Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After October 1, 2015

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Medical Review of Inpatient Hospital Claims

Starting on October 1, 2015, the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIOs) began conducting initial patient status reviews of acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims. The claims will be reviewed in accordance with the FY 2014 Hospital IPPS Final Rule CMS-1599-F, which provided two distinct, although related, medical review policies: a 2 midnight presumption and a 2 midnight **benchmark**. The 2 midnight presumption directs medical reviewers to select claims for review under a presumption that the occurrence of 2 midnights after formal inpatient hospital admission signifies an appropriate inpatient status for a medically necessary claim. CMS finalized proposed refinements to the two midnight policy in the FY 2016 OPPS Final Rule, which will be effective on January 1, 2016.

Beginning in January 2016, Recovery Auditors may conduct patient status reviews for those providers that have been referred by the QIO as exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to:

- consistently failing to adhere to the Two Midnight rule, or
- failing to improve their performance after QIO educational intervention.

Patient Status Reviews

Throughout this document, the term "patient status reviews" will be used to refer to medical record reviews conducted by the QIOs to determine the appropriateness of Part A payment for short stay inpatient hospital claims (i.e., assessing whether Part A (inpatient) or Part B (outpatient) payment is most appropriate).

Beginning October 1, 2015, QIOs will apply CMS-1599-F and any additional guidance CMS issues when conducting patient status reviews for claims submitted by acute care inpatient hospital facilities and Long Term Care Hospitals (LTCHs) for dates of admission within the previous 6 months. QIOs will NOT apply these instructions to admissions at Inpatient Rehabilitation Facilities (IRFs) and Critical Access Hospitals (CAHs). IRF patient status reviews are specifically excluded from the 2-midnight inpatient admission and medical review guidelines per CMS-1599-F.

When conducting a patient status review, QIOs will review the medical record to assess the hospital's compliance with:

a) the admission order requirements, and
b) the 2-midnight benchmark

I. Reviewing Hospital Claims for Inpatient Status: Inpatient Admission Order Requirements

When conducting patient status reviews, QIOs will assess whether the inpatient admission order requirements were met. Guidance related to the order for formal inpatient admission may be accessed at: https://www.cms.gov/MEdicare/Medicare-fee-for-service-payment/acuteinpatientPPS/downloads/IP-Certification-and-order-01-30-14.pdf.

II. Reviewing Hospital Claims for Inpatient Status: The 2-Midnight Benchmark

The 2-midnight **benchmark** represents guidance to Medicare review contractors to identify when an inpatient admission is generally appropriate for Medicare Part A payment under CMS-1599-F.

A. General Rule for Expected 0-1 Midnight Stays

A.1. General Rule for Services on Medicare's Inpatient Only List: Medicare's "Inpatient-Only" list, as authorized by 42 C.F.R. § 419.22(n), defines services that support an inpatient admission and Part A payment as appropriate, regardless of the expected length of stay. The QIOs will approve these cases so long as other requirements are met.

Providers are reminded that the list of procedural codes defined as "inpatient-only" are accessible at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html. Providers trying to determine if a procedure is classified as inpatient-only for the year in which the procedure is being performed shall access the final rule for the year in question, click on the "OPPS Addenda" under the related links, and review the file containing addendum E.

A.2 When the Expected Length of Stay was Less Than 2 Midnights:
Pursuant to the 2 Midnight Rule [or CMS-1599-F], except for cases involving services on the "Inpatient-Only" list, Part A payment is appropriate for admissions where the expected length of stay is less than two midnights only in rare and unusual circumstances. The process for determining whether an admission where the stay is expected to last less than two midnights is payable will be different when the revised exceptions policy in the OPPS Final Rule become effective. CMS will issue revised guidance at that time.

Examples of situations that do not represent instances in which Part A payment for an inpatient admission would be appropriate without an expectation of a 2 midnight hospital stay include:

- **Beneficiaries admitted for telemetry.**
  CMS does not believe that the use of telemetry, by itself, is the type of rare and unusual circumstance that would justify Part A payment for an inpatient admission in the absence of a 2 midnight expectation. We note that telemetry is neither rare nor unusual, and that it is commonly used by hospitals on outpatients (ER and observation patients) and on patients fitting the historical definition of outpatient observation; that is, patients for whom a brief period of assessment or treatment may allow the patient to avoid a hospital stay.

- **Beneficiaries admitted to an Intensive Care Unit (ICU).**
  As CMS specified in the FY 2014 Hospital IPPS Final Rule CMS-1599-F, the use of an ICU, by itself, would not be the type of rare and unusual circumstance that would justify Part A payment for an

inpatient admission in the absence of a 2 midnight expectation. An ICU label is applied to a wide variety of facilities providing a wide variety of services. Due to the wide variety of services that can be provided in different areas of a hospital, CMS does not believe that a patient assignment to a specific hospital location, such as a certain unit or location, would justify Part A payment for an inpatient admission in the absence of a 2-midnight expectation.

When a patient enters a hospital for a surgical procedure (not specified by Medicare as inpatient only under 42 C.F.R. § 419.22(n) or an otherwise noted national rare and unusual exception to the 2 midnight policy (i.e., newly initiated mechanical ventilation)), a diagnostic test, or any other treatment, and the physician expects to keep the patient in the hospital for 0-1 midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed.

Where the medical record indicates that the physician did not or could not have reasonably expected to keep the patient in the hospital for greater than 2 midnights, QIOs shall deny Part A payment unless the circumstances described above (inpatient only procedure or rare and unusual exception) apply.

B. General Rule for Expected 2 or More Midnight Stays

When a patient enters a hospital for a surgical procedure, a diagnostic test, or any other treatment and the physician expects the beneficiary will require medically necessary hospital services for 2 or more midnights (including inpatient and pre-admission outpatient time), and orders admission based upon that expectation, the services are generally appropriate for inpatient payment under Medicare Part A. QIOs will approve these cases so long as other requirements are met.

B.1. Unforeseen Circumstances: If an **unforeseen** circumstance results in a shorter beneficiary stay than the physician's reasonable expectation of at least 2 midnights, hospital inpatient payment may still be made under Medicare Part A despite the actual length of stay being less than 2 midnights. Such circumstances must be documented in the medical record in order to be considered upon medical review. Examples include unforeseen: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice care in lieu of continued treatment in the hospital.

B.2 Documentation Requirements: The 2-midnight benchmark is based upon the physician's expectation of the required duration of medically necessary hospital services at the time the inpatient order is written and the formal admission begins. QIOs will, when conducting patient status reviews, consider complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2-midnight benchmark. Both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered. In other words, if the reviewer determines, based on documentation in the medical record, that it was reasonable for the admitting physician to expect the beneficiary to require medically necessary hospital care lasting 2 midnights, the inpatient admission is generally appropriate for payment under Medicare Part A; this is regardless of whether the anticipated length of stay did not transpire due to unforeseen circumstances (See section B1.)

QIOs will continue to follow longstanding guidance to review the reasonableness of the inpatient admission for purposes of Part A payment based on the information known to the physician at the time of admission. The expectation for sufficient documentation is well rooted in good medical practice. Physicians need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. QIOs will expect such factors to be documented in the physician assessment and plan of care. The entire medical record may be reviewed to support or refute the reasonableness of the physician's expectation, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission.

B.3. The 2 Midnight Benchmark and Outpatient Time:

1. General

For purposes of determining whether the 2‑midnight benchmark was met and, therefore, whether a claim for Part A payment for an inpatient admission should be approved upon review, QIOs will consider time the beneficiary spent receiving outpatient services within the hospital prior to inpatient admission, in addition to the post-admission duration of care. This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area.

2. 2-Midnight Benchmark Reviews

Whether the beneficiary receives services in the ED as an outpatient prior to inpatient admission (for example, receives observation services in the ED) or is formally admitted as an inpatient upon arrival at the hospital (for example, inpatient admission order written prior to an elective inpatient procedure), the starting point for the 2 midnight timeframe for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital.

For the purpose of determining whether the 2-midnight benchmark was met, QIOs will exclude triaging activities (such as vital signs) and wait times prior to the initiation of medically necessary services responsive to the beneficiary's clinical presentation. If the triaging activities immediately precede the initiation of medically necessary and responsive services, it is the initiation of diagnostic or therapeutic services responsive to the beneficiary's condition that QIOs will consider to "start the clock" for purposes of the 2 midnight benchmark. QIOs will not count the time a beneficiary spent in the ED waiting room while awaiting the start of treatment.

In other words, a beneficiary sitting in the ED waiting room at midnight while awaiting the start of treatment would not be considered to have passed the first midnight, but a beneficiary receiving services in the ED at midnight would meet the first midnight of the benchmark.

NOTE: While the time the beneficiary spent as an outpatient before the beneficiary is formally admitted as an inpatient pursuant to a physician order will be considered during the medical review process for purposes of determining whether the 2-midnight benchmark was met, it will not be considered inpatient time.

B.4. The 2 Midnight Benchmark and Transfers: For the purpose of determining whether the 2-midnight benchmark was met, the QIO shall take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, the "clock" for transfers begins when the care begins in the initial hospital. Any excessive wait times or time spent in the hospital for non-medically necessary services shall be excluded.

The QIOs may request records from the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving care to ensure compliance and deter gaming or abuse. The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility.

B.5. Delays in the Provision of Care: 1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of reasonable and necessary medical treatment. As such, CMS expects Medicare review contractors will continue to follow CMS' longstanding instruction that Medicare payment is prohibited for care rendered for social purposes or reasons of convenience. Therefore, QIOs will exclude extensive delays in the provision of medically necessary care from the 2 midnight benchmark calculation. QIOs will only count the time in which the beneficiary received medically necessary hospital treatment. Factors that may result in an inconvenience to a beneficiary, family, physician or hospital do not, by themselves, justify Part A payment. When such factors affect the beneficiary's health, QIOs will consider them in determining whether inpatient hospitalization was reasonable and necessary for purposes of Part A payment. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify Part A payment for a continued hospital stay.

B.6. The Two Midnight Benchmark and Cancelled Surgical Procedures: QIOs will review claims in which a surgical procedure was cancelled based on the general 2-Midnight benchmark instruction. In other words, if the physician reasonably expects the beneficiary to require a hospital stay for 2 or more midnights at the time of the inpatient order and formal admission, and this expectation is documented in the medical record, the inpatient admission is generally appropriate for Medicare Part A payment.

C. Monitoring Hospital Billing Behaviors for Gaming

CMS may monitor inpatient hospital claims spanning 2 or more midnights after admission for evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. CMS may identify such trends through probe reviews and through its data sources, such as those provided by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and Program for Evaluating Payment Patterns Electronic Report (PEPPER).