HCPro, Inc., presents

2014 IPPS Final Rule Explained

A 90-minute interactive audio conference

Tuesday, September 10, 2013

1:00 p.m.–2:30 p.m. (Eastern)
12:00 p.m.–1:30 p.m. (Central)
11:00 a.m.–12:30 p.m. (Mountain)
10:00 a.m.–11:30 a.m. (Pacific)

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In our materials, we strive to provide our audience with useful and timely information. The live audio conference will follow the enclosed agenda. Occasionally, our speakers will refer to the enclosed materials. We have noticed that non-HCPro audio conference materials often follow the speakers' presentations bullet-by-bullet and page-by-page. However, because our presentations are less rigid and rely more on speaker interaction, we do not include each speaker's entire presentation. The enclosed materials contain helpful resources, forms, crosswalks, policies, charts, and graphs. We hope that you will find this information useful in the future.

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Dear Program Participant,

Thank you for participating in our “2014 IPPS Final Rule Explained” audio conference, featuring speakers Kristen Geissler, MS, PT, CPHQ, MBA, and Kimberly Anderwood Hoy Baker, JD, CPC, and moderated by Todd Hutlock.

Our team is excited about the opportunity to interact with you directly. We encourage you to ask our experts your questions during the program. If you would like to submit a question before the audio conference, please send it to the producer, Todd Hutlock, at thutlock@hcpro.com and provide the program date in the subject line. We cannot guarantee that your question will be answered during the program, but we will do our best to include a good cross section of questions.

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Thank you, again, for attending the HCPro program today. We hope you found it to be informative and helpful and that you will continue to rely on HCPro programs as an important resource for pertinent and timely information.

Sincerely,

Elizabeth Petersen
Vice President
HCPro, Inc.
Agenda

I. Quality of care
   a. Hospital-acquired conditions
   b. Readmission Reduction Program
   c. Hospital Value-Based Purchasing Program
   d. Inpatient Quality Reporting Program

II. MS-DRG changes

III. Payment updates
   a. Updated standardized amounts and other factors
   b. New technology

IV. Inpatient status criteria
   a. Inpatient physician order requirements
   b. 2-midnight rule
   c. Part B payment for inpatients (rebilling Part B)

V. Live Q&A
Speaker Profiles

Kristen Geissler, MS, PT, CPHQ, MBA

Kristen Geissler is a director at Berkeley Research Group, LLC, in Washington, D.C., and has over 20 years of experience in the healthcare field, including direct patient care, administrative, and consulting roles. She has expertise in various quality-based reimbursement methodologies, such as CMS IQR (Inpatient Quality Reporting) and VBP (Value-Based Purchasing), and has a detailed understanding of providers’ auditing and submission requirements related to the various required and voluntary national quality reporting policies.

Kimberly Anderwood Hoy Baker, JD, CPC

Kimberly Anderwood Hoy Baker is the director of Medicare and compliance for HCPro, Inc. She is a lead regulatory specialist for the HCPro Revenue Cycle Institute and is the lead instructor for HCPro’s Medicare Boot Camp®–Hospital Version and instructor for Medicare Boot Camp®–Critical Access Hospital Version. She is a former hospital compliance officer and in-house legal counsel, and developed and implemented corporatewide hospital compliance programs. She has experience conducting billing, compliance audits, and internal investigations.
Exhibit A

Presentation by Kristen Geissler, MS, PT, CPHQ, MBA, and Kimberly Anderwood Hoy Baker, JD, CPC

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2014 IPPS Final Rule Explained

An HCPro audio conference presented on
September 10, 2013

Speakers

- **Kristen Geissler, MS, PT, CPHQ, MBA**
  - Director
  - Berkeley Research Group, LLC
  - Baltimore, Md.

- **Kimberly Anderwood Hoy Baker, JD, CPC**
  - Director of Medicare and Compliance
  - HCPro, Inc.
  - Danvers, Mass.
Agenda

- Quality of care
  - Readmission Reduction Program
  - Hospital-acquired conditions (HAC)
  - Inpatient Quality Reporting Program
  - Hospital Value-Based Purchasing Program
- MS-DRG changes
- Payment updates
  - Updated standardized amounts and other factors
  - New technology
- Inpatient status criteria
  - Inpatient physician order requirements
  - 2-midnight rule
  - Part B payment for inpatients (rebilling Part B)

Hospital Readmission Reduction Program (HRRP) – Updates

- Financial impact increases to 2% for FY14

- Measurement period for FY14
  - July 1, 2009 – June 30, 2012
HRRP – Planned Readmissions

- Planned readmissions will be excluded from all readmission diagnosis categories beginning with FY14
  - Uses AHRQ’s Clinical Classification Software (CCS) to categorize diagnoses and procedures
  - Type of planned admissions/readmissions
    - Specific, limited types of care that are always considered planned (OB delivery, transplant surgery, chemo, rehab)
    - Non-acute readmission for a scheduled procedure
  - Very small impact of removing planned readmissions
    - PN readmission rate ↓s by 0.7%
    - AMI readmission rate ↓s by 1%
    - HF readmission rate ↓s by 1.5%
  - If a planned readmission occurs within 30 days of discharge, any subsequent unplanned readmission will NOT count

HRRP – New Categories

- MedPAC had recommended:
  - CABG
    - CMS may address in the future
  - COPD
    - Added
  - PCI
    - Inpatient volumes decreasing
  - Other vascular
    - Inpatient volumes decreasing
HRRP – New Categories

- New readmission categories to begin in FY15
  - Acute exacerbation of COPD (AECOPD)
    - 4th most costly preventable readmission
    - Median readmission rate of 22%
    - Includes principal Dx of COPD as well as:
      - Principal Dx of respiratory failure and secondary Dx of AECOPD
      - NQF #1891
  - Elective total hip or total knee arthroplasty
    - THA/TKA combined account for largest procedure cost in Medicare budget
    - Median readmission rate of 5.7%
    - NQF endorsed (#1551) January 2012

Hospital-Acquired Condition (HAC) Program

- Deficit Reduction Act (DRA) HACs
  - Continue with same program that reduces individual DRG payment
- National coverage determination (NCD)
  - Continue with nonpayment for wrong-side, wrong-patient, wrong-site surgery
- IQR public reporting
  - Continue with AHRQ PSI Composite measure
- Value-based purchasing (VBP)
  - Continue with AHRQ PSI Composite measure
- New HAC reduction program
DRA HAC Program

- Original HAC program (reduction to individual DRG payment for hospital-acquired condition that increases severity)
  - No changes to codes or included HACs
  - Beginning January 1, 2011, hospitals were required to use 5010 electronic reporting
    - Allows 24 secondary conditions (previously only 8)

New HAC Reduction Program – FY2015

- Original HAC program will still exist
- New program will look at HAC rates, and worst-performing hospitals risk 1% of Medicare DRG revenue
- 10 measures across 2 domains

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Domain 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY15 and beyond</td>
<td>FY15 and beyond</td>
</tr>
<tr>
<td>PSI-90 – Patient Safety for Selected Indicators Composite</td>
<td>CLABSI</td>
</tr>
<tr>
<td>Pressure ulcer rate (PSI 3)</td>
<td>CAUTI</td>
</tr>
<tr>
<td>Iatrogenic pneumothorax rate (PSI 6)</td>
<td>Add in FY16</td>
</tr>
<tr>
<td>Central venous catheter–related bloodstream infection rate (PSI 7)</td>
<td>Surgical site infection (SSI) – colon surgery and abdominal hysterectomy</td>
</tr>
<tr>
<td>Postoperative hip fracture rate (PSI 8)</td>
<td>Add in FY17</td>
</tr>
<tr>
<td>Postop PE or DVT rate (PSI 12)</td>
<td>MRSA infection</td>
</tr>
<tr>
<td>Postoperative sepsis rate (PSI 13)</td>
<td>C. diff infection</td>
</tr>
<tr>
<td>Postoperative wound dehiscence rate (PSI 14)</td>
<td></td>
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<tr>
<td>Accidental puncture or laceration (PSI 15)</td>
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</tbody>
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New HAC Program – FY2015

- Measurement period – both domains will be 2-year periods
  - AHRQ measures – claims-based
    - July 1, 2011 – June 30, 2013
  - CDC measures – reported quarterly through NHSN
    - January 1, 2012 – December 31, 2013

- Weighting
  - Domain 1 – 35%
  - Domain 2 – 65%

New HAC Program – FY2015

- Methodology
  - AHRQ PSI-90 Composite
    - Risk-adjusted and reliability-adjusted rates
  - CDC measures
    - SIR (Standard Infection Ratio), which compares actual number of HAIs at a facility to a national baseline (observed-to-expected ratio)
New HAC Program – FY2015

- Scoring

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Measure</th>
<th>Type of measure</th>
<th>Individual measure score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>PSI-90</td>
<td>Weighted average of rates of component PSI indicators</td>
<td>1–10 based on national percentile ranking</td>
</tr>
<tr>
<td>Domain 2</td>
<td>CDC NHSN</td>
<td>Standard Infection Ratio (SIR)</td>
<td>Average of each SIR score of 1–10 based on national percentile ranking</td>
</tr>
</tbody>
</table>

- Total score will be ranked nationally
  - Hospitals scoring in the lowest quartile will lose 1% of base DRG revenue

Inpatient Quality Reporting (IQR) – Measures Removed

- 17 measures removed for FY15
  - Discussed last year
- 8 measures to be removed or suspended for FY16
  - AMI-2 – Aspirin at discharge
  - AMI-10 – Statin at discharge
  - HF-3 – ACEI/ARB for LVSD
  - SCIP-Inf-10 – Surgical perioperative temperature management
  - These 4 measures removed due to MAP recommendations and/or being topped out
IQR – Measures Removed

- 8 measures removed or suspended for FY16 (cont.)
  - PN-3b – Blood culture before 1st antibiotic
    - No longer NQF endorsed
    - Topped out
    - Lacks association between process of care and patient outcomes
  - HF-1 – Discharge instructions
    - No longer NQF endorsed
    - Weak correlation between this measure and outcomes
    - Challenges in validating efficacy of the information the patient receives

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IQR – Measures Removed

- 8 measures removed or suspended for FY16 (cont.)
  - Structural measure – Stroke registry
    - Removed because there is now a stroke measure set
  - IMM-1 – Pneumonia vaccination *(suspended)*
    - New guidelines released from ACIP
    - New measure will need to be developed
IQR – FY15 Measure Refinements

- Incorporation of planned readmissions
- CLABSI/CAUTI – inclusion of non-ICU – deferred until Jan. 1, 2015 data collection
- Refinement of SCIP-Inf-4 – Controlled 6 a.m. glucose in cardiac surgery
  - Changed to 18–24 hrs. postoperatively and a requirement for documentation of corrective action if postoperative glucose levels are greater than 180 mg/dl
- Refinement of Medicare Spending per Beneficiary
  - Inclusion of Railroad Retirement Board beneficiaries starting with FY16

IQR – New Measures for FY16

- 30-day COPD readmission
  - NQF #1891
- 30-day COPD mortality
  - NQF #1893
- 30-day stroke (ischemic) readmission
  - Non-NQF
- 30-day stroke (ischemic) mortality
  - Non-NQF
- AMI payment per episode (30 days after index admission)
  - Non-NQF
Value-Based Purchasing (VBP)

- Financial impact increases to 1.25% for FY14
  - And 0.25% points per year thereafter
- Final financial impact will be published after final rule
  - Current proxy financial impacts published use FY13 Total Performance Scores (TPS)

VBP – New Measures

- Already finalized for FY15
  - CLABSI
  - AHRQ PSI Composite
  - Medicare Spending per Beneficiary (MSPB)
- New measures for FY16
  - IMM-2 (NQF #1659)
  - CAUTI (NQF #0138)
  - SSI – colon surgery (NQF #0753)
    - 2 strata
  - These new measures included in IQR FY14
    - Posted in December 2012
    - Data collection began in January 2012
VBP – Removed Measures

- Measures to be removed for FY16
  - AMI-8a – PCI within 90 minutes
  - SCIP-Inf-1a – Prophylactic antibiotic before incision
    - Both topped off
  - PN-3b – Blood cultures before antibiotics
  - HF-1 – Discharge instructions
    - Both no longer NQF endorsed

VBP – Performance Periods

<table>
<thead>
<tr>
<th>FY16 VBP</th>
<th>Performance Period</th>
<th>Baseline Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical process</td>
<td>CY14</td>
<td>CY12</td>
</tr>
<tr>
<td>HCAHPS</td>
<td>CY14</td>
<td>CY12</td>
</tr>
<tr>
<td>Efficiency</td>
<td>CY14</td>
<td>CY12</td>
</tr>
</tbody>
</table>
VBP Domain Weights

Maryland Hospitals

- Maryland no longer exempt from reporting POA indicators to Medicare
- Maryland hospitals are exempt from the following for FY14:
  - VBP
  - HRRP
- Maryland hospitals must apply annually for exemption from each program (VBP, HRRP, HAC)
Misc

- ICD-10 crosswalk in the measure specs in July 2013 release
- HAC list is available with ICD-10 translation tables

Payment Updates

Overall 0.7% increase to IPPS operating rates

Summary

+2.5 – market basket increase
-0.8 – Documentation and coding recoupment
-0.5 – ACA multifactor productivity reduction
-0.3 – ACA required adjustment
-0.2 – Increased admission under new criteria

Total  +0.7
Payment Updates

Overall 0.7% increase to IPPS operating rates

Factors affecting increase:

• Market basket update of plus 2.5%
  – Base year was adjusted from 2006 to 2010
  – Labor share for hospitals with wage index > 1 was increased from 68.8 to 69.6
    • This increases the positive impact of a high wage index by allowing the wage index to affect a higher portion of the standardized amount
  – Labor share was not adjusted for hospitals with wage index ≤ 1

Payment Updates

Overall 0.7% increase to IPPS operating rates

Factors affecting increase:

• Required 0.8% reduction to recoup “overpayments”
  – Recoups estimated $11 billion in increased payments from 2008 to 2013 due to the implementation of the MS-DRG system
  – Will apply in 2015, 2016, and 2017, then positive adjustment in 2018 to offset it
  – Did not make other “documentation and coding adjustments” this year
Payment Updates

Overall 0.7% increase to IPPS operating rates

Factors affecting increase:

- Required 0.3% reduction per ACA
- Required 0.5% multifactor productivity reduction (required under ACA)
- Reduction of 0.2% to balance anticipated increase in inpatient expenditures due to change in inpatient criteria (i.e., the 2-midnight rule)

Payment Updates: Cost Center CCRs

- CMS is increasing the number of cost center CCRs used for rate setting calculations from 15 to 19
- Adding:
  - Implantable devices: CCR = .361 (supplies .327 without this change, .293 with this change)
  - Cardiac catheterization: CCR = .135 (cardiology .134 without this change, .132 with this change)
  - MRI: CCR = .091 (radiology .128 without this change, .170 with this change)
  - CT scan: CCR = .045 (radiology .128 without this change, .170 with this change)
Payment Updates: Cost Center CCRs

- The effect of separating out costs in these cost centers ranged from:
  - -7.9% change to payment rate for Concussion w/o CC/MCC
  - +6.7% change to payment rate for Cardiac Defibrillator Implant without Cardiac Catheterization without MCC
- See page 50519 for table of most impacted DRGs

Payment Updates: GME

GME – maternity beds included as inpatient days
- Patients who are admitted as inpatients and receiving labor and delivery services at midnight census will be considered inpatients for GME
- Policy matches DSH policy
- Reduces GME payments because increases number of inpatient days, but generally will not increase the number of Medicare days (in calculating the Medicare portion)
Payment Updates: DSH

Disproportionate Share Hospital adjustment

- ACA changed payment, but not qualifying criteria
- 2014 DSH payment:
  - 25% of payment based on old calculation PLUS
  - Additional payment made up of three factors
    - CMS’ estimate of 75% of estimated DSH payments for 2014
    - Adjusted by 94.3% for changes in uninsured and underinsured patients, and
    - The hospital’s % of uncompensated care compared to uncompensated care for all DSH hospitals

Payment Updates: DSH

Disproportionate Share Hospital adjustment

- In FY2005 final rule, CMS adopted a policy of including Medicare Advantage plan days in the calculation for the disproportionate patient percentage for qualifying for DSH
  - 2012 court case (*Allina Health Services v. Sebelius*) ruled that interested parties were not put on notice and given an opportunity to comment
  - CMS is readopting after notice
Policy Update: Under Arrangements

- FY2012 CMS adopted a policy allowing only diagnostic and therapeutic services to be provided under arrangements
  - Routine services could no longer be provided under arrangement and had to be provided by the hospital where the patient is admitted
- FY2013 Final Rule extended effective date to October 1, 2013
- FY2014 Final Rule extended the effective date to January 1, 2015

Payment Updates: New Technology

New technology
- CMS retained add-on payment for 3 prior new technologies
  - Voraxaze®
  - DeficidTM
  - Zenith® Fenestrated Graft
- CMS adopted add-on payment for 3 additional new technologies
  - KcentraTM
  - Argus® II System
  - Zilver® PTX® Drug Eluting Peripheral Stent
Payment Updates: New Technology

- Voraxaze®
  - Used in the treatment of methotrexate toxicity
  - Identified by ICD-9-CM procedure code 00.95
  - Add-on payment cap $45,000 (1/2 the cost of the drug)

Payment Updates: New Technology

- DEFICID™
  - Used in the treatment of patients with C. difficile
  - Identified by ICD-9-CM diagnosis code 008.45 and National Drug Code 52015-0080-01
  - Add-on payment cap $868 (1/2 the cost of the drug)
Payment Updates: New Technology

- Zenith® Fenestrated Abdominal Aortic Aneurysm (AAA) Endovascular Graft
  - Used in the treatment of patients with an AAA that require renal alignment stents
  - Identified by ICD-9-CM procedure code 39.78
  - Add-on payment cap $8,171.50 (1/2 the cost of the device)

Payment Updates: New Technology

- Kcentra™
  - Used in the treatment of patients with acquired coagulation factor deficiency due to warfarin and who are experiencing a severe bleed; replacement therapy for fresh frozen plasma (FFP)
  - Identified by ICD-9-CM procedure code 00.96
  - Add-on payment is not available if the drug is administered to a patient with hemophilia
  - Add-on payment cap $1,587.50 (1/2 the cost of the drug)
Payment Updates: New Technology

- **Argus® II Retinal Prosthesis System**
  - Used in the treatment of patients who are profoundly blind due to retinitis pigmentosa by providing electrical stimulation to the retina to induce visual perception
  - Identified by ICD-9-CM procedure code 14.81
  - Add-on payment cap $72,028.75 (1/2 the cost of the device)

Payment Updates: New Technology

- **Zilver® PTX® Drug Eluting Peripheral Stent**
  - Used in the treatment of patients with peripheral artery disease (PAD) of the above the knee femoropopliteal arteries
  - Identified by ICD-9-CM procedure code 00.60
  - Add-on payment cap $1,705.25 (1/2 the cost of the device)
MS-DRG Updates

MS-DRG revision NOT adopted:

- Request to eliminate severity levels for heart and liver transplants
  - CMS did not agree that all transplant patients are equally complex and costly and maintained w/ & w/o MCC designation

MS-DRG revisions NOT adopted, modified:

- Request to move V45.88 status post administration of tPA from stroke and cerebral infarction DRGs to DRGs for stroke with thrombolytic agent
  - CMS did not agree costs for a hospital receiving a patient who had tPA administered were the same as the hospital who administered the tPA
  - CMS did move V45.88 from DRG 066 to higher weighted DRG 065 and renamed DRG 065 “Intracranial Hemorrhage or Cerebral Infarction with CC or tPA in 24 Hours”
MS-DRG Updates

MS-DRG revisions NOT adopted:

• Request to move endoscopic insertion of bronchial valve, single or multiple lobes from DRG for COPD to DRG for Major Chest Procedures
  – Note: This procedure involves the Spiration IBV Valve System that was formerly designated a new technology in FY2010 and FY2011
  – CMS declined to move this procedure because they consider it a non-operative procedure

MS-DRG Updates

MS-DRG revisions NOT adopted:

• Request for new DRGs for Pulmonary Thromboendarterectomy (PTE) with Full Cardiac Arrest and Hypothermia or reclassify the procedure to higher weighted DRGs
  – CMS declined to create new DRGs or reassign these procedures to a new DRG due to the low volume of cases and based on the advice of their clinical advisors
**MS-DRG Updates**

MS-DRG revisions NOT adopted:

- Request to move reverse total shoulder procedures to a higher weighted DRG or create a new DRG
  - CMS did not agree that reverse total shoulder should be moved from DRGs 483/484 “Major Joint/Limb Reattachment Procedure of Upper Extremities with CC/MCC or without CC/MCC”

- Request to move total ankle procedures to a higher weighted DRG or create a new DRG
  - CMS did not agree that total ankle procedures should be moved from DRGs 469/470 “Major Joint Replacement or Reattachment Procedure of Lower Extremities with MCC or MCC”
MS-DRG Updates

MS-DRG revisions PARTIALLY adopted:

• Moved certain V-codes for vaccinations and other procedures not carried out as planned from DRG 794 “Neonate with Other Significant Problems” to DRG 795 “Normal Newborn”
  - CMS moved V64.00–V64.04, V64.06–V64.3, but did not move V64.41–V64.43 for scope procedures converted to open procedures because they could indicate a significant problem

MS-DRG Updates: Discharge Status

Changes related to discharge status codes

• 16 new discharge status codes were added to grouper logic for DRG 280–282: Acute MI discharged alive, with MCC, with CC, without CC/MCC
  - Code 69 discharged/transferred to a designated disaster alternative care site
  - Codes 81–95 corresponding to current discharge status codes but with a planned acute care hospital inpatient readmission
    - E.g., 1: Discharged to home or self-care; 81: Discharged to home or self-care with a planned acute care hospital inpatient readmission
    - See the full list on page 50533 of the Final Rule
MS-DRG Updates: Discharge Status

Changes related to discharge status codes

• 3 of the new discharge status codes were added to grouper logic for DRG 789 – Neonates, died or transferred to another acute care facility
  
  – Code 82: Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
  
  – Code 85: Discharged/transferred to a designated cancer center or children’s hospital with a planned acute care hospital inpatient readmission
  
  – Code 94: Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission

Medicare Code Editor Update

• CMS removed the following codes from the list of pediatric codes because patients could have revision procedures as adults
  
  – 751.1 Atresia and stenosis of the small intestine
  
  – 751.2 Atresia and stenosis of large intestine, rectum, and anal canal
  
  – 751.61 Biliary atresia
CC and MCC Updates

CC/MCC revisions NOT adopted:

• Request to make Coronary atherosclerosis due to calcified coronary lesion (414.4) an MCC rather than a non-CC
  – CMS declined to move the diagnosis based on claims data showing the patient is not more expensive to treat

CC and MCC Updates

CC/MCC revisions adopted:

• Request to add 575.0 Acute cholecystitis to the CC exclusion list for 574.00 Calculus of gall bladder with acute cholecystitis without mention of obstruction
  – CMS added 575.0 to the CC exclusion list for 574.00, meaning that 575.0 will not be treated as a CC when reported with 574.00 because they represent the same clinical circumstances
CC and MCC Updates

CC/MCC revisions PARTIALLY adopted:

- Request to remove 440.4 Chronic total occlusion of artery of the extremities from CC exclusion list for specific vascular-related diagnoses
  - CMS removed from the CC exclusion list for all proposed diagnoses (see full list on page 50542 of the Final Rule) except peripheral angioplasty and peripheral vascular disease

Policy Update: Inpatient Orders and Certification

Physician orders for inpatient services

- New language at § 412.3 specifies a patient becomes an inpatient when admitted pursuant to a physician order
  - Order must be at or before the time of admission
  - Order must include the word “inpatient”
    - “admit”, “admit to 4th floor” does not suffice
  - Order is first element of “certification”
Policy Update: Inpatient Orders and Certification

Physician orders for inpatient services

- Order for admission must be furnished by a “qualified and licensed practitioner” who:
  - Has admitting privileges at the hospital
  - Is knowledgeable about the patient’s hospital course, medical plan of care, and current condition

Policy Update: Inpatient Orders and Certification

Physician certification for inpatient admission

- Certification components
  1. Service “provided in accordance” with new order requirements and 2-midnight criteria
  2. The reason for
     - Hospitalization OR
     - Special or unusual circumstances if cost outlier certification
Policy Update: Inpatient Orders and Certification

Physician certification for inpatient admission

- Certification components
  3. The estimated time the patient will remain in the hospital
  4. Plans for post-hospital care, if appropriate
- Certification by:
  - Attending physician OR
  - Physician knowledgeable about the case and authorized by the attending or the hospital’s medical staff

Policy Update: Inpatient Orders and Certification

Physician certification for inpatient admission

- Timing of certification
  - For all inpatient admissions completed, signed, and in medical record prior to discharge
  - Cost outliers subject to PPS, no later than date outlier payment is requested or 20 days into the hospital stay
    - Subsequent recertifications as required by the UR committee by policy or on a case-by-case basis
  - Outliers not subject to PPS [§424.13(e)] and psychiatric facilities [§424.14] have separate requirements
Policy Update: 2-Midnight Criteria

2-midnight benchmark

- Physician reasonably expects the patient to require a stay that crosses at least two midnights
  - Physician may consider time the patient spent receiving outpatient care
- §412.3(e): “generally appropriate for inpatient admission and inpatient hospital payment under Medicare Part A”

Policy Update: 2-Midnight Criteria

2-midnight benchmark

- Admission no longer based on level of care, but rather length of time:
  - Physicians should provide “any medically necessary services in an inpatient status whenever the benchmark is met and in all other instances providing identical services to patients staying at the hospital in a day or overnight outpatient status”
- Documentation that demonstrates reasonable expectation of two midnights
  - History, comorbidities, severity of signs and symptoms, current medical needs, and risk of adverse outcome as documented in the medical record
Policy Update: 2-Midnight Criteria

2-midnight presumption

- Applies if patient stay was at least two midnights after formal inpatient admission
  - Presumption does not include outpatient time
- Review contractors will presume the case is appropriate for inpatient admission and payment under Part A
  - Unless there is evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the presumption

Policy Update: 2-Midnight Criteria

How do medical review contractors apply the benchmark and presumption?

- Patient stays one night in the hospital
  - Medical review contractor applies 2-midnight benchmark — i.e., was the expectation of two midnights reasonable — including outpatient time
- Patient stays two nights in the hospital
  - Medical review contractor applies 2-midnight presumption and case is not reviewed unless hospital shows evidence of systematic abuse, gaming, or delays in care
Policy Update: 2-Midnight Criteria

When does the 2-midnight benchmark and 2-midnight presumption not apply?

- Inpatient-only procedures (as designated under OPPS)
- Unforeseen circumstances: Death or transfer are only two circumstances listed by CMS
  - AMA? Transfers in?
- Non-medically necessary time in the hospital for “social reasons” and patient convenience
- Inpatient rehabilitation facilities

Policy Update: Part B Inpatient Billing

Part B inpatient billing (TOB 012X) is different based on reason for no Part A payment:

- If no Part A payment due to exhaustion of benefits, no Part A eligibility, non-Part A service
  - Limited service billable (see prior guidance in Medicare Claims Processing Manual for allowable revenue codes)
- If no Part A payment because inpatient admission was not reasonable and necessary, but medical care was reasonable and necessary as outpatient – *only situation addressed by new rules*
  - Full scope of Part B payable services are billable as discussed later
Policy Update: Part B Inpatient Billing

Part B inpatient billing (TOB 12X)
- Two separate/related Part B inpatient billing rules:
  - CMS Ruling 1455-R (The Ruling)
    - Applies to services provided prior to October 1, 2013, regardless of when denial is made
    - Applies only to service denied by a contractor
    - 180 days to file claim after denial or final adjudication
  - CMS-1455-F (The Final Rule)
    - Applies to services provided on or after October 1, 2013
    - Applies to services denied by a contractor and to services self-denied through “self-audit” by the hospital
    - Must file claim within timely filing

Note on provider “self-audit” denials
- Applies to determinations after discharge and results in billing Part B inpatient
  - Prior to discharge condition code 44 (Part B outpatient)
- Must be pursuant to UR committee review under CoP 482.30(d)
  - Must consult attending and offer “opportunity to present their views”
  - 1 member if attending agrees/fails to present views, 2 members in other cases
  - Written notice must be given within 2 days to hospital/patient/attending
Policy Update: Part B Inpatient Billing

- Why 1 year timely filing for DOS on or after 10/1/13:
  - “We expect the majority of such improper payments to be resolved with the implementation of the 2-midnight instruction”
  - “…the likelihood that hospitals or physicians will have a different understanding than Medicare’s medical review contractors of what constitutes an appropriate inpatient stay will be significantly reduced as a result of these revised guidelines”

In other words

- CMS views new criteria effective 10/1/13 as so clear hospitals should get it right the first time

OR

- Determine within one year the proper status and bill accordingly
Part B Inpatient Billing: Applicability

- The Final Rule* applies to all types of hospitals including:
  - IPPS hospitals
  - Hospitals paid under OPPS, including cancer and children’s
  - LTCHs
  - IPFs
  - IRFs
  - CAHs
  - Maryland Waiver hospitals
  - Outpatient low-volume hospitals, excluded from OPPS

*The Ruling is not limited to IPPS hospitals and presumably also applies to these hospitals

Policy Update: Part B Inpatient Billing

Services payable on Part B Inpatient claim (12X) under The Ruling and The Final Rule:

- Services payable under the Outpatient Prospective Payment System (OPPS)
  - Except visits, observation, diabetes self-management
  - Unclear if policy of billing monitoring and nursing care on revenue code 0762 without HCPCS code applies?

- Physical therapy, speech-language pathology, occupational therapy (payable on Medicare Physician Fee Schedule (MPFS))
  - Therapy billed on Part B Inpatient claim is included in therapy caps and manual review threshold
Policy Update: Part B Inpatient Billing

Services payable on Part B Inpatient claim (12X) under The Ruling and The Final Rule (cont.):

- Ambulance services (payable on ambulance fee schedule)
- Specified durable medical equipment (DME) (payable on the DME fee schedule)
- Clinical diagnostic laboratory services (payable on clinical lab fee schedule)
- Screening and diagnostic mammograms (payable on the MPFS)
- Annual wellness visit (payable on the MPFS)

Policy Update: Part B Inpatient Billing

Claims and bill types (The Ruling and The Final Rule)

- Provider liable claim 110 (original or adjusted)
  - Must post in claims history before 12X will process
  - If appeal – must request dismissal
  - Can not maintain Part A and Part B claims simultaneously
- Part B Inpatient claim 12X
  - For all services after the inpatient order
- Part B Outpatient claim 13X
  - For all services before the inpatient order (new section 414.5(b))
Guidance Still Expected

- Offsetting inpatient coinsurance and outpatient coinsurance
- Continued use of condition code W2
- New information to beneficiaries
  - Medicare & You
  - Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!
  - New Medicare Summary Notice messages

Issues Related to Beneficiaries

- Beneficiary appeal stops the provider from billing Inpatient Part B until the appeal is resolved
- Beneficiary copay and self-administered drug concerns may be alleviated by proposed Comprehensive APCs in 2014 OPP Proposed Rule
- Part B inpatient days not counted against beneficiary utilization
Issues Related to Beneficiaries

- Days billed under Part B inpatient may count as SNF inpatient days for 3-day qualifying stay
  - “Thus, a beneficiary’s SNF coverage is not necessarily invalidated by a retroactive denial of the qualifying hospital stay…”
  - “Accordingly, the denial of the hospital stay itself would affect coverage of the related SNF stay only in those instances where it is further determined that ‘hospitalization for 3 days represents a substantial departure from normal medical practice.’ ”

- Not reasonable and necessary as hospital Part A inpatient services – but can be used as inpatient services for purposes of qualifying for SNF coverage?!

Questions?

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Thank you

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Exhibit B

List of useful industry acronyms

Source: HCPro, Inc.
### HIM Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AAPC</td>
<td>American Academy of Professional Coders</td>
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<tr>
<td>ABN</td>
<td>Advance beneficiary notice</td>
</tr>
<tr>
<td>ACDIS</td>
<td>Association of Clinical Documentation Improvement Specialists</td>
</tr>
<tr>
<td>ADR</td>
<td>Additional documentation request</td>
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<tr>
<td>AHA</td>
<td>American Hospital Association</td>
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<tr>
<td>AHIMA</td>
<td>American Health Information Management Association</td>
</tr>
<tr>
<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>AOA</td>
<td>American Osteopathic Association</td>
</tr>
<tr>
<td>APCs</td>
<td>Ambulatory payment classifications</td>
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<tr>
<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory surgery center</td>
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<tr>
<td>ASP</td>
<td>Average sales price</td>
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<tr>
<td>AWP</td>
<td>Average wholesale price</td>
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<tr>
<td>CAH</td>
<td>Critical access hospital</td>
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<tr>
<td>CC</td>
<td>Complication and comorbidity</td>
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<tr>
<td>CCHIT</td>
<td>Certification Commission for Health Information Technology</td>
</tr>
<tr>
<td>CCR</td>
<td>Continuity of care record/Cost-to-charge ratio</td>
</tr>
<tr>
<td>CDI</td>
<td>Clinical documentation improvement</td>
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<tr>
<td>CDM</td>
<td>Charge description master</td>
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<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
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<td>CPI</td>
<td>Consumer price index</td>
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<tr>
<td>CMI</td>
<td>Case-mix index</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CMSA</td>
<td>Consolidated Metropolitan Statistical Area</td>
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<tr>
<td>CPI</td>
<td>Consumer price index</td>
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<td>CPT</td>
<td>Current procedural terminology</td>
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<tr>
<td>CRNA</td>
<td>Certified registered nurse anesthetist</td>
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<tr>
<td>CT</td>
<td>Computed tomography</td>
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<tr>
<td>CY</td>
<td>Calendar year</td>
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<tr>
<td>DED</td>
<td>Dedicated emergency department</td>
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<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
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<tr>
<td>DSH</td>
<td>Disproportionate share hospital</td>
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<tr>
<td>ED</td>
<td>Emergency department</td>
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<td>EDMS</td>
<td>Electronic Document Management System</td>
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<td>EHR</td>
<td>Electronic health records</td>
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<tr>
<td>E/M</td>
<td>Evaluation and management</td>
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<tr>
<td>EMR</td>
<td>Electronic medical records</td>
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<tr>
<td>EOB</td>
<td>Explanation of benefits</td>
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<tr>
<td>ePHI</td>
<td>Electronic protected health information</td>
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<tr>
<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
</tr>
<tr>
<td>FFY</td>
<td>Federal fiscal year</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal intermediary</td>
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## HIM Acronyms to Know

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<tr>
<td>FY</td>
<td>Fiscal year</td>
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<tr>
<td>GAF</td>
<td>Geographic adjustment factor</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate medical education</td>
</tr>
<tr>
<td>H&amp;P</td>
<td>History and physical</td>
</tr>
<tr>
<td>HAC</td>
<td>Hospital-acquired condition</td>
</tr>
<tr>
<td>HCCCA</td>
<td>Health Care Compliance Association</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HCRIS</td>
<td>Hospital Cost Report Information System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home health agency</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
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<tr>
<td>HIC</td>
<td>Health insurance card</td>
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<tr>
<td>HIMSS</td>
<td>Healthcare Information and Management Systems Society</td>
</tr>
<tr>
<td>HINN</td>
<td>Hospital-Issued Notice of Non-Coverage</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HIS</td>
<td>Health information system/services</td>
</tr>
<tr>
<td>HIT</td>
<td>Healthcare information technology</td>
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<tr>
<td>HITECH Act</td>
<td>Health Information Technology for Economic and Clinical Health Act</td>
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<tr>
<td>HMO</td>
<td>Health maintenance organization</td>
</tr>
<tr>
<td>HSA</td>
<td>Health savings account</td>
</tr>
<tr>
<td>HSRVcc</td>
<td>Hospital-specific relative value cost center</td>
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<tr>
<td>HQA</td>
<td>Hospital Quality Alliance</td>
</tr>
<tr>
<td>HQI</td>
<td>Hospital quality initiative</td>
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<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, 9th Revision, Clinical Modifications</td>
</tr>
<tr>
<td>ICD-10-PCS</td>
<td>International Classification of Diseases, 10th Revision, Procedure Coding System</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>IPF</td>
<td>Inpatient psychiatric facility</td>
</tr>
<tr>
<td>IPPS</td>
<td>Inpatient prospective payment system</td>
</tr>
<tr>
<td>IRF</td>
<td>Inpatient rehabilitation facility</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
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<tr>
<td>LCD</td>
<td>Local coverage determination</td>
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<tr>
<td>LTC-DRG</td>
<td>Long-term care diagnosis-related group</td>
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<tr>
<td>LTCH</td>
<td>Long-term care hospital</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractors</td>
</tr>
<tr>
<td>MCC</td>
<td>Major complication and comorbidity</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed care organization</td>
</tr>
<tr>
<td>MCV</td>
<td>Major cardiovascular</td>
</tr>
<tr>
<td>MDC</td>
<td>Major diagnostic category</td>
</tr>
<tr>
<td>MDH</td>
<td>Medicare dependent hospital (small rural)</td>
</tr>
<tr>
<td>MedPAC</td>
<td>Medicare Payment Advisory Commission</td>
</tr>
<tr>
<td>MedPAR</td>
<td>Medicare Provider Analysis and Review</td>
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</table>
### HIM Acronyms to Know

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>MIC</td>
<td>Medicaid Integrity Contractors</td>
</tr>
<tr>
<td>MRHFP</td>
<td>Medicare Rural Hospital Flexibility Program</td>
</tr>
<tr>
<td>MS-DRG</td>
<td>Medicare Severity DRG</td>
</tr>
<tr>
<td>NAHIT</td>
<td>National Alliance for Health Information Technology</td>
</tr>
<tr>
<td>NCIC</td>
<td>National Correct Coding Initiative</td>
</tr>
<tr>
<td>NCD</td>
<td>National coverage determination</td>
</tr>
<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NCVHS</td>
<td>National Committee on Vital and Health Statistics</td>
</tr>
<tr>
<td>NHIN</td>
<td>National Health Information Network</td>
</tr>
<tr>
<td>NICU</td>
<td>Neonatal intensive care unit</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NQF</td>
<td>National Quality Forum</td>
</tr>
<tr>
<td>NVHRI</td>
<td>National Voluntary Hospital Reporting Initiative</td>
</tr>
<tr>
<td>OCE</td>
<td>Outpatient code editor</td>
</tr>
<tr>
<td>OCR</td>
<td>Office for Civil Rights</td>
</tr>
<tr>
<td>OES</td>
<td>Occupational employment statistics</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>OMB</td>
<td>Office of Management and Budget</td>
</tr>
<tr>
<td>OPPS</td>
<td>Outpatient prospective payment system</td>
</tr>
<tr>
<td>OR</td>
<td>Operating room</td>
</tr>
<tr>
<td>OSCAR</td>
<td>Online Survey Certification and Reporting (System)</td>
</tr>
<tr>
<td>PHR</td>
<td>Personal health record</td>
</tr>
<tr>
<td>PO</td>
<td>By mouth</td>
</tr>
<tr>
<td>POA</td>
<td>Present on admission</td>
</tr>
<tr>
<td>PPI</td>
<td>Producer price index</td>
</tr>
<tr>
<td>PPS</td>
<td>Prospective payment system</td>
</tr>
<tr>
<td>PRA</td>
<td>Per resident amount</td>
</tr>
<tr>
<td>PRM</td>
<td>Provider Reimbursement Manual</td>
</tr>
<tr>
<td>PRRB</td>
<td>Provider Reimbursement Review Board</td>
</tr>
<tr>
<td>PS&amp;R</td>
<td>Provider Statistical and Reimbursement (System)</td>
</tr>
<tr>
<td>QIO</td>
<td>Quality Improvement Organization</td>
</tr>
<tr>
<td>RA</td>
<td>Remittance advice</td>
</tr>
<tr>
<td>RAC</td>
<td>Recovery Audit Contractor</td>
</tr>
<tr>
<td>RBC</td>
<td>Red blood cell</td>
</tr>
<tr>
<td>RC</td>
<td>Revenue code</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural health clinic</td>
</tr>
<tr>
<td>RHIO</td>
<td>Regional health information organization</td>
</tr>
<tr>
<td>ROI</td>
<td>Release of information (OR return on investment)</td>
</tr>
<tr>
<td>RY</td>
<td>Rate year</td>
</tr>
<tr>
<td>SAF</td>
<td>Standard analytic file</td>
</tr>
<tr>
<td>SCH</td>
<td>Sole community hospital</td>
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### HIM Acronyms to Know

<table>
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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
</tr>
<tr>
<td>SOCs</td>
<td>Standard occupational classifications</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>ST</td>
<td>Status indicator</td>
</tr>
<tr>
<td>TAG</td>
<td>Technical Advisory Group</td>
</tr>
<tr>
<td>UHDDS</td>
<td>Uniform Hospital Discharge Data Set</td>
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<tr>
<td>WBC</td>
<td>White blood cell</td>
</tr>
<tr>
<td>ZPIC</td>
<td>Zone Program Integrity Contractor</td>
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</tbody>
</table>
Resources
FROM OUR TEAM TO YOURS

THANKS FOR BEING AN INTEGRAL PART OF TODAY'S AUDIO CONFERENCE. PARTICIPATION, QUESTIONS, AND FOLLOW-UP COMMENTS FROM YOU AND YOUR PEERS HELP HCPro CONTINUE TO DEVELOP QUALITY AUDIO CONFERENCE PROGRAMS YOU CAN USE TO TRAIN STAFF, IMPROVE INTERNAL PROCESSES, AND MEET REGULATORY DEMANDS.

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<tr>
<td>Sales tax (see below)**</td>
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<td>Grand total</td>
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<tr>
<td>Grand total</td>
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