CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1329	**Date: December 26, 2013**
	Change Request 8508

Transmittal 1315, dated November 15, 2013, is being rescinded and replaced by Transmittal-1329, dated 12- 26 -2013, to clarify the dates of admission (business requirement (BR) 8508.1) and to remove reference to a dual-chamber pacemaker National Coverage Decision (BR 8508.1.1). All other information remains the same.

SUBJECT: Immediate Suspension of Postpayment Patient Status Reviews of Inpatient Hospital Admissions 10/1/13-12/31/13

I. SUMMARY OF CHANGES: On August 2, 2013, the Centers for Medicare & Medicaid Services (CMS) issued Final Rule CMS-1599-F updating fiscal year FY 2014 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). The final rule modifies and clarifies CMS's longstanding policy on how Medicare contractors review inpatient hospital admissions for payment purposes. The rule is applicable to admissions at acute care inpatient hospital facilities, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs) and Inpatient Psychiatric Facilities (IPFs), but is not applicable to beneficiary admissions at Inpatient Rehabilitation Facilities (IRFs). IRFs are specifically excluded from the 2-Midnight inpatient admission and medical review guidelines per CMS-1599-F.

Reviews to check compliance with Final Rule CMS-1599-F are called "patient status" reviews. The purpose of this Change Request is to provide the contractors with instruction regarding their post-payment medical review strategy, particularly related to "patient status" reviews.

Medicare Administrative Contractors (MACs), Recovery Auditors, and the Supplemental Medical Review Contractor shall not conduct postpayment patient status reviews for inpatient claims with dates of admission 10/1/13 – 12/31/13. However, claims with evidence of systematic gaming, abuse or delays in the provision of care in an attempt to surpass the 2 midnight presumption could warrant medical review at any time.

MACs, Recovery Auditors and the Supplemental Medical Review Contractor may continue other types of inpatient hospital review (i.e. reviews for purposes other than determining the appropriateness of the inpatient admission versus treatment as an outpatient/observation, which are known as "patient status" reviews).

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: December 2, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1329	Date: December 26, 2013	Change Request: 8508

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SUBJECT: Immediate Suspension of Postpayment Patient Status Reviews of Inpatient Hospital Admissions 10/1/13-12/31/13

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: December 2, 2013

I. GENERAL INFORMATION

A. Background: On August 2, 2013 the Centers for Medicare & Medicaid Services (CMS) issued Final Rule CMS-1599-F updating fiscal year FY 2014 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). The final rule modifies and clarifies CMS's longstanding policy on how Medicare contractors review inpatient hospital admissions for payment purposes. The rule is applicable to admissions at acute care inpatient hospital facilities, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs) and Inpatient Psychiatric Facilities (IPFs), but is not applicable to beneficiary admissions at Inpatient Rehabilitation Facilities (IRFs). IRFs are specifically excluded from the 2-Midnight inpatient admission and medical review guidelines per CMS-1599-F.

Reviews to check compliance with Final Rule CMS-1599-F are called "patient status" reviews. The purpose of this Change Request is to provide the contractors with instruction regarding their post-payment medical review strategy, particularly related to "patient status" reviews.

Medicare Administrative Contractors (MACs), Recovery Auditors, and the Supplemental Medical Review Contractor shall not conduct postpayment patient status reviews for inpatient claims with dates of admission 10/1/13 – 12/31/13. However, claims with evidence of systematic gaming, abuse or delays in the provision of care in an attempt to surpass the 2 midnight presumption could warrant medical review at any time.

MACs, Recovery Auditors and the Supplemental Medical Review Contractor may continue other types of inpatient hospital review (i.e. reviews for purposes other than determining the appropriateness of the inpatient admission versus treatment as an outpatient/observation, which are known as "patient status" reviews).

B. Policy: Fiscal Year 2014 Hospital IPPS Final Rule CMS-1599-F:

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8508.1	Medicare Administrative Contractors (MACs), Recovery Auditors, and the Supplemental Medical Review Contractor shall not conduct postpayment patient status reviews for inpatient claims with dates of admission **10/1/13 – 3/31/14.** **NOTE:** Patient Status Reviews are those reviews conducted to determine if inpatient hospital admission and Part A payment was the appropriate status for the care provided. These review types are those that include denial language to indicate that while the patient care provided may have been appropriate, the setting in which it occurred was not warranted (i.e. it could have been provided on an outpatient basis).	X											All applications and business owners listed in the background section of this CR., RACs
8508.1.1	MACs, Recovery Auditors and the Supplemental Medical Review Contractor shall continue other types of inpatient hospital reviews (including but not limited to coding reviews, reviews for the medical necessity of a surgical procedure provided to a hospitalized beneficiary, and statutorily mandated therapy reviews) in accordance with their medical review strategy. **NOTE:** Medical necessity reviews of the surgical procedures performed will assess whether the procedure was reasonable and necessary for the beneficiary's medical condition and treatment. An example of this type of review includes decisions regarding the medical necessity of a dual-chamber pacemaker.	X											All applications and business owners listed in the background section of this CR., RACs
8508.2	Inpatient hospital reviews for dates of admission prior to 10/1/2013 should continue based on the applicable policy at the time of admission.	X											All applications and

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
													business owners listed in the background section of this CR., RACs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8508.3	CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:

Fiscal Year 2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rule CMS-1599-F.

V. CONTACTS

Pre-Implementation Contact(s): Jennifer Dupee, 410-786-6537 or Jennifer.Dupee@cms.hhs.gov , Vicki Chitwood, 410-786-7776 or Vicki.Chitwood@cms.hhs.gov , Jennifer Phillips, 410-786-1023 or Jennifer.Phillips@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.