Medicare Update for 2025 and Beyond

SPEAKER

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LEARNING OBJECTIVES

1. Provide updates on discharge planning regulations.
2. Describe the 2025 regulatory changes pertinent to case management professionals
3. Formulate the regulatory framework to implement the new CMS appeal rights for patients with status changes

Discharge Planning Update

Medicare and Medicare Advantage patients have discharge appeal rights

IMM must be provided within 2 calendar days of inpatient admission date and expected discharge date. (Not 48 hours)

If IMM copy given day of discharge, must offer 4 hours to decide on appeal. Document it was offered. Not required to stay all 4 hours.

M, W, F IMM???

Are hospitals permitted to deliver the follow-up copy of the IM routinely on certain days of the week to all Medicare beneficiaries, such as every Monday, Wednesday and Friday?

CMS: Hospitals may not pre-schedule delivery of the IM or the follow-up IM to all inpatients on certain days (e.g., deliver IMs to all patients every Tuesday, Thursday, Saturday). This practice specifically violates § 200.3.2 (" . . . no more than 2 calendar days before the planned date of discharge. Thus, when discharge seems likely . . .") in the manual instructions. This practice may also be a violation of the Conditions of Participation (COPs) under § 482.13 because it is inconsistent with properly informing patients of their health status.

Note- ACMA asked about M, W, F and CMS' answer has Tu, Th, Sat—why????

What does the QIO Want?

Acentra Health Medical Director poses these questions:

What are the key factors you are looking at for a safe discharge plan? What if a member needs a higher level of care, but there is no movement on finding a discharge plan?

https://acentraqio.com/bene/newsletter/november2024acute/

What are the key factors you are looking at for a safe discharge plan?

Answer:

Key considerations for a safe discharge plan:

- Secure a skilled nursing facility (SNF) bed, if applicable.
- If the beneficiary is going home, ensure they can safely return alone.
- Confirm that home health care is arranged.
- Ensure durable medical equipment (DME) is ordered and will arrive before discharge.

All arrangements needed for the discharge must be confirmed and not pending when the appeal is filed.

What if a member needs a higher level of care, but there is no movement on finding a discharge plan?

Answer:

Medical director did not provide answer

My answer:

Higher? If the patient needs a “higher” level of care, they continue to need inpatient care

Did the medical director mean SNF care? In that case, your days are medically necessary and covered.

42 CFR § 424.13

But … What if a member needs a SNF, but there is no movement on finding an accepting SNF?

Answer:

42 CFR § 424.13

(c) *Certification of need for hospitalization when a SNF bed is not available.*

(1) The physician may certify or recertify need for continued hospitalization if he or she finds that the patient could receive proper treatment in a SNF but no bed is available in a participating SNF.

(2) If this is the basis for the physician's certification or recertification, the required statement must so indicate; and the certifying physician is expected to continue efforts to place the patient in a participating SNF as soon as a bed becomes available.

Offering Choice of Post-Acute Providers

Choice must be offered to all patients

- Providers who can meet the patient's needs and have capacity
- Must present list for HHA, SNF, LTACH, IRF
- Offer choice of all providers – hospice, ESRD, etc
- Technically it is the patient's responsibility to find out if provider in network

For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.

Offering Choice of Post-Acute Providers

Must we get a signature or keep a copy of the list?

Nope!

> The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.

But will your accreditation agency ask for one? They may

Challenge their requirement at your own risk…

Choice and Bundled Payment Programs

Participation in a bundled payment program by the physician or hospital does not allow you to not offer full choice!

You may indicate partners or benefits or physician preference on list and verbally

What about Update to Interpretive Guidelines for CoPs for Discharge Planning?

A-0799
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

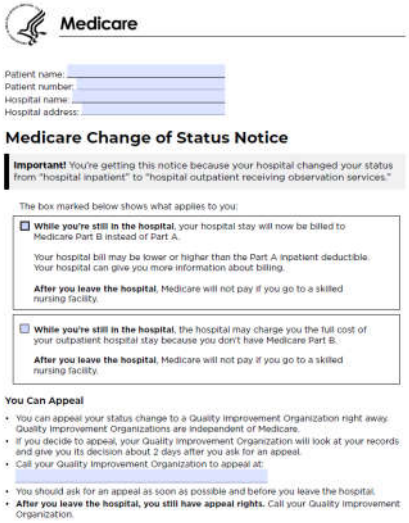
§482.43 Condition of Participation: Discharge Planning

The hospital must have in effect a discharge planning process that focuses on the patient goals and treatment preferences and includes the patient and his or her caregivers support person(s) in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions.

Interpretive Guidelines §482.43

Guidance is pending and will be updated in future release.

Another Form???? Don't Panic Just Yet



Medicare

Patient name:
Patient number:
Hospital name:
Hospital address:

Medicare Change of Status Notice

Important! You're getting this notice because your hospital changed your status from "hospital inpatient" to "hospital outpatient receiving observation services."

The box marked below shows what applies to you:

☐ **While you're still in the hospital,** your hospital stay will now be billed to Medicare Part B instead of Part A.

Your hospital bill may be lower or higher than the Part A inpatient deductible. Your hospital can give you more information about billing.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

☐ **While you're still in the hospital,** the hospital may charge you the full cost of your outpatient hospital stay because you don't have Medicare Part B.

After you leave the hospital, Medicare will not pay if you go to a skilled nursing facility.

You Can Appeal

- You can appeal your status change to a Quality Improvement Organization right away. Quality Improvement Organizations are independent of Medicare.
- If you decide to appeal, your Quality Improvement Organization will look at your records and give you its decision about 2 days after you ask for an appeal.
- Call your Quality Improvement Organization to appeal at:
- You should ask for an appeal as soon as possible and before you leave the hospital.
- **After you leave the hospital, you still have appeal rights.** Call your Quality Improvement Organization.

Long History Leading to Today

- RAC era habit by hospitals of long observation stays to avoid audits
- Lack of access to SNF benefit if no 3 day inpatient stay
- Big bills for SNF stays sent to patients
- Lawsuit filed against HHS for allowing this

The Result – Another New Rule

[CMS-4204-F]

RIN 0938-AV16

Medicare Program: Appeal Rights for Certain Changes in Patient Status

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule implements an order from the Federal district court for the District of Connecticut in *Alexander v. Azar* that requires HHS to establish appeals processes for certain Medicare beneficiaries who are initially admitted as hospital inpatients but are subsequently reclassified as outpatients receiving observation services during their hospital stay and meet other eligibility criteria.

Who Does this Affect?

Only Medicare fee for service – No MA patients

Only if admitted as inpatient then changed to outpatient via CC44 and Observation ordered and received

Only if no part B coverage

or

Stayed 3+ days after initial inpatient order

CMS expects < 10 per year per hospital!

Retroactive Appeals - No Worries for Us!

- Past patients since 2009 –
  - Had status changed from inpatient to outpatient and didn't have part B
  - Had status changed from inpatient to outpatient and stayed 3+ days and went to SNF and had to pay for SNF
  - Can now appeal their status change and get out of pocket payment refunded
  - Contractor will attempt to obtain medical records for stay – HIM nightmare!
    - Patient to supply documentation of payments made
    - MAC will try to substantiate that

If Patient Wins Appeal

- Hospital/SNF must refund any money collected from patient at that time
  - No mention of paying interest
- Hospital/SNF can then bill Medicare for services - OPTIONAL
  - Inpatient admission – must refund any part B payment then submit part A claim - ICD-9? ICD-10? What CPT codes? What disease definitions?
  - Will get DRG applicable at that time - MAC has to figure out how to calculate that
  - SNF – Refund any part B payment received then can bill for part A SNF stay – bill under RUG or PDPM???

CMS says billing instructions to follow– if they are ever allowed to talk again

Concurrent Appeal – Now You Worry (A little)

Two patient groups

1- Patients with part A and not part B
Admitted as inpatient
Condition code 44 change to outpatient
Observation services ordered and received by patient

2- Patients with part A with or without B
Admitted as inpatient
Condition code 44 change to outpatient
Observation services ordered and received by patient
Stayed 3 or more days starting with inpatient order

My First Tip

Determine how you can tell if a patient has Medicare part A but not part B

If face sheet only has Part A, is that because they don't have part B or that no one checked on part B?

My Second Tip

CC44 is a change from inpatient to outpatient

it is not inpatient to observation

Observation should only be ordered if the patient requires hospital care

If the patient is ready for discharge, get the order to change to outpatient but omit observation!

Now no appeal rights – it's the rule, we are not manipulating it

Should you stop doing CC44s? It's worth discussing…

What is Outpatient in a Bed?

If patient is staying for convenience or lack of safe discharge, there should not be an order for observation services

"Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

What Should We Order?

Work with Revenue Integrity and IT to set up a charge for convenience care.

Recommend HCPCS A9270, rev code 0760, charge per hour

If OPIB/custodial care ordered, start billing Convenience Care hours

If observation ordered and not appropriate, cancel order

If status changed to outpatient, can still bill convenience hours

If want to charge patient, must give an ABN

The New Notice

Medicare Change of Status Notice – MCSN

Form CMS-1868 https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative-bni/ffs-mcsn

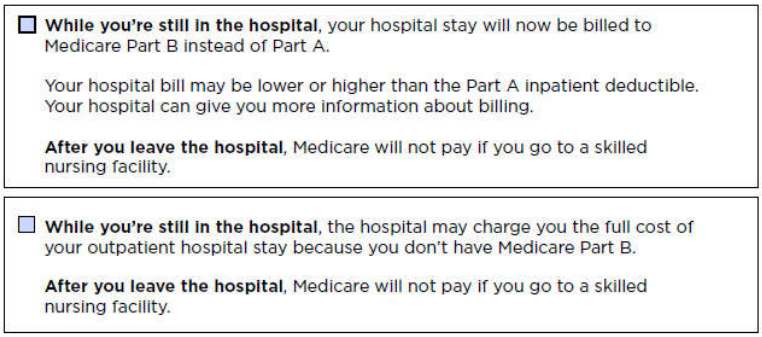
Requires patient signature and date

No explicit requirement for oral explanation as with MOON but you are obligated to ensure they understand content

Choose a Box and Check It

Part A but no Part B
Check box 2

Stayed 3+ days
Check box 1



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Quick Detour to the Payment (except Maryland since their payment is wacky!)

2025 Part A deductible - $1,676 – resets every 60 days
2025 Part B deductible - $257 once a year
C-APC 8011 national base approved amount - $2,647.73

Patient with part A and B, no supplement
- Admitted inpatient on January 1, 2025 – owe $1,676
- Placed Observation – owe $257 + $478.15 = owe $735.15

Patient with A but no B, no supplement
- Admitted inpatient on January 1, 2025 – owe $1,676
- Placed Observation – owe full chargemaster rate for stay - ~$5,000

When Do We Give New Notice?

Group 1 (no part B) – when you give Condition Code 44 written notice

Can this notice serve as written notification of CC44 change?

42 CFR 482.30(d)(3) says:

> (3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c);

MCSN says:

> **Important!** You're getting this notice because your hospital changed your status from "hospital inpatient" to "hospital outpatient receiving observation services."

When Do We Give New Notice?

Group 2- CC44 to outpatient, observation ordered, CC44 notice given

Then if still in hospital on day 4, give MCSN

Day 4 means they have passed 3 "qualifying days for SNF"

"Delivery no later than 4 hours prior to release from the hospital"

We expect for hospitals to build this relatively brief 4-hour window into their standard patient release planning processes, as appropriate, for beneficiaries receiving the MCSN, and for delivery to occur, no later than, 4 hours from the anticipated end of medically necessary services.

Hospitals are already adept at timing the issuance of other beneficiary notices to correspond with the end of medically necessary services. In the event a beneficiary voluntarily leaves the hospital prior to the hospital's schedule time of release, the hospital may document the time of and circumstances surrounding the beneficiary's departure on their copy of the MCSN.

Now What Happens?

Patient reads form, decides if they will appeal

If appealing, calls the QIO – can also email, fax, mail

If stable for discharge, can leave and appeal stays active

- No financial protection during appeal process!!!
- If no B, can go home and wait and hope
- If want SNF, has 30 days after discharge to enter SNF

What if They Want to Stay?

No financial protection

We can charge them to stay

- But how?
- They are outpatients so charge custodial care rate
- ABN required
- But if they win appeal and now inpatient, HINN 12 was right notice; patient cannot be charged

What if They Win?

Hospital will be told to process claim with inpatient order as valid order

- Billed as a 111 inpatient part A claim
- No part B liability for patient
- Common Working File will see 3+ day inpatient stay and SNF will be paid – but remember SNF necessity rules!

- Do doctors need to change their place of service codes?
- Do consultants need to change their visit codes?
- Does anyone compare facility and pro fee charges???

If you disagree, should you appeal the decision or take the DRG and run???

Take Home Messages for This

Do not start handing out MCSNs until Feb 14th

Look at your registration processes to be sure all payers visible

Look at your CC44 processes to be sure Obs only ordered when indicated

Best solution – get every patient in the right status every time

The Inpatient Only List

Changes for 2025

HCPCS Code	Short Descriptor	New SI
additions		
0894T	Cannulation liver allograft	C
0895T	Connj lvr algrft prfu dev 1	C
0896T	Connj lvr algrft prfu dev ea	C
49186	Opn exc/dstr ntra-abd 5 cm/<	C
49187	Opn exc/dstr ntra-abd 5.1-10	C
49188	Opn exc/dst ntra-abd 10.1-20	C
49189	Opn exc/dst ntra-abd 20.1-30	C
49190	Opn exc/dstr ntra-abd >30 cm	C
removal		
22848	Insert pelv fixation device	N

The Inpatient Only List

Don't use it

Use Addendum B and look for SI = C

47562	Laparoscopic cholecystectomy		J1	5361	65.4304	$5,834.36
47563	Laparo cholecystectomy/graph		J1	5361	65.4304	$5,834.36
47564	Laparo cholecystectomy/explr		J1	5362	116.7583	$10,411.22
47570	Laparo cholecystoenterostomy		C			
47579	Unlisted laps px biliary trc		J1	5361	65.4304	$5,834.36
47600	Cholecystectomy		C			
47605	Cholecystectomy w/cholang		C			
47610	Removal of gallbladder		C			
47612	Removal of gallbladder		C			
47620	Removal of gallbladder		C			

Transforming Episode Accountability Model (TEAM)

743 hospitals nationally

Mandatory participation

Starts 2026

lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures

Transforming Episode Accountability Model (TEAM)

Surgery and 30 days after discharge - total part A and B spending

Share in savings compared to "target" spend

Can share with doctors, SNFs, IRFs, DME, HHA, etc

Must still offer patient choice of post-acute providers

3-day Inpatient stay requirement waived if 3+ star facility

Screening for Social Drivers of Health

Voluntary screening for 2025, mandatory for 2026

Pay to screen, not pay to address

Results can help researchers understand prevalence

Of course, you should try to address

Don't forget there are Z codes for these!

The Measures

Food insecurity

limited or uncertain access to adequate quality and quantity of food at the household level

Housing instability

inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence

Transportation needs

limitations that impede transportation to destinations required for all aspects of daily living.

The Measures and some more details

Utility difficulties

Inconsistent availability of electricity, water, oil, and gas services

Interpersonal safety

screening for exposure to intimate partner violence, child abuse, and elder abuse

Hospitals get to select the tool they use and the manner of collection

Can carry forward EHR data collected in same reporting period

Aggregate data reporting, not patient-level data

Is it all Outpatient Services? Luckily No

- "The denominator is defined as the number of patients who are admitted to a HOPD, REH, or ASC, as applicable, and who are 18 years or older."
- "Patients receiving services that are limited to specific medical tests are not included in the denominator cohort. These services include imaging, laboratory, and pharmacy services, which are typically specific types of auxiliary services to a patient's more comprehensive care, where such screenings and referrals should be provided."

DRG and CDI and ICD-10 Code Changes

Every year CMS realigns DRGs based on claims data, new technologies, new and deleted codes

Document completely and the DRG falls where it does

Remember, diagnoses are not used only for CC/MCC and GMLOS

Also used for HRRP, mortality, PSI, US News, LeapFrog, CMS Star

New Technologies

CMS receives requests from companies to add their new technology and allow additional payment until DRG realignment can occur

new catheters, new stents, new wound care products, new drugs, new implants, etc.

2025 New Technologies

Technology	Maximum Add-on Payment
Annalise Enterprise CTB Triage - OH	$241.39
ASTar® System	$97.50
Edwards EVOQUE™ Tricuspid Valve Replacement System	$31,850.00
GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device)	$47,238.75
LimFlow™ System	$16,250.00
Paradise™ Ultrasound Renal Denervation System	$14,950.00
PulseSelect™ Pulsed Field Ablation (PFA) Loop Catheter	$6,337.50
Symplicity Spyral™ Multi-Electrode Renal Denervation Catheter	$10,400.00
TriClip™ G4	$26,000.00
VADER® Pedicle System	$28,242.50
ZEVTERA™ (ceftobiprole medocaril); ABSSSI and CABP indications	$2,812.50
ZEVTERA™ (ceftobiprole medocaril); SAB indication	$8,625.00
CASGEVY™ (exagamglogene autotemcel); Sickle Cell Disease indication	$1,650,000.00
ELREXFIO™ (elranatamab-bcmm) and TALVEY™ (talquetamab-tgvs)*	$12,899.59
HEPZATO™ KIT (melphalan for injection/hepatic delivery system)	$118,625.00
LYFGENIA™ (lovotibeglogene autotemcel))	$2,325,000.00

Who Pays For New Technologies?

Medicare does not, and we believe should not, assume responsibility for more than its share of the costs of procedures based on projected utilization for Medicare beneficiaries and does not set its payment rates based on initial projections of low utilization for services that require expensive capital equipment.

For the OPPS, we rely on hospitals to make informed business decisions regarding the acquisition of high-cost capital equipment, taking into consideration their knowledge about their entire patient base (Medicare beneficiaries included) and an understanding of Medicare's and other payers' payment policies.

Speaking of New Technology

Colon Cancer Screening

- Removing Barium Enema as covered screening test
- Add CT colonography as covered screening test

If colonoscopy needed after stool or blood screening, it is screening and covered 100%

If colonoscopy needed after CT colonography, it is a diagnostic service with usual coinsurance and deductible applicable

Medicare Advantage Update

MA plans should be following Two Midnight Rule

- Inpatient only list, two midnight expectation, two midnight benchmark, case-by-case exception, SNF and IRF qualification
- But permitted to question medical necessity for surgery, true need for hospital care
- **Two midnights are not appropriate for inpatient if delays in care, convenience, social, working up incidentals.**

(We complain about other's behavior but be sure to look within)

Don't Be This Hospital!

Oroville Hospital to Pay $10.25 Million to Resolve Allegations of Kickbacks and False Billing

Thursday, December 12, 2024

Share

For Immediate Release

U.S. Attorney's Office, Eastern District of California

Had doctors insert diagnoses that were not valid to increase CC/MCC rate

Had ED nurses write inpatient orders on patients before being seen by a doctor

Paid ED doctors and hospitalists $125 for each inpatient

Or This Hospital

Chesapeake hospital indicted for healthcare fraud involving unnecessary surgical procedures

Wednesday, January 8, 2025

Share

For Immediate Release

U.S. Attorney's Office, Eastern District of Virginia

Altered EDC to be able to induce deliveries
Performed sterilizations without proper consent
Performed hysterectomies without proper indications
Recredentialed despite felony conviction and previous hospital suspensions

Medicare Advantage Plans and 2 MN Rule

CMS tracking complaints

Be sure you have followed the payer's formal appeal process before filing complaint

Be sure case is worthy of a complaint – see prior slide
Complaint instructions at www.ronaldhirsch.com

2026 may see more MA plan oversight

Pass the PEPPER please!

"Updates to the Program for Evaluating Payment Patterns Electronic Report (PEPPERs) Coming Soon"

There will be a temporary pause in distributing PEPPERs as CMS works to improve and update the program and reporting system. This pause will remain in effect through the fall of 2024. We recognize the importance of these reports to your practice. Therefore, during this time, CMS will be working diligently to enhance the quality and accessibility of the reports. In

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