2026 Medicare Update

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Inpatient Only List Demise

Applicable to Medicare and Medicare Advantage

285 procedures removed but 1,437 procedures still remain on list
- need the CPT code from the surgeon!

Get the inpatient order before surgery
- Ensures right status
- Starts the SNF clock ticking if needed

Miss the Inpatient Order?

3 day payment window applies

MBPM Ch 1, section 10.2 – “intent to admit” allowed rarely
- reserve for inpatient only surgeries discharged as outpatient

What Should You Be Doing?

Don't forget documentation of medical necessity
Determine if prior authorization needed – WISeR, Outpt prior auth

If inpatient only, admit as inpatient
Discharge when stable
MCPM, Ch 3, section 40.2.2.K – add room charge

Not Inpatient Only

Is it worth the effort? Know your numbers – ask your finance team

Find out inpatient v outpatient payment

Crucial with MA plans – if paid % of charges for outpatient, may exceed inpatient "DRG" – then "settle for outpatient auth"

Example

Total Joint Arthroplasty – DRG 470

	Community Hospital	Teaching Hospital
Inpatient	$18,169	$33,530
Outpatient	$16,026	$18,781

Apply the Two Midnight Rule

What is the expected length of stay for the patient?

- What's the standard of care for post-op care?
- Any special factors that might extend LOS?
  - comorbid conditions that need longer care
    - COPD, HF, ESRD that will "exacerbate" and warrant days to monitor/treat
  - surgical/medical interactions
    - spine surgery on DOAC, needs to watch for bleeding

Need a SNF?

Medicare Advantage – doesn't matter – no 3 day SNF rule (now)

Medicare – if legitimate reason for SNF, admit as inpatient, document! "lives alone" "bathroom on 2nd floor" "wife frail"

CMS says "we would expect that those Medicare beneficiaries identified as appropriate candidates to receive a surgical procedure in the outpatient setting would not be expected to require SNF care following surgery."
90 FR 53786

By The Way…

What is a SNF?

By The Way…

Skilled wing = SNF

Long term care wing = NF

Who Can Get SNF Covered by Payer?

- The patient requires skilled nursing services or skilled rehabilitation the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services
- The patient requires these skilled services on a daily basis
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury

"Only in a SNF…"

As a "practical matter," daily skilled services can be provided only in a SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

The availability of capable and willing family or the feasibility of obtaining other assistance for the patient at home should be considered.

Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be *ineffective* because the patient would have insufficient assistance at home to reside there safely.

MBPM Ch 6

Back to Non-IOL Surgery
Apply the Case-by-Case Exception

Step 6 - Does the medical record support the admitting physician's determination that the patient required inpatient care **despite an expected length of stay that is less than 2 midnights** based on complex medical factors, such as:

- Patient history and comorbidities and current medical needs
- Severity of Signs and Symptoms, and
- Risk of an Adverse Event

https://www.cms.gov/files/document/r13409pi.pdf

What Does that Mean?

Plan is for surgery and extended recovery overnight then home

Patient has comorbidities that raise perioperative risk

or

Surgery will be technically more difficult than "usual" surgery

Both require

- documentation of increased risk
- admission order placed prior to surgery

Examples

"Due to COPD, CHF, DM, this patient is at high risk for surgery and warrants inpatient."

"Due to significant adhesions from multiple previous surgeries, this laparoscopic cholecystectomy will be complex and warrants inpatient"

There must be clinical validity to this determination

- No presumptive weight to physician statements

And Don't Forget

Surgery as outpatient

Patient requires a second midnight for necessary care

Admit as inpatient

Be sure documentation supports that second midnight

Every Day in Every Hospital

Patient seen in ED
Hospitalist called to admit patient
Hospitalist calls consultants
Patient gets better
Patient goes home
Patient told to make appt with consultants

Then This Happens

Patient gets home
Patient calls consultant offices
Patient told consultants not in their insurance network so no appts
Patient returns to ED when condition recurs
Patient readmitted
Hospital penalized for readmission

Care Coordination – Now It's Money At Stake

Effective January 1, 2026, participating facilities that continue to use nonparticipating care providers who do not have a contract with Anthem and provide services to our members in an inpatient or outpatient facility setting may be subject to corrective measures, which can include:

- An administrative penalty equal to 10% of the allowed amount of the facility's claims that involve the use of nonparticipating care providers.
- Potential termination from Anthem's networks.

https://files.providernews.anthem.com/6740/MULTI-BCBS-CM-093315-25-Nonpar-provider-policy_FINAL.pdf

What Should Be Done?

Patient-centered care would be to use doctors in the patient's insurer's network
- referrals from the ED
- consultants in the hospital
- referrals at discharge

But whose responsibility is it to do this?

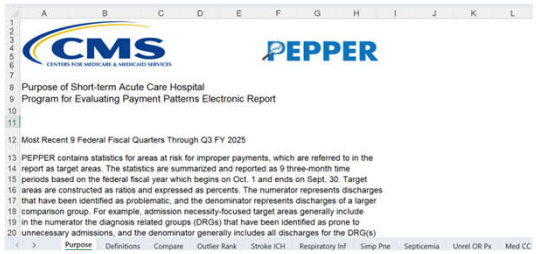
We will soon find out…

The PEPPER is Back!

Reminder – R in PEPPER is "Report"

Placed on hiatus in 2023 for improvement
- user feedback solicited
- contract put out for bids

New PEPPER finally returned December, 2025



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

PEPPER

Purpose of Short-term Acute Care Hospital
Program for Evaluating Payment Patterns Electronic Report

Most Recent 9 Federal Fiscal Quarters Through Q3 FY 2025

PEPPER contains statistics for areas at risk for improper payments, which are referred to in the report as target areas. The statistics are summarized and reported as 9 three-month time periods based on the federal fiscal year which begins on Oct. 1 and ends on Sept. 30. Target areas are constructed as ratios and expressed as percents. The numerator represents discharges that have been identified as problematic, and the denominator represents discharges of a larger comparison group. For example, admission necessity-focused target areas generally include in the numerator the diagnosis related groups (DRGs) that have been identified as prone to unnecessary admissions, and the denominator generally includes all discharges for the DRG(s)

Purpose | Definitions | Compare | Outlier Rank | Stroke ICH | Respiratory Inf | Simp Pne | Septicemia | Unrel OR Px | Med CC

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All the Categories

Stroke Intracranial Hemorrhage
Respiratory Infections
Simple Pneumonia
Septicemia
Unrelated OR Procedure
Medical DRGs with CC or MCC
Surgical DRGs with CC or MCC
Single CC or MCC
Ventilator Support
Severe Malnutrition
COPD
Percutaneous Cardiovascular Proced
Total Knee Replacement
Syncope
Other Circulatory System Diagnoses
Other Digestive System Diagnoses
Medical Back Problems
Spinal Fusion
3-Day SNF-Qualifying Admissions
30-Day Readm to Same or Elsewhere
30-Day Readm to Same Hospital
2DS Medical DRGs
2DS Surgical DRGs
1DS Medical DRGs
1DS Surgical DRGs

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Lots of Data

Short-term Acute Care Hospital PEPPER
Medical DRGs with CC or MCC

Time Period	Outlier Status	Percent (Numerator / Denominator)	Target Area Discharge Count (Numerator)	Denominator Count	Target Area Average Length of Stay (ALOS)	Denominator Average Length of Stay (ALOS)	Target Average Medicare Payment	Target Sum Medicare Payment
Q3 FY 2023	High Outlier	82.7%	243	294	6.9	6.5	$14,191	$3,448,455
Q4 FY 2023	High Outlier	85.1%	240	282	7.0	6.7	$14,388	$3,453,019
Q1 FY 2024	High Outlier	81.8%	224	274	7.0	6.5	$13,705	$3,069,855
Q2 FY 2024	High Outlier	84.9%	297	350	6.7	6.3	$14,186	$4,213,358
Q3 FY 2024	High Outlier	84.6%	236	279	6.2	5.9	$14,059	$3,317,843
Q4 FY 2024	High Outlier	86.2%	263	305	7.2	6.8	$15,018	$3,949,683
Q1 FY 2025	High Outlier	81.9%	249	304	6.0	5.6	$14,018	$3,490,448
Q2 FY 2025	High Outlier	84.7%	282	333	6.5	6.1	$13,946	$3,932,775
Q3 FY 2025	High Outlier	83.1%	265	319	6.5	6.0	$14,795	$3,920,550

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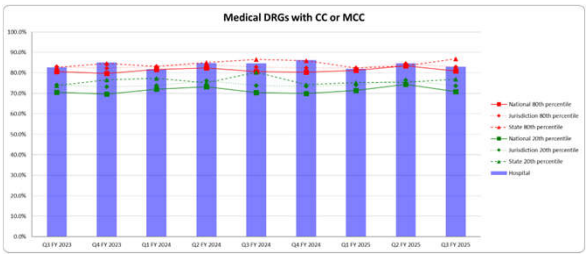
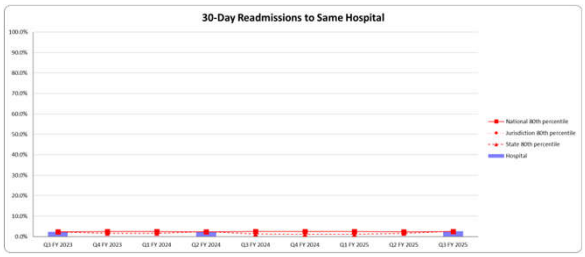
Also Pictures!



But is it Improved? Not so much…



And the Category “Changes”

Old List

- Stroke Intracranial Hemorrhage
- Respiratory Infections
- Simple Pneumonia
- Septicemia
- Unrelated OR Procedure
- Medical DRGs with CC or MCC
- Surgical DRGs with CC or MCC
- Single CC or MCC
- Excisional Debridement
- Ventilator Support
- Severe Malnutrition
- Percutaneous Cardiovascular Procedures
- Total Knee Replacement
- Syncope
- Other Circulatory System Diagnoses
- Other Digestive System Diagnoses
- Medical Back Problems
- Spinal Fusion
- 3-Day SNF-Qualifying Admissions
- 30-Day Readm to Same or Elsewhere
- 30-Day Readm to Same Hospital
- 2DS Medical DRGs
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- 1DS Surgical DRGs

New List

- Stroke Intracranial Hemorrhage
- Respiratory Infections
- Simple Pneumonia
- Septicemia
- Unrelated OR Procedure
- Medical DRGs with CC or MCC
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Eliminating “Excisional Debridement” is an improvement????

Prior Authorization Growing

Two new CMS initiatives

both optional – don't get prior auth, pre-payment review done

Nationwide ASC prior auth program

- Blepharoplasty
- Botulinum toxin injections
- Panniculectomy
- Rhinoplasty
- Vein ablation

WISeR

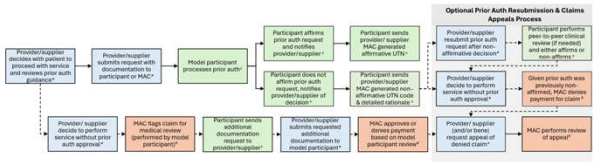
Wasteful and Inappropriate Service Reduction

New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington

Contracted AI companies to perform prior auth

AI review then human review if not AI-approved

The Simple WISeR Workflow



The Topics

Induced Lesions of Nerve Tracts

Vagus Nerve Stimulation

Phrenic Nerve Stimulators

Electrical Nerve Stimulators

Incontinence Control Devices

Sacral Nerve Stimulators for Urinary Incontinence

Diagnosis and Treatment of Impotence

Percutaneous Vertebral Augmentation for Vertebral Compression Fracture

Epidural Steroid Injections for Pain Management

Cervical Fusion

Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea

Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds

Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee

The Crucial Rule in WISeR

For non-affirmations, the WISeR Model requires that the WISeR participant have human clinicians with relevant clinical expertise review the determination before it is issued.

Associated Payments will be Denied

Payment for Associated Items Services

Claims related to or associated with a WISeR select item or service will not be paid if the WISeR select item or service is non-affirmed during prior authorization or denied payment during claims processing.

Associated items and services include anesthesiology services involved during the procedure, devices implanted during implantation surgery, physician services, and/or facility services.

Speaking of Prior Authorization

Medicare Advantage plans still must follow the Two Midnight Rule

MA plans are not required to offer P2P calls – contractual issue

CMS removing complaints about MA plans from STAR program
- But continue to file complaints!
- Encourage your patients to call their plan and complain
  - but ensure the complaint is legitimate and request meets CMS criteria for coverage

What About Aetna's New Tactic?

- For hospital stays where the member stays at least one (1) midnight but less than five (5) midnights, we will perform a level of severity review to determine whether a claim will be paid at the higher or lower level of severity rate:
  - If the inpatient stay meets MCG severity criteria, eligible claims pay at the higher level of severity rate
  - Inpatient stays that do not meet MCG severity criteria will be paid at the lower level of severity rate.
- For hospital stays where the member stays five (5) midnights and greater, we will pay the higher level of severity rate i.e. we will not perform a severity review for hospital stays of five midnights or greater.

What Does This Mean?

You ask for inpatient, they will approve inpatient
Patient gets access to their inpatient rights and benefits

If less than 5 days, will run MCG criteria
If inpatient criteria not met, will pay an "adjusted" inpatient rate equivalent to observation rate

MCG Inpatient Criteria

Medicare supplemental criteria

Patient with Medicare coverage requires inpatient admission if:

Patient has already received medically necessary care that meets the two midnight benchmark. The medical record must contain sufficient documentation to make clear the medical necessity of hospital care for 2 or more midnights.

How To Fight This

It's not your fight to fight

This is all on the finance/contracting team

They "allowed" the contract modification to apply to you

But you can get your doctors to document better!

Speaking of Documenation…Why?????
CC: Weakness of left Leg, 85 yr old

FAMILY HISTORY SECTION
Family History:: Reviewed;

Review of Systems
ROS:: All systems reviewed and negative, except as noted in HPI or noted below;

Physical Exam
CONST:
Const: Within normal limits, No apparent distress, Appears stated age;
EYES:
Eyes:: Within normal limits, Extraocular movements intact, PERRL, No conjunctival injection, Sclera anicteric;
HENT:
HENT:: Within normal limits, Normocephalic/ atraumatic, Tympanic membrane normal, No discharges, Oral mucosa moist/pink;
NECK:
Neck:: Within normal limits, No bruits, No lymphadenopathy;
CVS:
CVS:: Within normal limits, Regular rate and rhythm;
RESP:
Resp:: Within normal limits, Clear to auscultation bilaterally, No wheezes/ rales/ rhonchi;
GI:
GI:: Within normal limits, Non-tender, Normal bowel sounds;
GU:
GU:: Within normal limits;
MUSC:
Musc:: Within normal limits, Joints normal, Range of motion normal;
NEURO:
Neuro:: Within normal limits, No lateralizing deficits;
EXTREM:
Extrem:: Within normal limits, No clubbing/ cyanosis/ edema, No calf tenderness;
BACK:
Back:: Within normal limits, No CVA tenderness;

Have any of you ever been sick?

Case-

Ms. X is a healthy 35 year old female with presents to doctor with cough and low grade fever. No dyspnea, no high risk factors. PMH- negative. Exam- vitals normal, pulse ox- 97% crackles on right. CXR- small RLL infiltrate.

What will the doctor order?

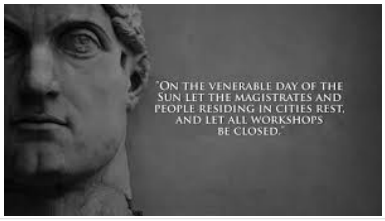
A. oral antibiotic for 7 days

B. oral antibiotic for 6 days

C. oral antibiotic for 8 days

Ever ask- Why 7 Days?

321 AD, Constantine the Great established the week as 7 days



And Why Do We Order Refills for 30 days?

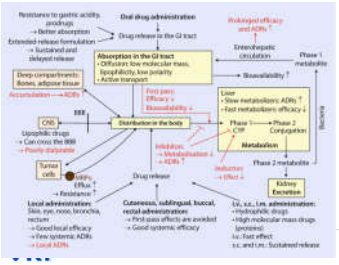
30 days – September, April, June and November – 4 months

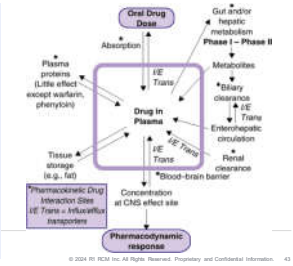
31 days – January, March, May, July, August, October, December – 7 months

28/29 days – February – 1 month

What about giving a drug once a day?

Could every drug have a 24 hour response curve?





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Dogma

a principle or set of principles laid down by an authority as incontrovertibly true.

Dogmatic

Synonyms: **bullheaded, dictative, doctrinaire, fanatical, intolerant**

Antonyms: amenable, flexible, manageable

Pragmatic

Synonyms: **common, commonsense, logical, practical, rational, realistic, sensible**

Antonyms: idealistic, unrealistic

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Lots of Dogma in Medicine

NPO after Midnight
Kayexelate for hyperkalemia
Treating asymptomatic elevated BP in hospital
Treat all prostate cancer
RICE for injuries
Hormone replacement at menopause*
Daily aspirin for CAD prevention
No seeds for diverticula
Start pap smears under age 21
Renal dose dopamine
Pluto is a planet

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What Can We Do?

Keep learning!!!!!

Empower staff to ask questions about treatment

Provide a resource to handle questions without judgement
(your physician advisor!)

Just because you can, you have to decide if you should
"Don't just do something, stand there!"

New Quality Measures Coming in the Future

Under consideration – those applicable to CM
- Advance care planning discussion or document in record
- shared decision-making for outpatient surgery
- excess days after hospitalization- ED, Obs, Inpt
- readmission after sepsis admission
- ED Timeliness – boarding > 4 hrs or total ED time > 8 hrs

https://p4qm.org/prmr-measures

Questions?

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