The Case Manager Role in Proper Medicare Hospital Billing of Hospitalizations

Medicare Hospital Billing of Short-Stay Hospitalizations
(or "Why is my Case Manager hounding me to put in an Inpatient order?")

Charles Locke, MD
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Disclosures: None

Special thanks to:
- Ron Hirsch, MD
- Eddie Hu, MD
- Andrew Hughes, MD
- Ann Sheehy, MD

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LEARNING OBJECTIVES

- Help identify when Medicare inpatient criteria have been met, both at the time of hospitalization and in the time following initial hospitalization
- Recognize the differences in hospital payment for short-stay hospitalizations based on visit status.
- Integrate collaboration between physicians and case managers in ensuring proper visit status for hospitalized Medicare beneficiaries, both Traditional and Medicare Advantage.

Medicare – A brief history

or

“The more I learn, the crazier this payment system seems.”

1912: Theodore Roosevelt, as the Bull Moose party candidate for president, supports national health insurance

The earliest reference to universal healthcare came in 1912 when former president Theodore Roosevelt, then running as the Progressive Party’s presidential candidate called for "the protection of home life against the hazards of sickness, irregular employment and old age through the adoption of a system of social insurance adapted to American use."

(He lost.)

President Harry S. Truman proposed a universal health care program in 1945. Photo by Edmonston Studio — The Library of Congress

5 Critical Goals of National Health

1. Address disparities, especially in low-income and rural communities

2. Develop and bolster public health services

3. Increase the nation’s investment in medical research and education.

4. Address the high cost of individual medical care.

5. Address lost earnings when serious illness strikes.

Truman's National Health Plan fails to pass Congress in 1946 and again in 1948

Concern for:

- Excess government spending and high taxes (Republican Party)
- Too much intrusion by federal government (Southern Democrats), i.e. federal involvement in health care might lead to integration of hospital care and the medical field in general

Sign from a segregated medical facility in Jackson, Mississippi, 1961. (Photo by William Lovelace)

Civil Rights and Healthcare: Remembering Simkins v. Cone (1963) | AAIHS

American Medical Association (AMA) attacked the bill as "socialized medicine."

The AMA derided the Truman administration as "followers of the Moscow party line."

President John F Kennedy

Congressional Democrats in the late 1950s focused on providing much-needed care to Americans over 65.

In order to ward off attacks from the AMA… the new plan was framed as an expansion of the already-existing Social Security administration.

Kennedy embraces plan during 1960 campaign and makes it a legislative priority.

https://drawing-blood.org/presidential-medicine/presidential-medicine-jfk/

- 1961, Ronald Reagan for AMA "Operation Coffee Cup" urging the public to call their congressmen to oppose the Forand bill, which would expand Social Security to provide hospital insurance for American men ≥ 65 y/o and women ≥ 62 y/o ("insured") and survivors of deceased "insured".

Ronald Reagan's 1961 recording for the American Medical Association's Operation Coffee Cup, which claimed the passage of pending Medicare legislation would shortly lead to a complete takeover of all medical services by government and shortly thereafter, a socialist dictatorship.

Medicare

Enacted July 1965 by Congress

Title XVIII of the Social Security Act: provide health insurance age 65 and older, regardless of income or medical history

1966: Medicare payments conditional on desegregation

It turned out those Southern Democrats in the 1940s were right.

When Medicare was established in 1965 there was only:

Medicare Part A: Hospital Insurance

Medicare Part B: Medical Insurance

Medicare

Medicare Part A (Hospital Insurance) covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. (1965)

Medicare Part B (Medical Insurance) covers certain doctors' services, outpatient hospitalizations (observation/extended surgical recovery), medical supplies, and preventive services.(1965)

Medicare Part C : Medicare Advantage Plans. Privately administered plans. also called Part C or Medicare private health plan. Each Medicare Advantage Plan must provide all Part A and Part B services covered by Original Medicare, but they can do so with different rules, costs, and restrictions that can affect how and when you receive care. (1997 – 1999)

Medicare Part D: prescription drug plan. (2003 – 2006)

From 1961 to 1968, W. J. Cohen served as Assistant Secretary, Under Secretary, and Secretary of the Department of Health, Education, and Welfare

"As I recall it, no major question arose in the House, Senate, or Administration on this unexpected addition of Part B, except for the issue of ***how to reimburse specialists like radiologists, pathologists, and anesthesiologists****. We had always assumed they would be reimbursed from the hospital insurance program (Part A)."*

"My view, and that of my colleagues, had been that these three specialties were traditionally hospital-based physicians who should be reimbursed under Part A as part of the hospital reimbursement and not in Part B as ***independent entrepreneurs****."*

Request by stakeholders that **Medicare part B be "voluntary**".

Even today, all physician professional fees, even those provided as part of a Traditional Medicare Inpatient hospitalization are paid under Medicare Part B.

Cohen W. J. (1985). ***Health care financing review, Suppl*****(Suppl), 3–11.**

2023 Medicare Part A hospital inpatient deductible and coinsurance and hospital payment

Beneficiary

- $1,600 deductible for each benefit period
- Days 1-60: $0 coinsurance for each benefit period
- Days 61-90: $400 coinsurance per day of each benefit period
- Days 91 and beyond: $800 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
- Beyond lifetime reserve days: all costs

Hospitals

- Inpatient Hospitalizations generally paid under the *Inpatient Prospective Payment System* (IPPS) Diagnosis Related Group (DRG) payment model

SNF

- **Days 1-20: 100% covered if preceded by qualifying 3-day inpatient stay***
- Days 21- 100: $200 coinsurance per day

**Waived during the COVID PHE; PHE set to expire May 11, 2023*

Medicare Hospital Payment before 1983

Original design reimbursed hospitals ***retrospectively*** for all services at their reported costs plus 2 percent for for-profits and plus 1.5 percent for nonprofits.

Replaced with a so-called nursing differential that paid hospitals an additional 8.5 percent above inpatient nursing costs.

Frakt, A.B., 2011. How much do hospitals cost shift? A review of the evidence. *The Milbank Quarterly*, *89*(1), pp.90-130.

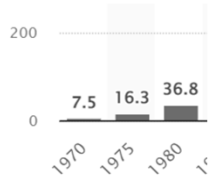
The Medicare "The Golden Stream" (before 1983)

"The more expenditures they incurred, the more income they received. Medicare tax funds flowed into hospitals **in a golden stream**, more than doubling between 1970 and 1975, and doubling again by 1980." (1)

(1)Stevens, In Sickness and in Wealth, 284.

Mayes, R, The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System, J of the History of Medicine and Allied Sciences, 2006

Total Medicare spending from 1970 to 1980 (in billion U.S. dollars)



Statistica.com

It turned out those Republicans in the 1940s were right

Medicare Part A Hospital Payment Since 1983

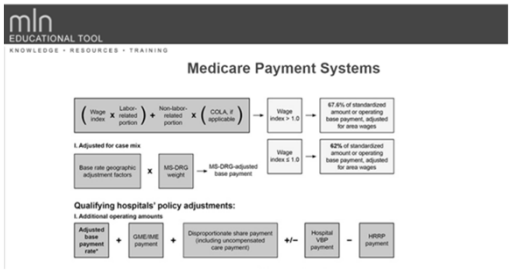
Since 1983, US hospitals have received payment for most inpatient Medicare hospitalizations under a Diagnosis Related Group (DRG) model.

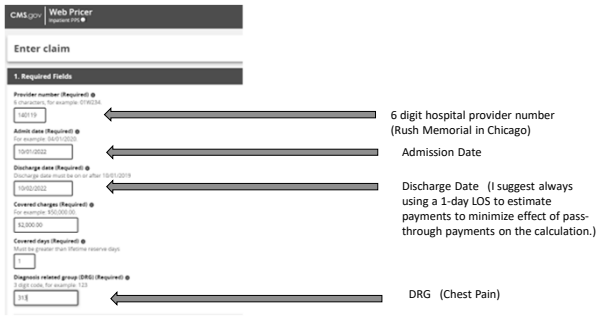
The DRG payment system evolved into the current Medicare Severity Diagnosis Related Group (MS-DRG) system in 2007.

MS-DRG payments are based ***prospectively*** on a formula used to calculate payment for a specific case [that] multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned.

Individual claims are largely independent of the actual length of stay or amount of hospital services used.

Average Medicare LOS in 1983 was 8.9 days.





6 digit hospital provider number (Rush Memorial in Chicago)

Admission Date

Discharge Date (I suggest always using a 1-day LOS to estimate payments to minimize effect of pass-through payments on the calculation.)

DRG (Chest Pain)

https://webpricer.cms.gov/#/pricer/ipps

2023 Medicare Part B outpatient insurance (and doctors' fees), premium deductible and coinsurance

Beneficiaries
- Voluntary
- Monthly premium: $164.90 (or higher, depending on your income; max: $560.50).
- Annual deductible: $226
- Co-pay: typically pay 20% of the Medicare-approved amount for most doctor services (including most doctor services while you're a hospital inpatient), outpatient therapy, and DME.

- About 80% of FFS Medicare beneficiaries have "Medigap" insurance. Several types and many vendors.
- Medigap policies generally cover co-pays and deductibles of allowable Medicare benefits.
- Some Medicare Part A beneficiaries do NOT have Part B. (Approximately 4 million)

Hospitals
- Outpatient Hospitalizations (which include "observation hospitalizations") generally paid under the *Outpatient Prospective Payment System* (OPPS) Ambulatory Payment Classification (APC) payment model

SNF
- Will cover therapy in a non-covered SNF stay if medically necessary

Outpatient Prospective Payment System (OPPS) Comprehensive Ambulatory Payment Classification (C-APC) Payment Model

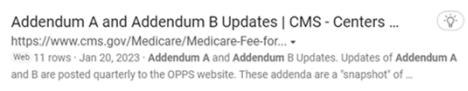
B. Policy: Comprehensive Observation Services C-APC (APC 8011) Effective January 1, 2016, CMS will provide payment for all qualifying extended assessment and management encounters through newly created C-APC 8011 (Comprehensive Observation Services). Any clinic visit, Type A ED visit, Type B ED visit, critical care visit, or direct referral for observation services furnished in a non-surgical encounter, by a hospital in conjunction with **observation services of eight or more hours will qualify for comprehensive payment through C-APC 8011.*,#**

**CMS Manual System Department of Health & Human Services (DHHS) Pub 100-02 Medicare Benefit Policy Centers for Medicare & Medicaid Services (CMS) Transmittal 215 Date: December 18, 2015*

011 not paid if patient has a SI=T or J1 procedure.

Outpatient Prospective Payment System (OPPS) Comprehensive Ambulatory Payment Classification (C-APC) Payment Model

- Observation C-APC is in CMS Addendum A
- Procedure C-APCs are reported in CMS Addendum B



Addendum A and Addendum B Updates

Updates of Addendum A and B are posted quarterly to the OPPS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates, that are in effect at the beginning of each quarter. The quarterly updates of Addendum A and Addendum B reflect the OPPS Pricer changes that are part of the quarterly OPPS recurring update notification transmittals.

Showing 1-10 of 192 entries Show entries: 10 per page Filter On Apply

Release Date	Subject	Year
January 2023 - updated 01/20/2023	Addendum B	2023
January 2023 - updated 01/20/2023	Addendum A	2023
July 2022	Addendum B	2022
October 2022 - updated 11/14/2022	Addendum A	2022
January 2022 - Correction	Addendum A	2022
October 2022 - updated 11/14/2022	Addendum B	2022

Outpatient Prospective Payment System (OPPS) Comprehensive Ambulatory Payment Classification (C-APC) Payment Model

payment **S**tatus **I**ndicator
J2 = Hospital part B services paid through a C-APC

Addendum A.. OPPS APCs for CY 2023

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
8010	Mental Health Services Composite	S	3.134	$268.22		$53.65
8011	Comprehensive Observation Services	J2	28.4982	$2,439.02		$487.81
90[illegible]	Tenecteplase injection	K	[illegible]	$[illegible]3.651		$28.74

Observation services of ≥ 8 hours: C-APC 8011 "Comprehensive Observation Services"
2023 C-APC 8011 Base Payment: $2,439.02

Outpatient Prospective Payment System **(OPPS) Comprehensive Ambulatory Payment Classification (C-APC) Payment Model**

Addendum B.. OPPS Payment by HCPCS Code for CY 2023

CPT codes and descriptors only are copyright 2022 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental The inclusion of an HCPCS code does not mean that an item or service is covered or non-covered. As a reminder, the fact that a drug, device,

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	Note: Actual copayments would be lower due to the cap on copayments at the Inpatient Deductible of $1,600.00	Device Pass-Through Expiration during Calendar Year	Indicators Change
27120	Reconstruction of hip socket	C								
27122	Reconstruction of hip socket	C								
27125	Partial hip arthroplasty	C								
27130	Total hip arthroplasty	J1	5115	16.[illegible]476	$13,048.08		$2,609.62			
27132	Total hip arthroplasty	C								
27134	Revise hip joint replacement	C								

Outpatient THA
Base Payment = $13,048.08

C = Inpatient Procedures Not paid under OPPS. Admit patient. Bill as inpatient.

Outpatient Prospective Payment System **(OPPS) Comprehensive Ambulatory Payment Classification (C-APC) Payment Model**

Observation services of ≥ 8 hours: C-APC 8011
"Comprehensive Observation Services"
2023 C-APC 8011 Base Payment: $2,439.02

Hospital Payment = APC Base Payment adjusted by hospital Wage Index (WI)
(You can find your hospital's WI in a variety of places.)

Hospital Payment = (0.6 x $2,439.02 x WI) + (0.4 x $2,439.02)
Mayo Clinic = (0.6 x $2,439.02 x 1.0632) + (0.4 x $2,439.02) = $2,531.51

Q: So, does a hospital get paid the MS-DRG or the C-APC for a hospitalization?

A: Well, it depends on whether the hospital bills the hospital stay under Part A.

Physicians should write an inpatient order if*:

- *The [beneficiary is provided] a service on Medicare's inpatient-only list.*
- *The physician expects the beneficiary to require hospital care spanning at least two midnights.*
- *The physician expects the beneficiary to require hospital care for less than two midnights but feels that inpatient services are nevertheless appropriate. ("2016 exception".)*

*The Hospitalist, Public Policy, Medicare's two-midnight rule, What hospitalists must know, By Charles Locke, MD; Edward Hu, MD, February 22, 2019

CMS Inpatient Only List (IPOL)

2000: CMS establishes an IPOL, which historically has contained > 1,700 procedures.

2020: CMS finalized plans to begin a 3-year phaseout of the IPOL.

January 1, 2021: Approximately 300 primarily MSK-related services removed from the IPOL.

July 2021: CMS Proposes Rescinding Phaseout of the IPOL

Research Article

Potential Financial Effects on Hospitals of the Removal of Common Orthopaedic and Spinal Procedures From Medicare's "Inpatient-Only" List: A Comparison of the Medicare Fee-for-service Payment Model Versus Maryland's Global Budget Revenue Model

Charles F. S. Locke, MD
Ronald L. Hirsch, MD
Edward P. Hu, MD
Andrew H. Hughes, MD
James R. Ficke, MD

ABSTRACT

Background: When treating Medicare beneficiaries, orthopaedic surgeons must follow Centers for Medicare & Medicaid Services (CMS) policies regarding whether to perform surgical treatments under inpatient or outpatient status. Recently, most orthopaedic and spinal procedures were removed from the CMS's "inpatient-only" list (IPOL).

Locke CF, Hirsch RL et al, JAAOS, January 15, 2022, Vol 30, No 2

Table 1 - Comparison of DRG Versus APC Payments for Eight Common Hospital Orthopaedic/Spinal Procedures for an Academic Medical Center (Rush University Medical Center) and a Community Hospital (Saint Anthony Medical Center) in Chicago, IL, and an Academic Medical Center (MedStar Georgetown University Hospital) and a Community Hospital (Sibley Memorial Hospital) in Washington, DC, for 2021

Procedure	Year Removed from IPOL	HCPCS Code	C-APC	MS-DRG Range[2]	GMLOS	Rush University Medical Center Payment, $		Saint Anthony Medical Center Payment, $		MedStar Georgetown University Hospital Payment, $		Sibley Memorial Hospital Payment, $	
						C-APC	MS-DRG	C-APC	MS-DRG	C-APC	MS-DRG	C-APC	MS-DRG
ACDF	2017	22551, 22845[3]	5115	473–471	1.6–0.8	12,573	25,815–69,898	12,573	22,067–67,043	12,310	22,175–43,396	12,310	16,484–32,555
Hemiarthroplasty for hip fracture	2021	27236	5114	522–521	4.1–0.2	6,397	22,184–30,728	6,397	19,370–26,076	6,263	19,167–25,858	6,263	14,266–19,879
Intramedullary nail for hip fracture	2021	27245	5114	482–480	3.3–0.2	6,397	16,885–30,348	6,397	15,221–25,778	6,263	14,520–26,325	6,263	10,687–19,627
Posterior lumbar fusion	Before 2005	22612	5115	460–459	2.7–0.9	12,573	39,223–66,575	12,573	32,738–54,188	12,310	34,107–58,099	12,310	25,520–43,685
Posterior lumbar interbody and posterior fusion	2020	22633	5115	455–453	2.4–7.5	12,573	47,690–90,631	12,573	39,195–73,053	12,310	41,469–79,385	12,310	31,090–59,660
Total hip arthroplasty	2020	27130	5115	470–469	1.8–3.1	12,573	19,356–30,933	12,573	17,160–26,237	12,310	16,689–26,838	12,310	12,329–20,016
Total knee arthroplasty	2018	27447	5115	470–469	1.8–3.1	12,573	19,356–30,933	12,573	17,160–26,237	12,310	16,689–26,838	12,310	12,329–20,016
Total shoulder arthroplasty	2021	23472	5115	483	1.4	12,573	24,112	12,573	20,888	12,310	20,856	12,310	15,485

ACDF = anterior cervical diskectomy and fusion, C-APC = comprehensive ambulatory payment classification, GMLOS = geometric mean length of stay, HCPCS = Healthcare Common Procedure Coding System, IPOL = inpatient-only list, MS-DRG = Medicare Severity Diagnostic Related Group
[2]MS-DRG ranges are shown in inverse numerical order to correspond to the associated GMLOS and MS-DRG payments.
[3]Single-level ACDF (22551) was removed from the IPOL in 2012. The additional interspace code, 22552, was removed from the IPOL in 2016. However, 1- to 2-level ACDF procedures typically use the anterior instrumentation add-on Current Procedural Terminology code 22845 (anterior instrumentation; two to three vertical segments), which was removed from the IPOL in 2017. Three-level ACDF uses add-on code 22846, which was removed from the IPOL in 2021.

Locke CF, Hirsch RL et al, JAAOS, January 15, 2022, Vol 30, No 2

MS-DRG 470 (THA/TKR w/o CC) payments exceeded C-APC 5115 payments by 1% ($19) at Sibley Memorial Hospital to 54% ($6,785) at Rush University Medical Center.

MS-DRG 483 (TSA) payments exceeded C-APC 5115 payments by 26% ($3,175) at Sibley Memorial Hospital to 92% ($11,539) at Rush University Medical Center.

MS-DRG 473 (ACDF w/o CC) payments exceeded C-APC 5115 payments by 34% ($4,174) at Sibley Memorial Hospital to 104% ($13,042) at Rush University Medical Center.

Payment for Total Shoulder Arthroplasty (MS-DRG: 483, C-APC: 5115, HCPCS Code: 23472) Removed from IPOL in 2021 at Rush University Medical Center, Chicago, Ill.

FY 2021

GMLOS (Days)	C-APC	MS-DRG*	Difference
1.4	$12,573	$24,122	$11,549

FY 2023

GMLOS (Days)	C-APC	MS-DRG*	Difference
1.4	$13,511	$25,956	$12,445

**Estimated using CMS IPPS Pricer. Does not include "pass-through payment".*

Difference in payment at Johns Hopkins Hospital for 0 or 1 night stay, inpatient vs outpatient under the Maryland GBR:

FY 2021: $1,272.95, FY 2023: $1,161

Geometric Mean Formula:

$$\textbf{Geometric Mean} = \sqrt[n]{x_1 \times x_2 \times x_3 \ldots x_n}$$

The geometric mean doesn't get affected as much as the arithmetic mean by outliers .

For example, consider a set of data values with an outlier, say, 10, 12, 14, and 99.
AM = (10 + 12 + 14 + 99) / 4 = 33.75
GM = $(10 \times 12 \times 14 \times 99)^{1/4} \approx 20.19$.
We can see that most of the data values are very far from AM whereas GM is not that much affected.
CUEMATH.COM

CMS Inpatient Only List (IPOL)

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2020: CMS finalized plans to begin a 3-year phaseout of the IPOL.

January 1, 2021: Approximately 300 primarily MSK-related services removed from the IPOL.

July 2021: CMS Proposes Rescinding Phaseout of the IPOL

January 1, 2022: most of the 300 primarily MSK-related services removed in January, 2021 restored to the IPOL

What if we looked at the differences in payments for MS-DRG vs. C-APC payments for short-stay medical (non-procedural) MS-DRGs?

Q: So, does a hospital get paid the MS-DRG or the C-APC for a hospitalization?

A: Well, it depends on whether the hospital bills the hospital stay under Part A.

Physicians should write an inpatient order if*:

- *The [beneficiary is provided] a service on Medicare's inpatient-only list.*
- *The physician expects the beneficiary to require hospital care spanning at least two midnights.*
- *The physician expects the beneficiary to require hospital care for less than two midnights but feels that inpatient services are nevertheless appropriate. ("2016 exception".)*

*The Hospitalist, Public Policy, Medicare's two-midnight rule, What hospitalists must know, By Charles Locke, MD; Edward Hu, MD, February 22, 2019

CMS Recovery Audit Contractor (RAC) program

The Centers for Medicare & Medicaid Services identified $3.75 billion in improper payments within the Medicare Recovery Audit Contractor (RAC) program, according to CMS' annual RAC report to Congress for fiscal year (FY) 2013.

The vast majority of improper payments--**$3.65 billion**--were overpayments, with the figure up $1.35 billion from overpayments in 2012. **More than 94 percent of the identified overpayments derived from inpatient hospital claims, many of them specifically from short-stay inpatient hospital admissions later determined to be medically unnecessary.**

FierceHealthcare, October 1, 2014

Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

ORIGINAL RESEARCH

Recovery Audit Contractor Audits and Appeals at Three Academic Medical Centers

Ann M. Sheehy, MD, MS[1*], Charles Locke, MD[2,3], Jeannine Z. Engel, MD[4], Daniel J. Weissburg, JD, CHC[5], Stephanie Mackowiak, RN, ESQ[6], Bartho Caponi, MD[7], Sreedevi Gangireddy, MD[7], Amy Deutschendorf, MS, RN, ACNS-BC[8]

OBJECTIVE: To detail complex Medicare Part A RAC activity.

DESIGN, SETTING AND PATIENTS: Retrospective descriptive study of complex Medicare Part A audits at 3 academic hospitals from 2010 to 2013.

Journal of Hospital Medicine Vol 10 | No 4 | April 2015

Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

ORIGINAL RESEARCH

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RESULTS:

Of 101,862 inpatient Medicare encounters, RACs audited 8110 (8.0%) encounters

RACs alleged overpayment in 31.3% (2536/8110), and hospitals disputed 91.0% (2309/2536).

No overpayment determinations contested the need for care delivered, rather that care should have been delivered under outpatient, not inpatient, status.

Journal of Hospital Medicine Vol 10 | No 4 | April 2015

Short-Term National Q4FY20 Report
Top 20 Medical DRGs for Same- and 1-Day Stays
Discharges for most recent 4 quarters, ending Q4FY20
3308 PPS Hospitals
In Descending Order by Same- and 1-Day Stay Counts Per DRG

DRG Code and Description	Same- and 1-Day Stay Count*	Total Discharges for DRG*	Proportion of Same- and 1-Day Stays to Total Discharges	Average Length of Stay for DRG
291 : Heart failure & shock w MCC	14,943	282,990	5.3%	5.2
392 : Esophagitis, gastroent & misc digest disorders w/o MCC	12,952	87,854	14.7%	3.3
871 : Septicemia or severe sepsis w/o MV >96 hours w MCC	11,319	454,924	2.5%	6.8
309 : Cardiac arrhythmia & conduction disorders w CC	10,978	57,298	19.2%	3.0
310 : Cardiac arrhythmia & conduction disorders w/o CC/MCC	10,871	34,374	31.6%	2.2
641 : Misc disorders of nutrition, metabolism, fluids/electrolytes w/o MCC	10,047	63,797	15.7%	3.4
065 : Intracranial hemorrhage or cerebral infarction w CC or tPA in 24 hrs	9,087	78,494	12.3%	3.7
312 : Syncope & collapse	8,972	43,496	20.6%	3.1
690 : Kidney & urinary tract infections w/o MCC	8,330	85,240	9.8%	3.6
313 : Chest pain	7,969	21,668	36.7%	2.3
189 : Pulmonary edema & respiratory failure	7,736	93,366	8.3%	4.7
287 : Circulatory disorders except AMI, w card cath w/o MCC	7,705	33,736	22.8%	3.2
378 : GI hemorrhage w CC	7,640	93,764	8.2%	3.6
683 : Renal failure w CC	7,278	84,476	8.6%	4.0
640 : Misc disorders of nutrition, metabolism, fluids/electrolytes w MCC	7,091	63,979	11.1%	4.7
065 : Transient ischemia w/o thrombolytic	6,124	23,961	25.6%	2.6
812 : Red blood cell disorders w/o MCC	6,097	37,316	16.3%	3.5
194 : Simple pneumonia & pleurisy w CC	5,983	69,916	8.6%	3.8
066 : Intracranial hemorrhage or cerebral infarction w/o CC/MCC	5,803	20,745	28.0%	2.8
192 : Chronic obstructive pulmonary disease w MCC	5,467	76,675	7.1%	4.4
Top Medical DRGs	**172,834**	**1,808,168**	**9.6%**	**4.7**
All Medical DRGs	**407,521**	**4,645,870**	**8.8%**	**5.0**

PEPPER Resources (cbrpepper.org)

So what should I do next?

Time to get the band back together.

Received: 4 October 2021 | Accepted: 14 March 2022
DOI: 10.1002/jhm.12823

CHOOSING WISELY®: NEXT STEPS IN IMPROVING HEALTHCARE VALUE

Journal of Hospital Medicine shm

Improving healthcare value: Medicare reimbursement for short-stay inpatient versus outpatient medical hospitalizations

Charles F. S. Locke MD[1] | Edward P. Hu MD[2] | Ronald L. Hirsch MD[3] | Andrew H. Hughes MD[1,4] | Ann M. Sheehy MD, MS[5]

TABLE 1 Comparison of C-APC and MS-DRG estimated payments for seven medical DRGs with high percentage of short stays (Q4 FY2020)

				Hospital reimbursement							
				AMC Washington, DC[c]		Community Hospital Washington, DC[c]		AMC Chicago, IL[c]		Community Hospital Chicago, IL[c]	
DRG description	MS-DRG	Number (%) of same and 1-day stays to total discharges	Average LOS (GMLOS)[a]	C-APC	MS-DRG	C-APC	MS-DRG	C-APC	MS-DRG	C-APC	MS-DRG
Chest pain	313	7969/21,688 (36.7%)	2.3 (1.7)	8011	$2213	$6425	$2213	$4554	$2250	$7576	$2250	$8085
Cardiac arrythmia & conduction disorder w/o CC/MCC	310	10,871/34,374 (31.6%)	2.2 (1.9)	8011	$2213	$5113	$2213	$3561	$2250	$6097	$2250	$6923
Intracranial hemorrhage or cerebral infarction w/o CC/MCC	66	5803/20,745 (28.0%)	2.4 (2.0)	8011	$2213	$6439	$2213	$4565	$2250	$7592	$2250	$8098
Transient ischemia	69	6124/23,961 (25.6%)	2.6 (2.0)	8011	$2213	$6972	$2213	$4969	$2250	$8192	$2250	$8570
Circulatory disorder except AMI, with cardiac Cath w/o MCC	287	7705/33,736 (22.8%)	3.2 (2.3)	5191	$2864	$10,100	$2864	$7336	$2918	$11,717	$2918	$11,342
Syncope & collapse	312	8972/43,496 (20.6%)	3.1 (2.3)	8011	$2213	$7277	$2213	$5199	$2250	$8536	$2250	$8840
Cardiac arrythmia & conduction disorder w/CC/MCC	309	10,978/57,298 (19.2%)	3.0 (2.4)	8011	$2213	$6770	$2213	$4816	$2250	$7964	$2250	$8391

J. Hosp. Med. 2022;17:476–480.

Payment for Short-Stay Medical DRGs vs. C-APC for "Medical short-stay" DRGs at Rush University Medical Center, Chicago, Ill for FY 2020.

DRG	GMLOS (Days)	% Short-stays*	C-APC	MS-DRG**	Difference
Chest Pain (313)	**1.7**	**36.7%**	**$2,205**	**$8,085**	**$5,880**
Transient Ischemia (069)	**2.0**	**25.6%**	**$2,205**	**$8,570**	**$6,365**
Syncope & Collapse (312)	**2.3**	**20.6%**	**$2,205**	**$8,840**	**$6,635**

*** % of same and 1-day stays to total discharges**

Estimated using CMS IPPS Pricer. Does not include "pass-through payment".

Difference in payment at Johns Hopkins Hospital for FY 2021 for a 1 night "medical" inpatient stay Vs. 24 observation services: +$468.14 vs. 36 observation services: -$780.94

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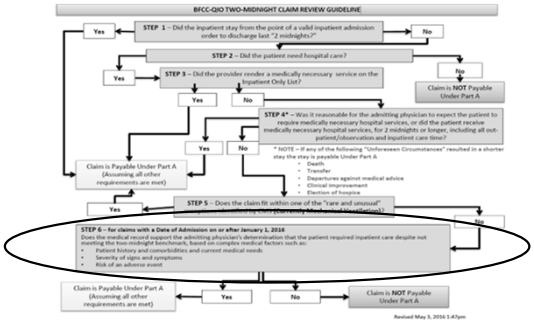
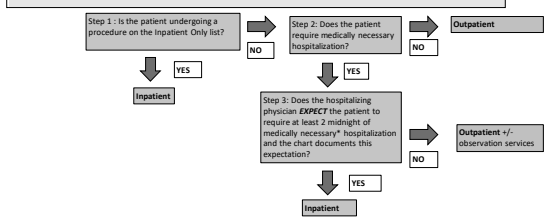
- The 8011 C-APC (Comprehensive Observation Services) payment ranged from $2213 to $2250 at the four non-Maryland study hospitals
- The estimated MS-DRG payments four non- Maryland study hospitals for MS-DRG 313 (Chest Pain, GMLOS 1.7 days) ranged from $4554 to $8085.



CFL SIMPLIFIED TWO MIDNIGHT STATUS DETERMINATION FLOWCHART

(Good for teaching busy clinicians who have other priorities or suggested status determination for Case Managers for Status Determination.)

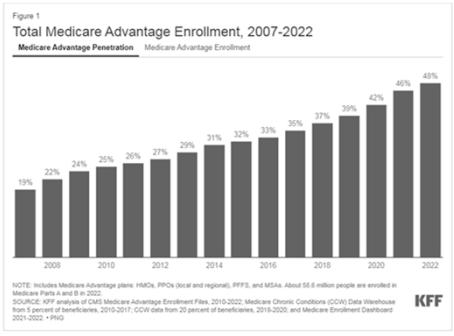


***If uncertain, OK to hospitalize as an outpatient and "convert" to Inpatient if and when it becomes clear that a second midnight of hospitalization is medically necessary.**

**** Observation services may be appropriate in patients hospitalized under outpatient status**

Federal Register/Vol. 78, No. 160/Monday, August 19, 2013/ Rules and Regulations ; p. 50946

…if the beneficiary has already passed 1 midnight as an outpatient observation patient or in routine recovery following outpatient surgery, the physician should consider the 2-midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. This means that the decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in medically necessary hospitalizations should not pass a second midnight prior to the admission order being written.



www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

Does the 2-midnight rule and the IPOL apply to Medicare Advantage plans?

April 5, 2023 CMS Releases CMS-4201-F

- Therefore, under § 422.101(b)(2), an **MA plan must provide coverage**, by furnishing, arranging for, or paying **for an inpatient admission when**, based on consideration of complex medical factors documented in the medical record, **the admitting physician expects the patient to require hospital care that crosses two-midnights (§ 412.3(d)(1), the "two midnight benchmark")**; when admitting physician does not expect the patient to require care that crosses two-midnights, but determines, based on complex medical factors documented in the medical record that inpatient care is nonetheless necessary (§ 412.3(d)(3), the "case-by-case exception"); and when **inpatient admission is for a surgical procedure specified by Medicare as inpatient only** (§ 412.3(d)(2)). H

Conclusions

- The concept of "visit status" for hospitalizations is a product of Medicare's establishment in the 1960's with a Part A & B
- Passage of the legislation that created Medicare was heavily politicized and was not part of comprehensive national health care policy
- Differences in hospital payment for hospitalizations with similar services can differ substantially depending on whether they are billed under Part A (MS-DRG payment) vs Part B (C-APC payment)
- Hospital reimbursement for most hospitalizations can be estimated using the CMS IPPS Pricer, CMS Addendum A & CMS Addendum B

Thank you.

Questions or comments?

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References

- Locke CF, Hirsch RL et al, Potential Financial Effects on Hospitals…Removal…From Medicare's "Inpatient-Only" List…, JAAOS-Journal of the American Academy of Orthopaedic Surgeons. 2021 Nov 25:10-5435.
- Sheehy AM, Locke CF et al, Recovery audit contractor audits and appeals at three academic medical centers, *J. Hosp. Med*. 2015 Apr;10(4):212-9.
- Locke CF, Hu EP et al, Improving healthcare value: Medicare reimbursement for short-stay inpatient versus outpatient medical hospitalizations. Journal of hospital medicine. 2022 Jun;17(6):476-80.
- Locke CF, Hu E, The Hospitalist, Public Policy, Medicare's two-midnight rule, What hospitalists must know, February 22, 2019.
- Federal Register/Vol. 78, No. 160/Monday, August 19, 2013/Rules and Regulations ; p. 50946.
- Does the 2-midnight rule and the IPOL apply to Medicare Advantage plans? April 5, 2023 CMS Releases CMS-4201-F.

References

- Black Perspectives, Civil Rights and Healthcare: Remembering Simkins v. Cone (1963),by Ezelle Sanford III, February 4, 2017.
- Drawing Blood, Comics and Medicine, Dec 7, 2019, https://drawing-blood.org/presidential-medicine/presidential-medicine-jfk/.
- Cohen W. J. (1985). *Health care financing review*, *Suppl*(Suppl), 3–11.
- Frakt, A.B., 2011. How much do hospitals cost shift? A review of the evidence. *The Milbank Quarterly*, *89*(1), pp.90-130.
- Stevens, In Sickness and in Wealth, p. 284.
- Mayes, R, The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System, J of the History of Medicine and Allied Sciences, 2006.