

For the guidance prior to January 1, 2016, please see <http://qioprogram.org/sites/default/files/20151109-ReviewingHospitalClaimsforAdmissionMemo%20Final.pdf>.

For the guidance on or after January 1, 2016, please see <http://qioprogram.org/announcements>

cms.gov <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/inpatienthospitalreviews.html>



Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016

(Last Updated: 1/5/2015)

Medical Review of Inpatient Hospital Claims

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 are being 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**. Under the 2-midnight presumption, inpatient hospital claims with lengths of stay 2 midnights or greater after the formal admission following the order are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. CMS finalized proposed refinements to the 2-midnight policy in the FY 2016 OPSS Final Rule, CMS-1633-F, effective 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).

On October 1, 2015, QIOs began applying CMS-1599-F when conducting patient status reviews for adjudicated claims that were 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. While the inpatient admission order continues to be required for all admissions, effective January 1, 2015, the physician certification is only required for outlier cases and long stay cases of 20 days or more under the Inpatient Prospective Payment System.

A. Claims Eligible for Review

A.1. BFCC-QIOs will conduct patient status reviews on a sample of inpatient hospital Part A claims for appropriateness of inpatient admission under the 2 midnight rule for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities impacted by CMS-1599-F.

A.2. Twice a calendar year, the BFCC-QIOs will conduct patient status reviews using a provider sample from claims paid within the previous 6 months.

B. Medical Records

B.1. BFCC-QIOs will request a minimum of 10 records in a 30-45-day time period from hospitals. The maximum number of record requests per 30 days will be 30 records.

B.2. A hospital's failure to provide the requested medical record for the identified claim(s) to the BFCC-QIO within 30-45 days of the request may result in the BFCC-QIO reopening the initial determination on the claim and a subsequent denial of payment on the claim(s) selected for review.

C. Provider Education

BFCC-QIOs shall rate and stratify providers for education and corrective action based upon the results of the completed initial patient status claim review.

1. C.1. Provider Results Letters
 - a. The BFCC-QIO shall develop a detailed results letter for all providers after the completion of the initial patient status claim review.
 - b. CMS minimally expects detailed results letters to include individualized, claim-by-claim denial rationales and encourages the BFCC-QIO to include the written clinical details that are to be discussed during any 1:1 telephonic education.
 - c. The letter shall include a specific phone number and/or point of contact, clearly indicated on the face of the letter for providers to request or schedule a provider education teleconference.
 - d. CMS will approve a letter template for the BFCC-QIOs to use to share the provider's results.
2. 1 on 1 Provider Education
 - a. The 1 on 1 (1:1) provider education is to be done within 90 days after BFCC-QIO's completion of the initial patient status claim review.

- b. The BFCC-QIO conducting 1:1 telephonic education for providers will use or facilitate the educational session with a clinician who is knowledgeable of the denied claim(s). **NOTE:** This knowledge may be the result of serving as the primary or secondary clinical reviewer for the identified claim(s).
 - c. The 1:1 provider education session is designed to be provider-specific and interactive giving the provider the opportunity to review the BFCC-QIO claim(s) decisions, ask questions and receive meaningful feedback conducive to behavioral change to increase provider compliance. The provider determines the appropriate personnel to receive the education.
 - d. The BFCC-QIO is to notify providers at the start of every teleconference that the discussion may be monitored by CMS as a third party for quality assurance purposes.
3. QIO Referral to the Review Auditors
- a. At the direction of CMS, the BFCC-QIO will refer providers with inpatient status claims identified as having ‘Major Concerns’ to the Recovery Audit Contractor (RACs) to implement provider specific audits.

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, as revised by CMS-1633-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 generally not appropriate for admissions where the expected length of stay is less than two midnights. Under the revised exceptions policy pursuant to CMS-1633-F, for admissions not meeting the two midnight benchmark, Part A payment is appropriate on a case-by-case basis where the medical record supports the admitting physician’s determination that the patient requires inpatient care, despite the lack of a 2 midnight expectation. The QIOs will consider complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event to determine whether the medical record supports the need for inpatient hospital care. These cases will be approved by the QIOs when the other requirements are met.

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 "supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities," according to § 1156 of the Social Security Act. 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 the QIOs will review the claim to determine if either the benchmark is met or the medical record supports the determination that the

patient required inpatient care. 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.

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 the initial determination on paid Part A inpatient 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).