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Recent Changes in the Innovative Postanesthesia Care Unit Gatekeeper Role

Elaine Coulter, RN, BSN, MHA, CNE, and Mary Elizabeth VanGelder, RN, BSN, MRE

ABSTRACT

Purpose/Objectives: This article responds to issues raised to M. E. VanGelder and E. Coulter (2013). Focused areas of this article include (a) a review of the gatekeeper role in the postanesthesia care unit (PACU) at the Mayo Clinic Hospital in Phoenix, AZ, (b) clarification of the Medicare Inpatient Only list, (c) a review of how the Mayo Clinic Hospital schedules a Medicare same-day procedure, (d) preadmission orders, (e) postadmission procedure orders for outpatient in a bed and observation status and inpatient, (f) case examples, (g) amplification of the Medicare Two-Midnight Rule, and (h) emerging hospital billing issues.

Primary Practice Setting: Hospital PACU.

Findings and Conclusions: The increased yearly savings demonstrated by the PACU case management gatekeeper role has substantiated this essential hospital role.

Implications for Case Management: The PACU case management position will become more important in the future because of rapid changes regarding surgical reimbursement to hospitals. Unit case managers must collaborate with PACU case managers to become familiar with new reimbursement models. The development of new strategies for accurate compensation will be mandatory throughout the hospital continuum.

Key words: *case manager, inpatient-only surgical procedures, Medicare hospital reimbursement, Medicare Two-Midnight Rule, PACU gatekeeper role, same-day surgical admits*

Medicare same-day procedure admissions to the Mayo Clinic Hospital in Phoenix, AZ, are closely monitored by the postanesthesia care unit (PACU) case manager (CM). The role has evolved over a time span of approximately 5 years. Significant savings increased in 2011 when a yearly documented record was initiated. The $1 million of realized savings in 2011 and $2.8 million in 2012 demonstrate the value of documenting Medicare savings (Zehring, 2013).

PACU Savings

VanGelder and Coulter (2013) outlined the process for initiating a PACU case management gatekeeper position. Emphasis was placed on the importance of the Medicare Inpatient Only list that impacts reimbursement. A step-by-step action plan was described that ensures compliance with the Centers for Medicare & Medicaid Services (CMS) guidelines regarding same-day hospital surgical admissions and the achievement of successful patient outcomes. Attention to Current Procedural Terminology (CPT) code designations on the Medicare Inpatient Only list is key to appropriate and timely reimbursement from Medicare.

Future decreases in Medicare payments will obligate hospitals and stakeholders to search for innovative interventions to limit an organization's financial exposure. Becoming proficient with correct patient status designation and the Medicare Inpatient Only list will realize benefits and financial returns. Judicious oversight of the correct status of Medicare patients is well worth the intense effort and investment that is required to initiate a PACU CM gatekeeper program (VanGelder & Coulter, 2013).

The Medicare Inpatient Only List

The Medicare Inpatient Only list is composed of a number of surgical procedures, which the CMS deems to be inpatient-only encounters. Each procedure has an attached CPT code. The CPT codes are published and are updated annually by the American Medical Association. The list is organized by physiological systems that are generally grouped in numerical order. Any Medicare patient who has a procedure on this list must be admitted as an

Address correspondence to Mary Elizabeth VanGelder, RN, BSN, MRE, Mayo Clinic Hospital, 5777 E. Mayo Blvd, Phoenix, AZ 85 054 (vangelder.mary@mayo.edu).

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inpatient to the hospital following the procedure. The procedures on this list are provided in the Medicare Inpatient Only List (2014) and are updated with additions and deletions of codes annually. The CMS has stipulated that services appearing on the Inpatient Only list and supporting an inpatient admission may be appropriately billed under Part A payment, regardless of the expected length of stay (CMS, 2013a, 2013b, 2013c). Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) have been directed by the CMS to approve these cases.

Scheduling a Medicare Same-Day Procedure

When a Mayo Clinic Hospital provider contacts a surgical scheduler to arrange a procedure for a Medicare patient, a patient account is initiated. The precertification department follows up to determine the patient's Medicare insurance and benefits coverage. A CPT code will be attached to the procedure. The code will be verified with the Medicare Inpatient Only list to determine the type of procedure that will be performed. This confirmation will determine whether the procedure will be completed in the inpatient or outpatient setting. Documentation of the proposed procedure is then entered into the Mayo Clinic Hospital electronic medical record (EMR) system. The success of this process will depend on the patient account matching the expected encounter. If the patient account sequence is built correctly, the preadmit orders that have been entered by the provider will ensure the correct status for the scheduled Medicare surgery. A correct status, right from the beginning, optimizes hospital reimbursement and minimizes out-of-pocket expenses for Medicare patients (see Table 1).

Preadmission Procedure Orders

According to Meyerson (2013), facilities that accept Medicare patients are cautioned regarding the requirement for a preoperative inpatient admission order for an anticipated procedure to be entered into the EMR prior to the commencement of the procedure. This stipulation is verified by Ritter, Deputy Director of the Hospital and Ambulatory Policy Group at the CMS (personal communication, May 16, 2013). "A patient is considered an inpatient only after a physician issues an order for inpatient admission. A written physician order for inpatient admission must precede an inpatient-only procedure, according to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2K."

Similarly, when a Medicare procedure does not appear on the Medicare Inpatient Only list, the procedure will be determined to be an outpatient procedure. An outpatient CPT code will then appear in the precertification screen of the patient's EMR. At the Mayo Clinic Hospital, either (a) an extended recovery order or (b) an anticipate discharge from PACU order must be entered into the EMR prior to the patient being taken to the operating room. It should be noted that extended recovery is a peculiar term that is used by the Mayo Clinic Hospital. Other facilities may use the term "outpatient in a bed" to denote their outpatient Medicare procedures.

Postadmission Outpatient Orders

When an anticipated outpatient arrives in the PACU and the provider determines to admit for further monitoring, an extended recovery order is entered into the EMR. At the Mayo Clinic Hospital, the only outpatient order option that is available to providers following a scheduled procedure is extended recovery. This designation is *not* considered a status determination;

TABLE 1
Status Definitions (for Traditional Medicare/Fee-For-Service)

Ambulatory: Anticipate discharge from PACU postprocedure.
Extended recovery: A 4- to 6-hr time frame in PACU postprocedure that is billed as recovery room services.
Outpatient in a bed: A status that is used following extended recovery when criteria for observation are not met.
Observation: A status that is used following extended recovery on the basis of medical criteria and a two-midnight benchmark.
Inpatient: A status that is determined by being on the Medicare Inpatient Only list or by complex medical factors that necessitate an inpatient stay.
Condition code 44: A code used on outpatient claims when a Medicare inpatient admission has been changed to observation prior to discharge.

A correct status, right from the beginning, optimizes hospital reimbursement and minimizes out-of-pocket expenses for Medicare patients.

rather, it is an extended recovery time period of 4–6 hr that immediately follows a surgical procedure. Per the CMS guidelines, hospitals must not bill observation hours for the first 4–6 hr postprocedure. These hours are deemed a standard recovery period and are to be billed as recovery room services. In the case of diagnostic testing, recovery time is built into the Medicare payment for these services (Medicare Claims Processing Manual, 2011).

At the conclusion of the 4- to 6-hr time frame, a review of the patient's condition will be completed. If the patient is medically stable and does not meet intensity-of-service (IS) criteria for observation, extended recovery/outpatient in a bed will become the *status*. The patient will be transferred to a hospital unit bed for an overnight stay. The following day the CM on the unit will review the EMR for discharge orders. If a discharge is not anticipated because of medical reasons, the unit CM will follow up with the provider regarding the patient's plan of care, anticipated discharge needs, and correct status orders, should a hospital admission be required.

Example of Extended Recovery/Outpatient in a Bed Status

A patient is admitted to the Cardiac Catheterization Laboratory (CCL) for a right atrial lead revision and a dual-chamber pacemaker insertion; the CPT codes 33206, 33218, and 33237 are *not* on the Medicare Inpatient Only list. Postprocedure, the patient is transferred to the PACU, orders are written, and the patient is placed in extended recovery. Six hours postprocedure, the progress of the patient exhibits no complications; however, the provider decides to keep the patient overnight for monitoring and interrogation of the cardiac device in the morning. This particular patient is appropriate for continued extended recovery/outpatient in a bed status.

Medicare Observation Orders

An observation order is obtained by the provider and entered into the EMR when a Medicare patient completes the 4- to 6-hr extended recovery period but has experienced a complication. Certain criteria such as pain management, oxygen requirements, nausea, hyper/hypotension, arrhythmias, abnormal laboratory values, or failure to void are used at the Mayo Clinic Hospital to determine the observation status following the 4- to 6-hr time frame postprocedure. Should any of these criteria be met, observation would be the appropriate postoperative status. The patient will then be transferred to a hospital unit bed for an overnight admission. It must be noted that Medicare permits observation status to continue for up to two midnights if inpatient criteria are not met. When this issue occurs, the surgical practice and/or the hospital physician advisor should be consulted for plan-of-care considerations.

Hoy (2014) noted that Medicare would not cover observation services under the following circumstances and should not be billed as such:

- Services were provided for the convenience of a patient, their family, or the physician.
- An inpatient admission would have been more appropriate.
- The services provided were standard for diagnostic, surgical, or therapeutic services.
- The services were part of the standard preparation or recovery period for diagnostic, surgical or therapeutic services.
- The monitoring was incidental to other diagnostic, surgical, or therapeutic services.

In support of this view, Hale (2012) stated that observation must be medically necessary, and that it is rarely appropriate for a postsurgical procedure. Payment for the standard recovery period following surgery is built into the outpatient Ambulatory Payment Classification payment structure.

Case Example: Extended Recovery to Observation

Case Example 1

A patient is admitted for a scheduled thyroidectomy (CPT code 60240). Postprocedure the patient is taken to the PACU, orders are written, and the patient is placed in extended recovery. The progress of the patient is reviewed 4 hr later. Hypertension and nausea are noted and documented by the PACU nurse. The patient has received three doses of an intravenous beta-blocker, two doses of intravenous ondansetron (Zofran), and oxygen at 3 L/min with continuous pulse oximetry. Following this review, observation status is deemed to be appropriate. The provider is contacted and an observation order is obtained and entered into the EMR.

Case Example 2

In this example, the reason for a decision to change a patient status is not always obvious. The patient may meet criteria for an inpatient stay; however, the question may arise as to whether the patient will require a hospital stay longer than one to two midnights. This

decision must involve critical thinking and astute nursing assessment skills as the following case illustrates.

A patient was admitted to the Cardiac Catheterization Laboratory for a left-sided heart catheterization. The CPT code 93452 is an outpatient procedure. Preprocedure, an arterial catheter was inserted because of a history of uncontrolled hypertension. During the procedure, two drug-eluding stents were placed. Admission to the PACU is accompanied with an extended recovery order.

Throughout the next 4–6 hr, elevated systolic blood pressures remained uncontrolled, and a nitroglycerin drip with titration was initiated. When the patient was stable, an order for transfer to the intermediate/stepdown unit was entered for close monitoring. At this juncture, inpatient IS criteria were met; however, the discharge plan had not been determined. A call was placed to the intermediate/stepdown registered nurse (RN) caring for the patient, and several inquiries were made concerning the condition of the patient, recovery time, and intended care plan. The unit RN had spoken to the provider and understood the care plan of the patient.

- How long do you anticipate the intravenous nitroglycerin drip will continue?
  Answer: The patient is scheduled to go to dialysis this afternoon and following his dialysis treatment, the drip will be discontinued.
- How long do you anticipate keeping the arterial catheter in?
  Answer: The arterial catheter will also be discontinued following dialysis treatment.
- Do you think the patient will discharge home tomorrow?
  Answer: Yes, the patient's attending physician has indicated that the patient will be discharged tomorrow if the patient remains medically stable.

On the basis of the information given by the unit RN, an order for observation was obtained from the provider and entered into the EMR. The care plan as stated by the intermediate/stepdown unit RN was executed; the patient went for dialysis treatment later in the day. Both the nitroglycerin drip and arterial catheter were discontinued that evening, and the patient was discharged home the next morning. The total hospital stay, from admission to the CCL to discharge home the following day, was only one midnight. Observation was the correct status for this Medicare patient.

Postadmission Inpatient Admission Orders

Once a scheduled surgical procedure is performed, and the CPT code appears on the Medicare Inpatient Only list, an inpatient postoperative admission order is entered by the provider into the EMR when the patient arrives in the PACU setting. A preadmission order and a postprocedure order must be documented in the medical record in order for the facility to be reimbursed by Medicare. If either inpatient order is omitted, the facility will receive zero reimbursement (Meyerson, 2013).

Example of Inpatient Status

A Medicare patient is scheduled for a total hip arthroplasty. This procedure is on the Medicare Inpatient Only list (CPT 27130):

- RN/CM reviews the initial preoperative/preprocedure order—inpatient admit status is intended postprocedure.
- A left total hip arthroplasty is performed.
- RN/CM confirms the procedure by checking the intraoperative documentation, the Operating Room progress note, or the documented operative report.
- The postop order for inpatient status is entered and initiated in the EMR.
- The correct status of inpatient is determined, and a hospital bed is ordered. The patient is then moved out of the PACU to the floor, and the assigned RN/CM on the floor will continue to follow the patient until they are discharged from the hospital.
- The attending physician signs the inpatient certification statement prior to discharge.
- The Mayo Clinic Hospital will have met the statutory requirements that are required to bill Medicare.

The other component for an inpatient stay is the certification by the attending. This certification is a new statutory requirement for hospital payment that was enacted on October 1, 2013, called the "Two-Midnight Rule." It stipulates that a physician with knowledge of the patient's history must certify the inpatient status of the Medicare beneficiary. At the Mayo Clinic Hospital, the attending physician must sign the certification that documents the inpatient admission order prior to patient discharge to ensure compliance with this Medicare inpatient certification ruling (CMS, 2013a, 2013b, 2013c).

Medicare Two-Midnight Rule: A Game Changer for Inpatient Admissions

In the past, the reason for a decision to admit a patient has not always been crystal clear, and many hospital organizations have erred by billing for observation instead of billing for the full inpatient fee. Faced with

the prospect of incurring the entire cost of the hospital stay because of the RAC and MAC denials for payment of services rendered, hospitals have made the decision to enter orders for observation services. However, Medicare regulations have been vague and nonspecific. This has frequently left hospitals guessing on many of their observation versus inpatient service admissions. There has been much discussion recently on this subject, especially because the RACs and the MACs have begun to bear down on hospitals nationwide by auditing past files and claims for overpayment, because of the incentive of receiving a percentage of the recoveries as payment for their service (CMS, 2013a, 2013b, 2013c).

In 2011, HCPro discussed the criteria to be used when making decisions concerning medical necessity for inpatient status (HCPro/Revenue Cycle Institute, 2011):

- Invasive procedure criteria
- The CMS coverage guidelines
- Published CMS criteria
- Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community)

The real game changer came in 2013 with the recent initiation of the Two-Midnight Rule. According to the CMS, "In the FY 2014 Inpatient Prospective Payment System (IPPS) rule, CMS finalized their policy for inpatient admissions stating that surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least two midnights" (Egan, 2013). Inpatient status is appropriate under the CMS guidelines if the patient is expected to have a two or more midnight stay, and the attending physician documents the complex medical factors that necessitate an inpatient hospital admission in the EMR. The complex medical factors that the provider is required to document in the EMR include the following:

- Delineating patient comorbidities
- The severity of the signs and symptoms
- Any current medical needs
- A posthospital plan of care that is discussed with and agreed to by the patient
- The adverse risks associated with an early discharge

The CMS also clarified that admissions following this order will not be the subject of the MAC or the RAC medical reviews absent efforts of *systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the two-midnight presumption until October 1, 2015, pending US Senate approval of the Two-Midnight Rule Coordination and Improvement Act (S 2082*) (Menendez & Fischer, 2014). In effect, the Two-Midnight Rule has weakened the ability of the RACs to collect claims during this transition period. This delay will give hospitals more time to understand the rule before it is enforced and may result in drastically lower recoveries to the Medicare Trust Fund because overpayments and improper payments are not being audited and returned (Egan, 2013).

The ruling also points out that if hospital inpatient services covered under Medicare Part A were initially denied because of the admission being deemed *not reasonable or necessary*, the hospital could effectively bill Medicare Part B if the beneficiary was enrolled in Part B. Payment for hospital services under Part B could also be determined through the utilization review process after the patient has been discharged. If the review concludes that the patient's inpatient admission did not meet reasonable and necessary inpatient criteria and that the patient was discharged before a condition code 44 could be placed in the EMR, the hospital could bill for outpatient services and may be paid for the Part B services rendered during the course of stay (Centers for Medicare and Services, 2006).

Currently, a condition code 44 is used when the physician orders inpatient services when, prior to patient discharge and prior to the claim being submitted for payment, it is determined that the services do not meet inpatient criteria per hospital utilization review standards. The patient is changed from an inpatient to outpatient admission prior to discharge, for which Medicare Part B services are then billed

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under the outpatient prospective payment system. Under the present Two-Midnight Rule, hospitals may bill for outpatient Part B services after utilization review, even if a condition code 44 was not instituted before discharge of the Medicare beneficiary (CMS, 2013a, 2013b, 2013c).

According to Egan (2013), the Two-Midnight Rule also applies to any Medicare outpatient procedure, where the attending physician determines that the patient is expected to be in the hospital for two or more midnights and exhibits complex medical factors. Therefore, a physician may write orders that will place the patient directly into inpatient status, without a 4- to 6-hr recovery time prior to status determination following arrival into PACU postprocedure. The order may be placed by a qualified physician assistant, resident, or nurse practitioner following a discussion with the attending physician. However, the attending physician is required to authenticate the inpatient order and certify that the stay met inpatient medical necessity prior to the patient's discharge. This documentation must offer compelling reasons for the inpatient stay on the basis of good medical practice (Egan, 2013). Following a surgical procedure that is not on the Medicare Inpatient Only list, such as a laparoscopic ventral hernia repair with mesh (CPT codes 49560 and 49568), this ruling could be applied because these patients typically require a longer recovery time because of medical needs and IS.

Since October 2013, the CMS has issued some further clarification that has been helpful regarding the Two-Midnight Rule (note that exceptions to the rule are evolving) as follows:

1. *Mechanical ventilation*: The CMS confirmed that patients on mechanical ventilation may be appropriately inpatient with less than a two-midnight stay. Please note that this does not include routine intubation for surgical cases.
2. *Two-midnight clock*: The two-midnight clock starts with a benchmark. There are two questions that the CMS posed:
    i. Is hospital care required? Can services be only provided in the hospital setting? If yes, the patient would remain at the hospital for that care.
    ii. What is the duration of care expected?
        a. Less than two midnights: Outpatient
        b. Two midnights or more: Inpatient
        c. If unclear at admission, start as an outpatient and convert to inpatient when it is determined that an additional midnight in the hospital is needed.
3. *Medical necessity*: The CMS stated that the determination of inpatient is based on the actual services provided to the beneficiary and not to the setting, where it was provided (inpatient, observation, or outpatient). For example, telemetry monitoring is the service, which is medically necessary; it is not the status of the patient. Therefore, if a patient requires two midnights of medically necessary telemetry, it is inpatient.
4. The benchmark for two midnights begins when the care is initiated at the first facility and continues when the patient is transferred to another acute care setting for continuing care (Medicare Learning Network, 2014).
5. Medicare Part A may be billed if a scheduled procedure requires a two-midnight stay, is cancelled, and this expectation is appropriately documented in the EMR.

In summary, for the Mayo Clinic Hospital in Phoenix, AZ, to be in compliance with the CMS Two-Midnight Rule, the following three requirements must be met:

1. The inpatient hospital admission order must be entered into the EMR.
2. The certification document must be signed by the attending physician before discharge.
3. The patient must meet the two-midnight benchmark with compelling documentation that supports inpatient status. The exception is that the patient had an inpatient-only procedure.

An exception to this ruling, identified by the CMS, is mechanical ventilation initiated during the hospital stay (except routine intubation for surgical procedures). If the Medicare beneficiary requires only a one midnight hospital stay using mechanical ventilation, it is to be treated the same as a Medicare Inpatient Only procedure. This is considered an inpatient admission, and Part A may be billed appropriately for payment.

Case Example of Two-Midnight Inpatient Stay

The patient was a same-day surgical admit for a scheduled tracheostomy (CPT code 31600), an outpatient Medicare procedure (see Figure 1). Medical history included tracheal stenosis status post-tracheal resection with reanastomosis and secondary dyspnea because of tracheomalacia. The planned hospital stay was documented in the EMR to be at least 4 days. Because of the medical history and the expected 4-day postoperative stay, an inpatient preoperative order was entered into the EMR by the provider. Postoperatively, the patient was admitted to the PACU in an inpatient status. The PACU/CM had a decision to make: was the correct order inpatient or

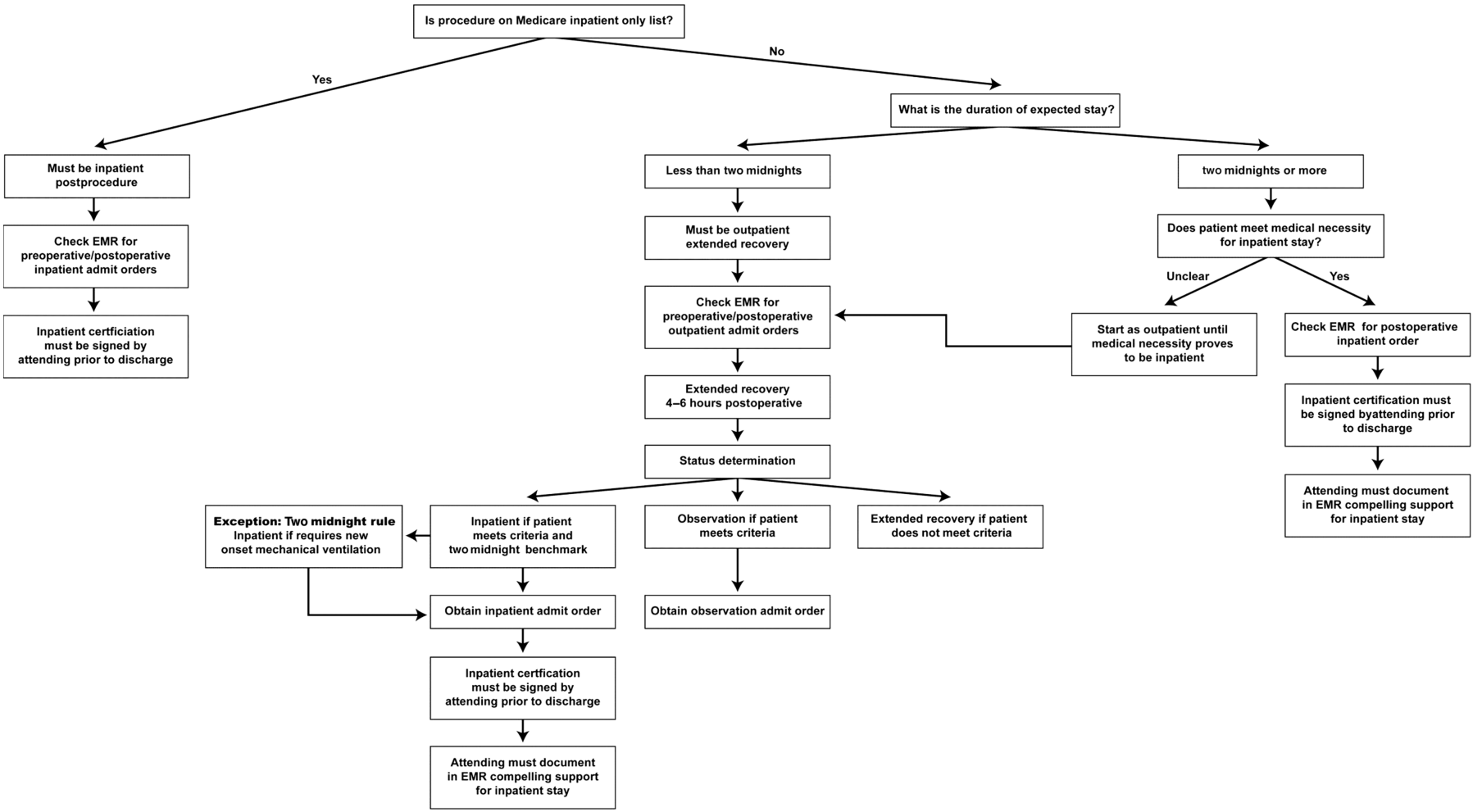

FIGURE 1
Medicare same-day surgical admits: Status is critical.

extended recovery based on outpatient procedure code for Medicare? The PACU/CM spoke with the provider who had signed the inpatient certification and confirmed the intended length of stay indicated in the EMR. A joint decision was made to allow the inpatient order in the EMR to stand. The PACU/CM informed the unit CM on the intended length of stay and asked to continue to follow for possible care plan changes that might warrant a condition 44. Subsequently, the patient was transferred to the intermediate/stepdown unit for 1 day and then to a medical/surgical floor for an additional 5 days. The patient remained on 10 L O_2/min through the tracheal collar for the duration of the hospital stay, and tube feeds were initiated. Per the CMS guidelines, the patient met inpatient criteria. The patient required continuing services and monitoring beyond two midnights, and the patient's condition was severe enough to require inpatient treatment that was documented in the EMR by the provider. Inpatient was the correct status for this Medicare patient, even though the patient had an outpatient procedure done per Medicare guidelines.

Emerging Hospital Billing Trends

Data published by the CMS in a 2011 document included nationwide inpatient hospital billing charge statistics for certain surgical procedures. The logic behind the decision to publish was to provide consumers with vital information and comparisons of hospital charges within their specific communities. In addition, the evidence indicated that hospital calculations of charges were essentially determined on an individual basis and at the level that the local market would bear (CMS, 2013a, 2013b, 2013c).

According to Attucker and Hansen (2013), an example of this type of variation of charges between communities in Arizona for a joint replacement procedure ranged from $15,527 to $108,200. This information revealed that Arizona billed for more than the national average for this procedure and that, for every $4 billed to the CMS, $1 was reimbursed. Hospital administrators argued that charges for many procedures could be difficult to compute because of the individual differences that each patient may present with, either medically or surgically. In an effort to promote increased transparency and standardization of charges for the public, the Arizona Legislature has sponsored a bill that requires hospitals to reveal pricing for a number of common procedures.

In view of nationwide hospital charging disparities, a recent CMS publication indicated that consideration is being given to initiating statistical sampling and extrapolation to determine a more efficient and reasonable hospital billing procedure for Medicare charges. This method of analyzing Medicare claims resembles actuarial calculations. The rationale is to bring hospital service disparities into a more equitable position nationwide (CMS, 2013).

Conclusions

Implications for the CM role in the PACU have become even more critical in view of the constant and rapid changes that Medicare is instituting with little time for hospitals to adapt and initiate. The situation is currently quite fluid considering the recent launch of the inpatient certification statement and the Two-Midnight Rule documents, both of which must be signed by the attending physician either upon admission to the PACU or sometime before the patient discharges from the hospital. These documents require close monitoring by the PACU and unit nurse CMs. Also, the RACs have been directed by Medicare not to review patient charts during this amnesty period. The MACs are currently auditing hospital charts for medical necessity and compliance with the Two-Midnight Rule as an educational tool in preparation for the final rollout that is targeted for October 1, 2015, pending US Senate approval (Menendez & Fischer, 2014).

Accurate verification of orders and correction of incorrect orders of admissions to the PACU by the RN/CM have resulted in increased yearly savings since the inception of the PACU CM gatekeeper role began in 2009. Anticipated savings of more than $3 million for 2013 are anticipated. During this time span, hospital attendings, residents, mid-level personnel, and preoperative and PACU RN staff have gained insight into the importance of accurate patient status determination because of educational in-services that have been conducted by case management. Excellent rapport has been fostered.

In summary, this article addressed recent Medicare guideline changes. Particular focus was placed on a review of the gatekeeper role in the PACU, scheduling a Medicare same-day surgical procedure, preadmit and postadmit procedure orders for

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extended recovery/outpatient in a bed, observation and inpatient status, case examples, amplification of the Medicare Two-Midnight Rule and, finally, emerging hospital billing issues. Defending the decision to initiate the PACU role at the Mayo Clinic Hospital has been proven to be irrefutable.

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Elaine Coulter, BSN, RN, MRE, is a Case Manager in the PACU at the Mayo Clinic Hospital in Phoenix, AZ. Her experience includes a variety of nursing roles that encompass ICU/CCU, Home Health, UM, and Case Management. In addition, she is an adjunct Nursing Instructor in the College of Nursing at the Grand Canyon University in Phoenix, AZ.

Mary Elizabeth VanGelder, RN, BSN, MHA, CNE, has nearly 30 years of recent operating room nursing experience in both scrubbing and circulating and brings a strong surgical background to the PACU Case Management team at the Mayo Clinic Hospital in Phoenix, AZ. Prior to this role, she worked as a Case Manager at St. Luke's South in Overland Park, KS.