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THE LIVANTA CLAIMS REVIEW ADVISOR

A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

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Short Stay Review (SSR) Atrial Fibrillation Case Scenarios

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the Two-Midnight Rule in Fiscal Year (FY) 2014 to assist in determining when an inpatient admission would be appropriate for payment under Medicare Part A (inpatient hospital services). Under the Two-Midnight Rule, inpatient admissions are generally payable under Part A if the admitting practitioner has a reasonable expectation that the patient will require a hospital stay that crosses two midnights and the medical record supports that expectation.

In the FY2016 Outpatient Prospective Payment System (OPPS) Final Rule, CMS amended the Two-Midnight Rule and clarified that, in certain circumstances, Medicare would also pay for inpatient stays that lasted less than two midnights on a case-by-case basis if the documentation in the medical record supports the determination that the patient required inpatient hospital care. The Two-Midnight Rule does not apply to procedures on the Inpatient-Only List.

Livanta is the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) conducting post-pay fee-for-service claim reviews of acute care inpatient hospitals, long-term acute care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims. These claims are reviewed in accordance with the Two-Midnight Rule published in FY 2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rule CMS-1599-F, as revised by CMS-1633-F.

This Rule outlines two medical review policies: (1) a two-midnight presumption; and (2) a two-midnight benchmark. CMS issued the following BFCC-QIO Two-Midnight Claim Review Guideline that graphically depicts the tenets of the Two-Midnight Rule. Livanta utilizes this Guideline when making payment determinations for SSR claims.

CMS Two-Midnight Claim Review Guideline (file may appear in a download folder)
https://www.cms.gov/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimReviewGuideline.%20508.pdf

SSR Case Scenarios as a Learning Tool

This month's issue of The Livanta Claims Review Advisor includes illustrative case scenarios in which the patients presented with atrial fibrillation. Atrial fibrillation (A-fib) is a common cardiac rhythm that increases in prevalence with advancing age. This irregular and often very rapid heart rhythm (arrhythmia) can lead to blood clots in the left atrium of the heart which may embolize to other parts of the body. A-fib increases the risk of stroke, heart failure, and other heart-related complications.

Atrial fibrillation can cause inefficient left heart function resulting in clotting that can embolize into the arterial circulation. Altered cardiac function from atrial fibrillation can decrease cardiac output resulting in hypotension or congestive heart failure. Atrial fibrillation associated with rapid ventricular response can lead to tachycardia with rate-related myocardial ischemia, chest pain, and hypotension.

Livanta is sharing these composite case scenarios describing the Medicare medical review process for SSR based on Medicare's Two-Midnight Rule. These case scenarios illustrate Medicare review considerations and documentation expectations related to application of the Two-Midnight Claim Review Guideline published by CMS. Through these scenarios, Livanta hopes to clarify the reasoning, the clinical considerations, and the necessary documentation related to compliance with the Two-Midnight Rule.

Pathophysiology of Atrial Fibrillation

Atrial fibrillation occurs due to structural and/or electrophysiologic abnormalities that alter atrial tissue. Diverse pathophysiologic mechanisms can cause these abnormalities leading to A-fib.

Atrial Electrical Abnormalities	Extra Cardiac Factors	Genetic Variants	Atrial Structural Abnormalities
Increased Heterogeneity	Hypertension	Channelopathies	Fibrosis
Decreased Conduction	Obesity	Cardiomyopathy	Dilation
Decreased Action Potential Duration	Sleep apnea		Ischemia
Increased Automaticity	Hyperthyroidism		Infiltration
Abnormal Intracellular Calcium	Alcohol/drugs		Hypertrophy

Management of A-fib has three objectives:

- rate control;
- prevention of thromboembolism; and
- correction of the rhythm disturbance.

Initial acute management primarily involves a rate control strategy. Addressing rhythm correction is another important consideration. All patients should be evaluated for reversible causes. Although the need for anticoagulation and the need to "rule out" myocardial infarction (MI) are often cited as indications for hospitalization, most patients with new onset A-fib can be successfully treated as an outpatient without needing inpatient admission.

Atrial Fibrillation Case Scenarios

Scenario 1

Case Summary

The patient is a 67-year-old male who presented to the hospital for elective cardioversion after amiodarone loading for persistent symptomatic atrial fibrillation (A-fib). The patient has a history of implantable cardioverter defibrillator (ICD) and coronary artery disease. Recently, the patient was treated as an outpatient for frequent episodes of A-fib. Outpatient treatment consisted of diuresis with furosemide and beta blockers with metoprolol tartrate 100 mg twice a day. Due to chronic atrial arrhythmia not associated with chest pain or acute hemodynamic changes, the patient underwent cardioversion without complications and was discharged to home the day of the procedure, after an overnight stay. He was to continue systemic anticoagulation with apixaban 5 mg twice a day.

Analysis using Two-Midnight Claim Review Guideline

See the BFCC-QIO Two Midnight Claim Review Guideline, below, for reference.

Step 1: Did the inpatient stay from the point of a valid inpatient admission order to discharge last two midnights?

No. The patient was discharged home after one midnight.

Step 2: Did the patient need hospital care?

Yes.

Step 3: Did the provider render a medically necessary service on the Inpatient-Only List?

No.

Step 4a: Was it reasonable for the admitting physician to expect the patient to require medically necessary hospital services for two midnights or longer?

No. The plan of care indicated that the patient would be discharged after successful cardioversion the day after admission.

Step 4b: Did the patient receive medically necessary hospital services for two midnights or longer including all outpatient/observation and inpatient care time?

No.

Step 4c: Did any of the following "unforeseen circumstances" result in a shorter stay?

- Death
- Transfer
- Departures against medical advice
- Clinical improvement
- Election of hospice

No.

Step 5: Does the claim fit within one of the "rare and unusual" exceptions identified by CMS (currently mechanical ventilation)?

No.

Step 6: Does the medical record support the admitting physician's determination that the patient required inpatient care despite not meeting the two-midnight benchmark based on complex medical factors such as:

- Patient history and comorbidities and current medical needs
- Severity of signs and symptoms
- Risk of an adverse event

No. The plan was for amiodarone loading, cardioversion, then discharge. There was no documentation to support the need for inpatient care without a two-midnight expectation. There was no documentation of or reason to believe that the patient was at increased risk of an adverse event occurring during the time for which hospitalization was considered.

Decision: Medicare requirements for inpatient admission under the Two-Midnight Rule, including medical necessity, were not met.

Scenario 2

Case Summary

This 79-year-old female presented to the emergency department (ED) after hitting the right side of her head during a fall associated with lightheadedness. The patient related that she had had several falls in recent weeks. Her medical history included hypertension (HTN), hyperlipidemia (HLD), chronic kidney disease (CKD), and hypothyroidism. She had recently stopped taking her home diltiazem. On presentation, the patient was no in acute distress. Her vital signs were remarkable for a heart rate of 156 and blood pressure of 170/80. The laboratory test results were significant for a white blood cell (WBC) count of 12.09, D-dimer of 1.35, initial troponin of 41, and brain natriuretic peptide (BNP) of 1,662. Electrolytes were normal. The computed tomography (CT) scan of the head showed no acute intracranial abnormalities and a CT scan of the cervical spine showed no acute fractures. The patient had a CT angiography (CTA) of the chest which was negative for pulmonary embolism. An electrocardiogram (ECG) showed atrial fibrillation (A-fib). There was no evidence of acute cardiac ischemia or an acute pulmonary event. Cardiology was consulted and the patient was treated with intravenous (IV) diltiazem with conversion to sinus rhythm while still in the ED prior to inpatient admission. The patient was admitted to inpatient status with a plan of care that included telemetry monitoring, diltiazem, and an echocardiogram. The patient was discharged to home the day after presentation in normal sinus rhythm.

Analysis using Two-Midnight Claim Review Guideline
See the BFCC-QIO Two Midnight Claim Review Guideline, below, for reference.

Step 1: Did the inpatient stay from the point of a valid inpatient admission order to discharge last two midnights?
No. The patient was discharged home after one midnight.

Step 2: Did the patient need hospital care?
Yes.

Step 3: Did the provider render a medically necessary service on the Inpatient-Only List?
No.

Step 4a: Was it reasonable for the admitting physician to expect the patient to require medically necessary hospital services for two midnights or longer?
No. It was not reasonable to expect this patient to stay two midnights in the hospital based on the patient's resolved symptoms and plan of care. The patient converted to normal sinus rhythm while still in the ED before the inpatient admission order was given and she was hemodynamically stable upon admission.

Step 4b: Did the patient receive medically necessary hospital services for two midnights or longer including all outpatient/observation and inpatient care time?
No.

Step 4c: Did any of the following "unforeseen circumstances" result in a shorter stay?
- Death
- Transfer
- Departures against medical advice
- Clinical improvement
- Election of hospice

No.

Step 5: Does the claim fit within one of the "rare and unusual" exceptions identified by CMS (currently mechanical ventilation)?
No.

Step 6: Does the medical record support the admitting physician's determination that the patient required inpatient care despite not meeting the two-midnight benchmark based on complex medical factors such as:
- Patient history and comorbidities and current medical needs
- Severity of signs and symptoms
- Risk of an adverse event

No. The patient presented with A-fib with rapid ventricular response (RVR). She had recently stopped her home diltiazem. She was started on diltiazem drip and converted to sinus rhythm prior to the inpatient admission order. She was hypertensive on presentation and her home dose of diltiazem was restarted. There were no acute findings on imaging, including chest x-ray, CT scan of head, and CT scan of cervical spine. The chest CT scan showed no evidence of pulmonary embolus. According to the history and physical documentation, the elevated troponin was likely due to a history of CKD and

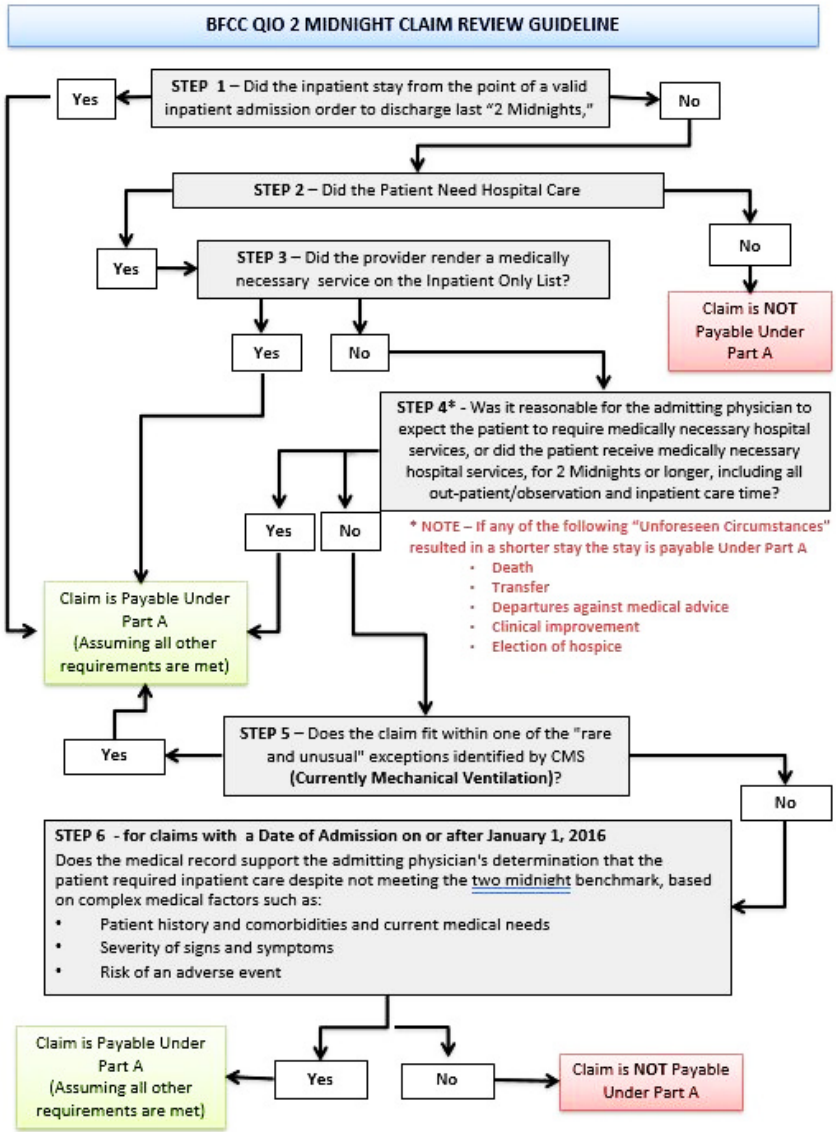
underlying arrhythmia leading to demand ischemia. There was no documentation to support the need for inpatient care without a two-midnight expectation. There was no documentation of or reason to believe that the patient was at increased risk of an adverse event occurring during the time for which hospitalization was considered.

Decision: Medicare requirements for inpatient admission under the Two-Midnight Rule, including medical necessity, were not met.

CMS Two-Midnight Claim Review Guideline

The CMS Two-Midnight Claim Review Guideline is posted on the cms.gov website. Livanta includes a copy of the Guideline here, for convenience. A link is also included for reference.

CMS Two Midnight Claim Review Guideline (file may appear in a download folder)
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/-Policy-Decision-Guideline-Temporary-Suspension-of-Two-Midnight-Reviews.pptx



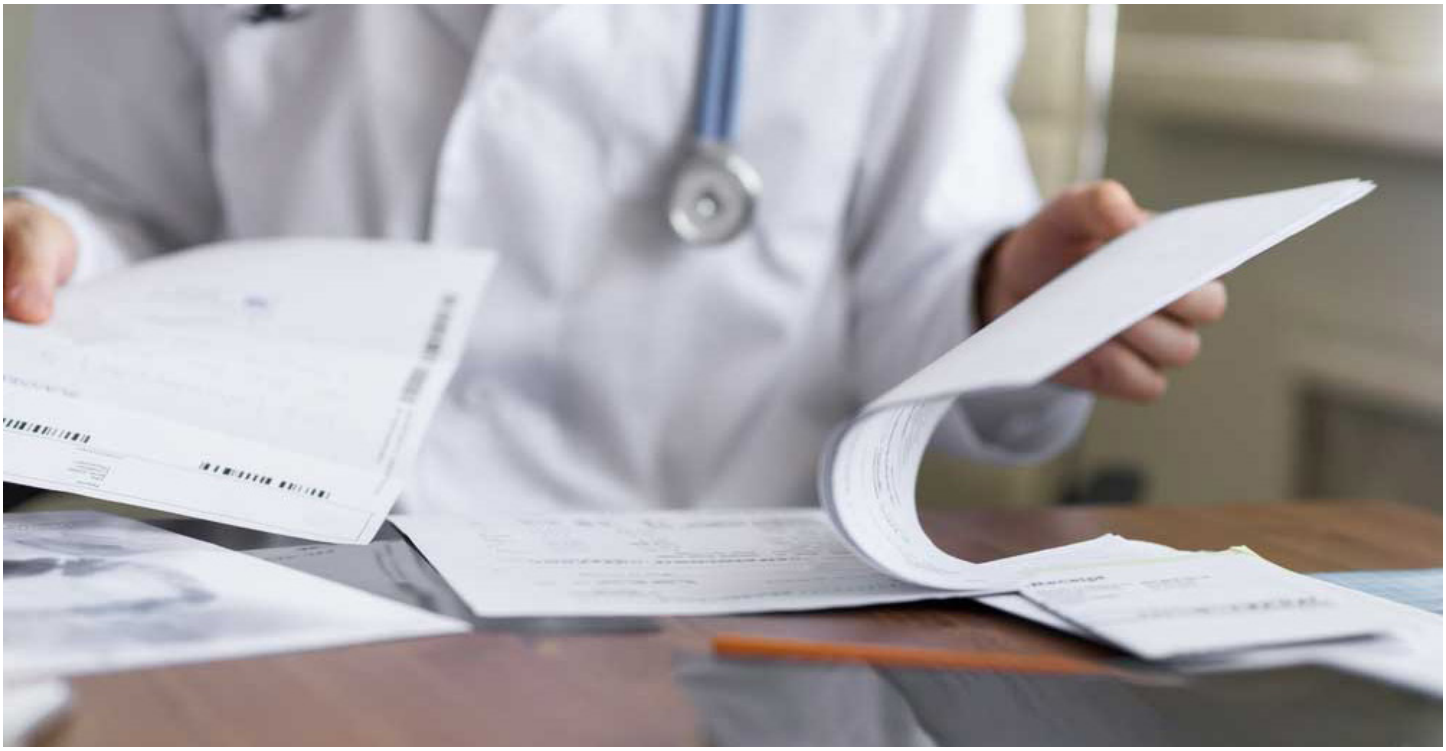
SSR Review Steps and Considerations

Livanta evaluates each sampled claim using the Two-Midnight Claim Review Guideline featured herein to determine if the payment made was appropriate under Medicare Part A. If the Part A payment is deemed not appropriate, a letter outlining the concern is sent to the hospital QIO Liaison. The hospital is encouraged to respond with their rationale and/or to request an education session to discuss the potential denial.

If the hospital does not agree with the initial determination, appropriate personnel should outline their specific concerns in a request for a second review. In this request, the hospital should note specific information in the medical record that would support the decision for inpatient admission. The support for the decision should be confined to the application of the SSR Claim Review Guideline as it pertains to the documentation in the medical record. Speculation on the physician's intent that is not supported with documentation in the record cannot be considered. Livanta is restricted to the written documentation in making their determination. It is important to note that CMS does not consider commercial clinical decision support systems (e.g., InterQual or MCG) authoritative, so reference to these guidelines as the major or sole support for an inpatient admission decision that does not adhere to the Two-Midnight Rule requirements will not support Part A payment.

If the claim is ultimately denied, the hospital can file an appeal with the Medicare Administrative Contractor (MAC) that processed the claim for payment.

Documentation to Support the Inpatient Admission Decision



Atrial Fibrillation – following are some examples of documentation that would support the need for an inpatient stay.

- Documentation of severe bradycardia or blood pressure instability after cardioversion

- Treatment of an associated medical problem which may be the reason for the arrhythmia (for example, the treatment of infection, exacerbation of chronic obstructive pulmonary disease, pulmonary embolism, persistent myocardial ischemia, or acute pericarditis)

Patients are often placed in an observation protocol to rule out acute MI, and inpatient hospitalization is not required unless there is ongoing ischemia or suspected acute coronary syndrome that requires intervention.

As demonstrated with the case scenarios above, documentation of the physician's reasons supporting inpatient admission is critical to a good review outcome. Denial may be avoided if the inpatient admission decision is delayed until there is sufficient information available to support a plan of care that would reasonably require two midnights in the hospital. If the physician determines that inpatient care is required even though the expected stay is less than two midnights, reasonable support for this decision must be documented in the medical record.

Questions?

Should you have questions, please email **ClaimReview@Livanta.com**.

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