Case Management Rules, Regulations & Compliance in 2015

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Objectives

1. Describe regulations for patient choice, Medicaid and the Department of Health Services.

2. Explain the importance of the hospital audit & compliance department.

3. Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.

4. Evaluate case management protocols and penalties.
Federal website:  www.cms.gov

- CMS = Centers for Medicare & Medicaid Services
- Federal (and some State) laws regarding federal programs
- Conditions of Participation
- Billing rules found in CMS Manuals
- New programs – rules and regulations
- Changing rules/regs
- Resource to build hospital policies
Conditions of Participation

• To receive Medicare/Medicaid funds, hospitals must:
  • provide the required services in the law (example - UM Committee)
  • Bill services as required in the Policy Manuals (example - Condition Code 44)
  • Treat all Medicare/Medicaid beneficiaries as required by the law (example – offer choice)
  • Conditions not met (reported or found on survey) = possible loss of inclusion in the Medicare/Medicaid programs
Conditions of Participation (CoP’s)

- CMS (Centers of Medicare/Medicaid Services) rules and regulations
- These rules must be followed in order to receive payment for services rendered
- Affects:
  - Level of Care
  - Pt Choice
  - Conflict of Interest
  - Billing/Transfer DRG’s
Congressional Federal Register

- Abbreviation – CFR
- www.ofr.gov
- All laws finalized by Congress are printed here
- Massive document available online
- Search by keyword or Section/article
- The “how to” of carrying out the law is found in the Policy Manual regulations – can be highly detailed and tedious
- Title 42 – Public Health; Chapter IV (Hospitals) Parts 400 – 505 (Example Part 482 – Utilization Review)
CMS Manuals = How to follow the Law

- Benefit
- Policy
- Claims Processing
- State Operations
- Program Integrity
- National Coverage Determinations
- General Information, Eligibility & Entitlement
- Secondary Payor Financial Management
- Contractor Beneficiary & Provider Communications
Discharge Planning

- CFR Title 42, Subsection (or Part) 482.43 – Condition of Participation: Discharge Planning
- Covers hospital requirements + interpretive language – what will the survey be looking for
  - Who can do a discharge planning assessment
  - Who can request an assessment
  - How staff identifies patients who need discharge planning
  - Documentation
  - Offering options/choice
  - Patient/Family involvement
Introduction: What is Discharge Planning?

• CMS defines it as “a process used to decide what a patient needs for a smooth move from one level of care to another.

• Discharge planning is a federally mandated process to transition through the levels of care.

• The description of discharge planning as stated in the Social Security Act (SSA) reads as follows:

  “The Secretary of Health and Human Services shall develop guidelines and standards for the planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care.”
Why is Discharge Planning so Important to include in the regulations?

- Assures high quality transitions to other levels of care
- Improves quality and safety of the care of the patient
- May decrease length of stay and readmissions
- Ensures the beneficiary is included in the plans
3 Day IP Stay for SNF Coverage

• Found in the Medicare Benefit Manual – Chapter 8, Subsection 20.1

• “20 - Prior Hospitalization and Transfer Requirements (Rev. 1, 10-01-03)
• A3-3131, SNF-212
• In order to qualify for post-hospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. In addition, effective December 5, 1980, the individual must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in § 20.2 applies.”
Three Day Prior Hospitalization

- The three consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. (Combining of acute days is only for patients who are transferred from “inpatient” status to “inpatient” status).

- The date of admission, but not the date of discharge, is counted as a hospital inpatient day.

- The extended care services must be for the treatment of a condition for which the patient was receiving inpatient services.
Thirty Day Transfer

• To CMS “Post-hospital” means: if initiated within 30 days after discharge from hospital, that included at least a 3 day stay of medically necessary inpatient care.

• In addition to prior hospitalization, the SNF coverage policy states the patient must require “daily therapy”. This means the patient needs SNF services or rehab on a 7 days-a-week basis (in other words the patient is not at a custodial LOC).
Determining the 30 Day Transfer Period

- The date of discharge is not counted.

- The 30-day period begins on the day following actual hospital discharge.

- The 30 day transfer period may be extended as in § 20.2.2 which states “when a patient’s condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after hospital discharge, and it is “medically predictable” at the time of the hospital discharge that the patient will require covered care within a predetermined time period. (Example of this- hip fracture skilled service will be required generally 4-6 weeks after acute discharge when weight bearing) Condition Code 56.
Jimmo vs. Sebelius Settlement

• 2013 Settlement – Medicare contractors inappropriately applying an “Improvement Standard”
• Center for Medicare Advocacy represented Ms. Jimmo who was denied home health services based on lack of restorative potential
• She won – there is no “Improvement Standard”
• If patient needs skilled care to prevent or slow further deterioration in clinical condition – they qualify for rehab
• 42 CFR 409.32(c) - …”restoration of a patient is not the deciding factor whether skilled services are needed.”
• This ruling also applies to all MCARE Managed Care pts.
All Medicare Providers

- Home Health – Homebound
- Hospice – Eligibility
- DME – recently went to geographically bidding – regulations for equipment changed July 1, 2013
- Example – to qualify for a manual wheelchair:
  - “Your health makes it very hard to move around in your home even with the help of a walker or cane;
  - You have significant problems in your home performing activities of daily living such as getting to the toilet, getting in and out of a bed or a chair, bathing, and dressing and
  - You can safely use the wheelchair yourself or always have someone with you to help you use it and
  - A statement from your doctor confirming that you the required office visit took place.”
Utilization Management

- CFR Title 42, Subsection (or Part) 482.30
- Condition of Participation: utilization review
  - Defines utilization management
  - What kind of structure is required in the hospital setting
  - Composition of the UM committee
  - Duties of the committee
  - Scope & frequency of review
  - Examples: Condition code 44; Outliers; 2ndary review
Observation vs. Inpatient Level of Care

• This is about BILLING
• Medicare Benefit Policy Manual – Chapter 1 – Inpatient Hospital Services covered under Part A:

“....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 includes such things as:
• The severity of the signs and symptoms exhibited by the patient;
• The medical predictability of something adverse happening to the patient;....”
2 MN Rule – Effective Oct 1, 2013

- Found in the IPPS Final Regulation for FY14
- Time trumps criteria
- Every patient who stays 2 MNs or less is Obs.
- Every patient who stays 2 MNs or longer is IP
- Requires MD certification

This led to numerous open forums for hospital providers attempting to clarify the regulation;
Declared exceptions were determined (death, new vent, leaving AMA, decision to go hospice, etc)
Changes made in the OPPS Final Rule Effective Jan 1 2015 = no required MD certification on admission
Condition Code 44

- Applies when hospital admits patient as IP, then determines that the patient stay should be billed as Obs.
- Requires UM Committee involvement
- Is simply a code applied to the final bill to indicate that there was a change in level of care billing status
- Serves as an “alert” that the hospital is reviewing level of care on a daily basis
- Found in the Claims Processing Manual, Chapter 1, Section 50.3
- How to apply it to the bill?
  - “When a hospital submits a 13X or 85X type of bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report Condition Code 44 in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition Code 44 will be used by CMS and QIOs to track and monitor these occurrences.”
EMTALA

- Emergency Medical Treatment & Active Labor Act
- Requires physician examination of patient and stabilization before considering transferring
- Cannot transfer expensive, difficult or non-coverage patients to other hospitals for your convenience
- Patients must agree to transfer
- Transfer to a higher level of care that cannot be provided on site
Hospital Compliance

- Provides oversight to ensure that hospital business/services are conducted within regulatory and ethical guidelines
- All patients are treated fairly
- Provides guidance to hospital departments in following regulations governing that department’s functions and activities
- Investigates complaints
- Conducts auditing of services
Hospital Organizational Compliance

• Compliance – process of meeting regulations, laws and policies in order to meet the expectations of others

• Meet expectations of those who:
  • Pay for hospital services
  • Grant facility money
  • Regulate the industry
  • Enforce federal and state laws

• Ethical and good business practices
Hospital Compliance Department

• Often reports to Board
• Works closely with Case Management
• Will develop policies on vendors; gifts
• Develops Conflict of Interest policies – may have annual attestation document for Case Managers to sign
• Performs behind the scenes audits
• Should be Ad Hoc committee members of new process development to ensure compliance with Conditions of Participation
Conflicts of Interest

- Maintain appropriate relationships with vendors that provide post acute services
- STARK laws refer to conflict of interest for physicians – financial involvement in post-acute providers
- Always offer choice
- Use a wide range of vendors
- Violation of Conflict of Interest federal regulations can lead to job loss and federal prosecution
State Government Websites

• Check your state government website
• Medicaid – rules + billing regulations
• Eligibility for Medicaid
• Department of Healthcare Services/Public Health – specific rules or letters to facilities
• Accountable Care Act insurance exchanges
• Managed Care rules and regulations
State Regulations

• Rules on SNF placement – distance from home
• Bed holds for Medicaid beds in SNF’s
• Different billing procedures for IP vs. Obs level of care
• Specific rules on transfers
• Rules and regulations on private pay post acute providers (example – assisted living or Board & Care)
• See your Nurse Practice Act for who can perform discharge planning in your state
Hospital Policies

- Should be build on CMS and your state regulations
- Written generally – to allow for individual styles of practice
- Policies should be in place for all required rules and regulations
- Important to be very well versed in your departments policies
- Review every 2-3 years – validate and update
Types of Hospital Surveys

- CMS – Conditions of Participation
- State or Department of Public Health
- Sentinel Events
- The Joint Commission
- DNV – NIAHO
The Joint Commission

- Builds their standards on CMS rules and regulations
- Can incorporate state regulations
- Look to how a hospital follows their own policies
- TJC is voluntary
- Used by approx. 4,400 hospitals nationally
- Hospital pays TJC to be surveyed
- Will have access to the standards – electronically (check your facility internal intranet or check with Compliance or Quality Management)
National Integrated Accreditation for Healthcare Organizations (NIAHO).

- Conducted by Det Norske Veritas Healthcare (goes by DNV)
- In about 375 hospitals nationally
- Combines CMS Conditions of Participation with Quality issues and standards
What if you break the rules?

- Self reporting is required for certain standards (example – Sentinel Event; incorrect billing)
- Surveyor finds problems
  - Corrective action plan
  - Immediate fix
  - Plan to prevent errors
  - Ongoing data collection and reporting
  - Re-survey
- Regulations for Conditions of Participation prevent patient harm and billing fraud
Government Oversight

- OIG – Office of Inspector General/Health & Human Services
  - Performs audits to look at general and specific provider practices – compliance issues
  - Can determine if the Regulations have not been followed

- DOJ – Department of Justice
  - Can investigate reported wrongdoing and prosecute
  - Can imprison providers – fines and jail terms

See their websites for more information; subscribe to daily emails on what they are investigating and their plans to audit

www.oig.hhs.gov
www.justice.gov
How to learn about regulations?

• Use your favorite search engine and key word searches
• Join a professional organization for Case Management – attend their educational conferences to learn about the latest regulations and how they affect your practice
• Read the journals in your field – these often have articles discussing the latest regulations that may affect your practice
• Subscribe to a list serv to keep up to date on the latest information
• National organizations, such as ACMA, have active Public Policy Committees that will keep you up to date on upcoming legislation
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Thank you!

Questions?

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