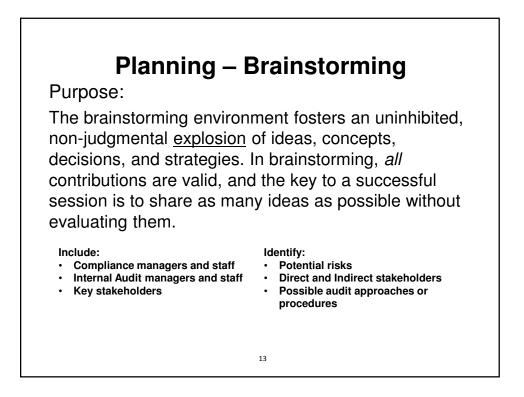
- Noncompliance with Code of Federal Regulations
- Noncompliance with CMS's Guidance
- Possible recoupment
- Potential fines
- Gaming
- Audit by the Medicare Beneficiary and Family Centered Care (BFCC) Quality Improvement Organization (QIO)

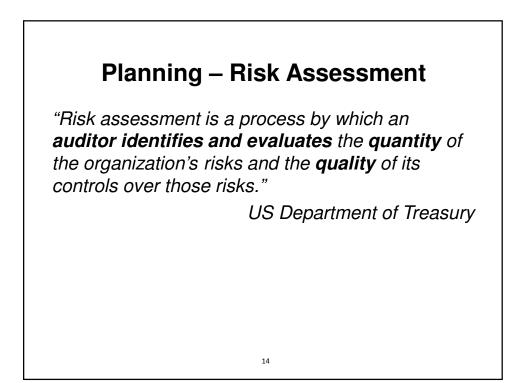
Internal

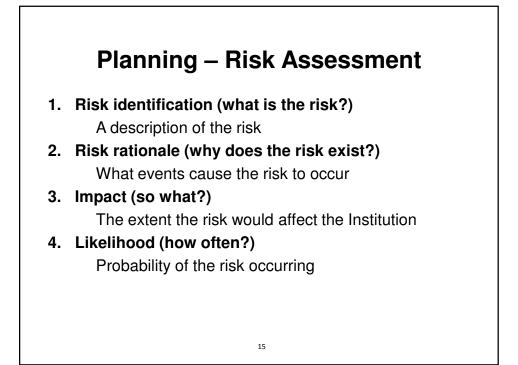
- · EMR technical issues
- Lack of or inadequate Policy and Procedure
- Noncompliance with existing Policy and Procedures
- Gaming
- Provider judgement
- Deficient provider documentation
- Possible recoupment
- Failure to maximize revenue











	Planning – Risk	Asses	sme	n l	
	Inpatient/Outp	atient			
	Risk Assessm	ient			
	Auditor's Evaluati	on of Risk			
ITEM #	PROJECT RISK (Inherent Risk)	LIKELIHOOD	IMPACT	INITIAL RISK SCORE	
	Brainstorm a list of potential risks related to the process, function, department or system. For each risk identified, rate the likelihood that it could happen and the impact if it did happen.	0=UNLIKELY 1=POSSIBLE 2=PROBABLE 3=HIGHLY LIKELY	0=N/A 1=LOW 2=MEDIUM 3=HIGH	Likelihood + Impact	
1	Physician fails to document justification for two- midnight inpatient admission	3	3	6	
2	Admission Orders not signed	1	3	4	
3	Discharge summary not documented	2	2	4	

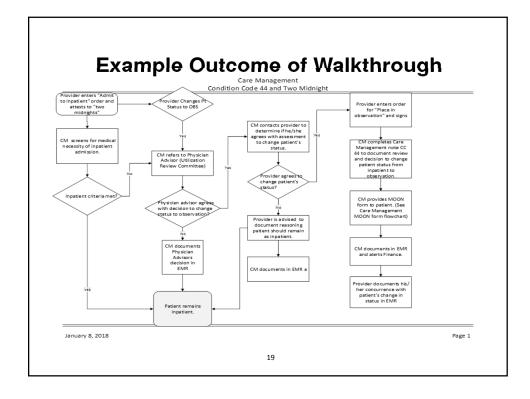
, V 6		Management	's Evaluation of	Risk	
Do managers of this process or area agree with the risk score? Describe and rate the likelihood that the risk could happen and the impact if it did happen, considering the mitigating factors. will apply if management agrees. Adjusted score may otherwise apply. (Y/N) (Y/N)	ITEM #				
sician fails to document justification v 6			this process or area agree with	likelihood that the risk could happen and the impact if it did happen, considering the	will apply if management agrees. Adjusted score may
, V 6			(Y/N)		
	1	Physician fails to document justification for two-midnight inpatient admission	Y		6
nission Orders not signed Y 4	2	Admission Orders not signed	Y		4
charge summary not documented N Discharge summary is included in discharge packet 2	3	Discharge summary not documented	Ν		2
nission Orders not signed Y 4	-	for two-midnight inpatient admission			

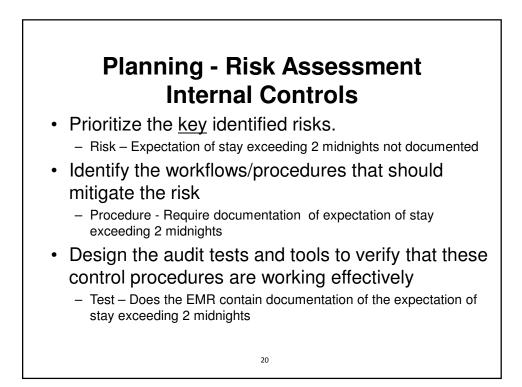
Planning – Risk Assessment Walkthroughs

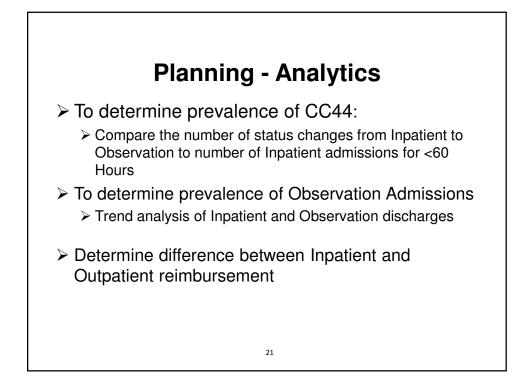
Using information from stakeholders, identify key processes and perform walkthroughs:

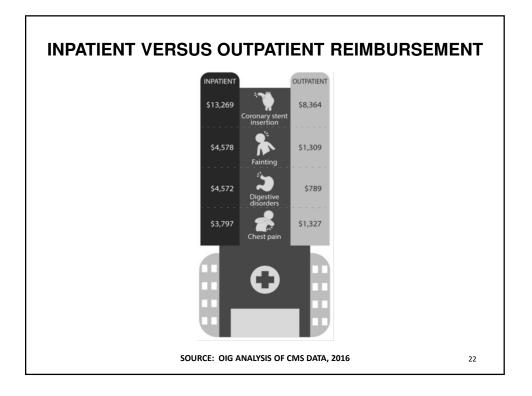
Providers, Care Management, and Revenue Cycle

- Workflows vs. Routines
- EMR Training vs. EMR Use
- Coding & Denials

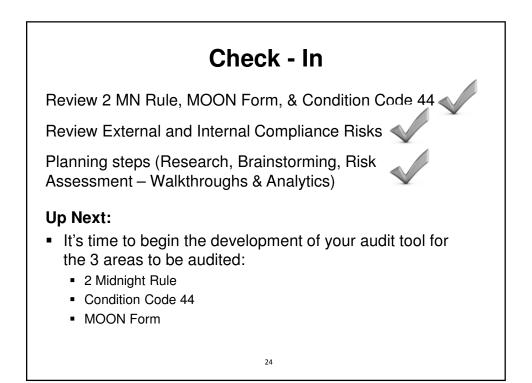


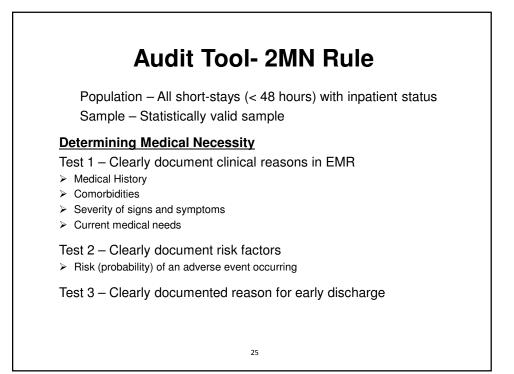


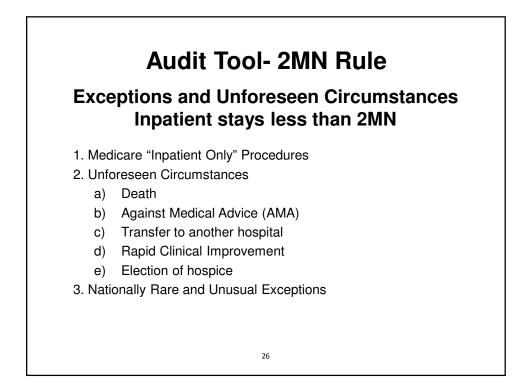


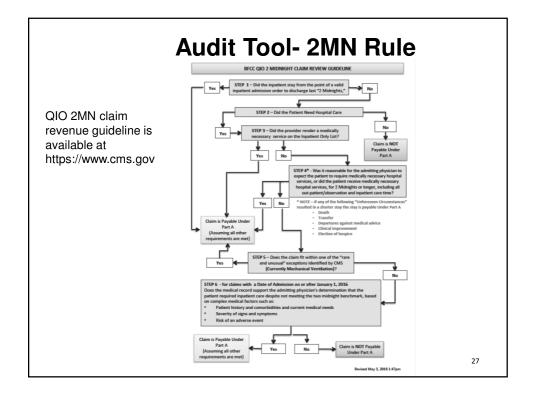


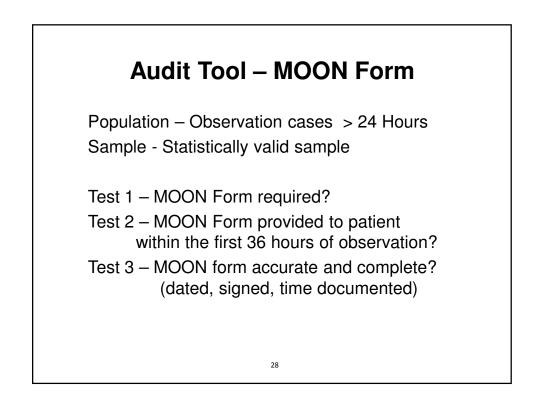












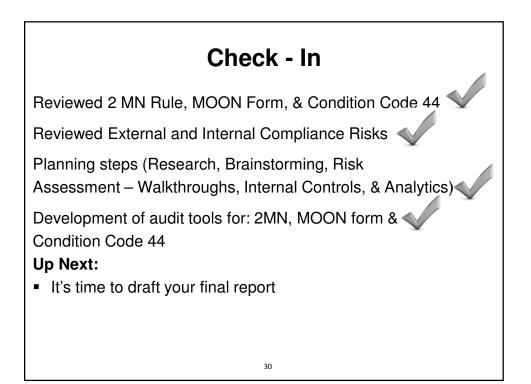
Audit Tool -Condition Code 44

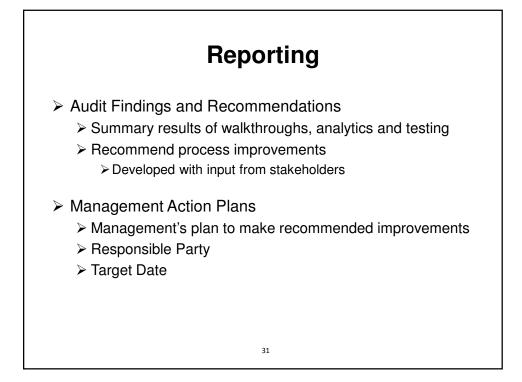
Population – All accounts billed with Condition Code 44 Sample – Statistically valid sample

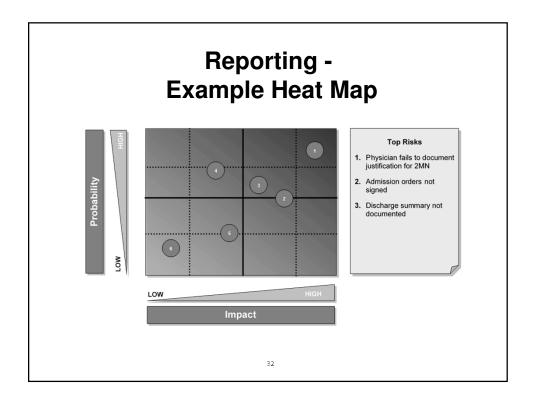
Test 1 – Was status changed from Inpatient to Outpatient before patient discharged?

29

- Test 2 Physician's concurrence with UR?
- Test 3 Patient signs MOON before discharge?
- Test 4 Physician's concurrence documented?







Reporting -Example Results Grid

Detail Findings:

Risk Indicator	Discrepancies Identified	Comments
A1. Physician fails to document justification for two- midnight inpatient admission	2 (out of 30)	Two (2) accounts did not have clear documentation of rationale of expectation of two- midnight stay.
A2. Admission Orders not signed	2 (out of 30)	Two (2) accounts did not have a signed admission order in the record.
A3. Discharge summary not documented	2 (out of 30)	Two (2) accounts are missing discharge summary.

Recommendations and Required Corrective Actions:

A1. Physician fails to document justification	
for two-midnight inpatient admission	
A2. Admission Orders not signed	
A3. Discharge summary not documented	

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