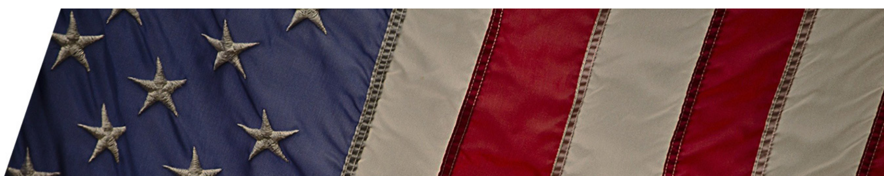
January 2023

THE LIVANTA CLAIMS REVIEW ADVISOR



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

Volume 1, Issue 12 www.LivantaQIO.com Open in browser

The Two-Midnight Rule

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, an inpatient admission is generally appropriate for Medicare Part A payment if the physician (or other qualified practitioner) admits the patient as an inpatient based upon the expectation that the patient will need hospital care that crosses at least two midnights and the medical record supports that expectation. This Rule outlines two medical review policies: (1) a two-midnight presumption; and (2) a two-midnight benchmark.

In the FY2016 Outpatient Prospective Payment System (OPPS) Final Rule, CMS amended the Two-Midnight Rule and clarified that Medicare would allow exceptions to the two-midnight benchmark to be determined on a case-by-case basis by the physician responsible for the care of the patient, subject to medical review. CMS continues to expect that stays under 24 hours would rarely qualify for an exception to the two-midnight benchmark.

The Two-Midnight Rule does not apply to procedures on the Inpatient-Only List.

SSR Case Scenarios as a Learning Tool

This month's issue of *The Livanta Claims Review Advisor* includes composite case scenarios for patients who presented with a transient ischemic attack (TIA). TIA is defined as a transient episode of neurologic dysfunction due to focal brain, spinal cord, or retinal ischemia, without acute infarction or tissue injury. The historical time-based definition was based on full resolution of all symptoms within 24 hours of onset.

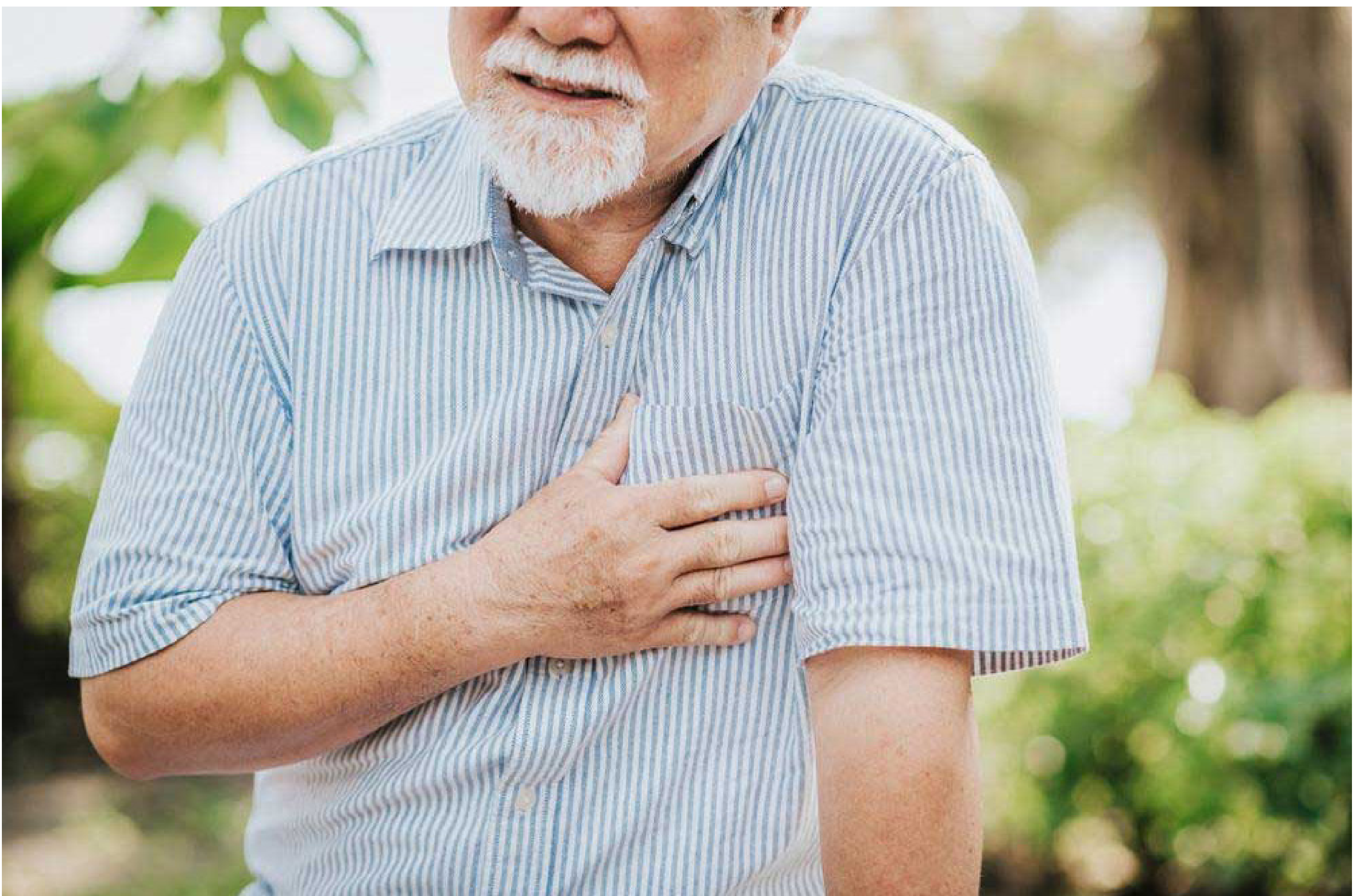
Transient Ischemic Attack

TIA is diagnosed in approximately 0.3 percent of all emergency department (ED) visits (1). Lacking compelling evidence establishing significant outcome differences between TIA and minor stroke, the two terms are often used interchangeably and are managed similarly. Aided by history, examination,

and imaging, finding the cause of transient ischemia is key to preventing recurrent stroke: up to 80% of strokes after TIA are preventable (2). Therefore, for practical purposes, the comments below on TIA can be applied to minor stroke. A minor stroke is generally defined as a National Institute of Health Stroke Scale (NIHSS) score of 3 or less (3).

Patients with TIA are at risk of recurrent ischemic stroke. Approximately 15 percent of strokes are preceded by TIA (4). The goals of management include establishing the severity of the deficit, its etiology, and appropriate management, including secondary prevention of major adverse cardiovascular events (MACE) including stroke. Initial evaluation including history, physical, laboratory assessment, neuro-imaging, and vascular assessment can usually be accomplished expeditiously. Brain computed tomography (CT) scan is the initial scan of choice due to its rapid and wide availability. It can exclude hemorrhage and large mass occupying lesions. However, CT is not sensitive to ischemia within the first 48 hours of ischemic events; thus, MRI might be indicated based on timing and presentation of a patient’s condition (3). Hemorrhagic stroke will not be discussed in this article.

Establishment of the source of embolic stroke for treatment and secondary MACE prevention is important at initial evaluation. In addition to CT scan and MRI, evaluation may include echocardiography, carotid ultrasound, and further laboratory evaluation including lipids.



An accurate diagnosis of ischemic stroke or TIA is essential for justifying and optimizing stroke prevention. Control of hypertension, blood glucose, and lipids, smoking cessation, diet, and exercise have been proven effective for reducing the risk of ischemic stroke. An assessment of whether the patient is at therapeutic goal helps to optimize therapy (3).

TIA and the Two-Midnight Rule

Patients with resolved deficits or persistent minor deficits may be risk-stratified for discharge from the emergency department with close outpatient follow up or further hospital based testing. From a reimbursement perspective, the expectation of a two-midnight stay or need for inpatient care despite the lack of a two-midnight expectation is based upon the patient's clinical condition and documentation at the time of the inpatient admission order. Documentation should include the severity of any deficits, the plan of care, including secondary testing, and treatment currently being provided.

Reasonable Expectation of a Two-Midnight Stay

Documentation required to support a two-midnight expectation should be patient-specific and include the plan of care, treatment being provided, and an estimate of reasonable timeframe to complete. Part A payment is not appropriate for lengths of stay less than two midnights due to hospital convenience, physician convenience, or patient request. Optimal documentation also includes any other comorbid conditions that require urgent or emergent treatment and the plan of care for these conditions. Livanta advises that patient specific information informing the two-midnight expectation be documented in the medical record so that the hospital physician's reasoning is clear to the medical reviewer.

Need for Inpatient Care Without a Two-Midnight Expectation

For Part A payment without a two-midnight expectation, the documentation must support the inpatient admission plan of care and evaluation that places the patient at increased risk **during** the timeframe for which hospitalization is considered. Documentation of treatment such as high-risk medication such as nicardipine to control blood pressure or difficult to control cardiac dysrhythmias are some examples of treatments that place the patient at high risk **during** the hospitalization. Stable comorbid conditions are considered in assessing clinical risk. However, the provider must keep in mind the risk that is used for determining Part A payment is not the same clinical risk that assessment tools use to risk-stratify patients for ED discharge with outpatient follow-up or for further testing or evaluation in the hospital setting.

Risk

Numerous risk prediction scores have been developed to help identify high-risk patients in order to prioritize services. However, these tools are not designed to determine payment source, hospital length of stay (LOS), or risk of an adverse event during the timeframe for which hospitalization is considered. The documentation at the time of inpatient admission must support a two-midnight expectation or an increased risk **during** the time period for which hospitalization is anticipated. The

patient's risk assessment and evaluation of possible underlying etiology of the TIA (e.g., cardiac thrombus in atrial fibrillation or carotid stenosis) does not generally require two midnights of care to evaluate and maximize medical therapy. Low- and medium-risk patients are often evaluated in the outpatient clinical setting within seven days of presentation. Documentation should be clear enough to make the reason for inpatient care evident to the medical reviewer.

TIAs are medical emergencies that require prompt multimodal therapeutic interventions specifically targeted at identifying and managing the underlying etiology for immediate stabilization and to initiate steps to reduce the risk of recurrent strokes. Risk stratification tools such as ABCD2 or ABCD3-I are useful for determining high risk patients that should not be discharged without further evaluation with MRI and neurological specialty consultation. However, these tools were not designed to determine LOS or resource utilization and are not alone sufficient justification for Part A payment. Case-specific documentation at the time of the inpatient admission order clarifying the factors that led to the decision for inpatient admission guides the medical review decision.

References

1. Edlow JA, Kim S, Pelletier AJ, Camargo CA Jr. National study on emergency department visits for transient ischemic attack, 1992-2001. Acad Emerg Med. 2006 Jun;13(6):666-72. doi: 10.1197/j.aem.2006.01.014. Epub 2006 Apr 11. PMID: 16609106. Available at https://pubmed.ncbi.nlm.nih.gov/16609106/. Accessed 9/26/2022.
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3. 2021 Guideline for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack: A Guideline From the American Heart Association/American Stroke Association. Dawn O. Kleindorfer, Amytis Towfighi, Seemant Chaturvedi, et al. Originally published 24 May 2021 https://doi.org/10.1161/STR.0000000000000375Stroke. 2021;52:e364–e467. Available at https://www.ahajournals.org/doi/10.1161/STR.0000000000000375. Accessed 9/26/2022.
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Transient Ischemic Attack Case Scenarios

Scenario 1

Case Summary

This 70-year-old patient presented to the emergency department (ED) from the colonoscopy suite with complaints of acute dysarthria and perioral numbness. The patient stated that symptoms had occurred before and resolved. The patient has a history of a cerebrovascular accident (CVA), hypothyroidism, hypertension, hyperlipidemia, and shingles. This episode of dysarthria lasted about five minutes. Upon presentation to the ED, the patient was hemodynamically stable and afebrile. All neurologic symptoms had resolved prior to presentation. A CT scan showed no acute intracranial

abnormality. The patient was admitted to inpatient status with a plan of care that included a neurology consultation, neurological checks, and repeat imaging. Neurology advised that the patient could be discharged and followed up as outpatient. The patient was discharged to home after an overnight stay.

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 documented plan of care at the time of the inpatient admission order was to obtain a neurology consultation, perform neurologic checks, and obtain an MRI. The patient was neurologically asymptomatic and hemodynamically stable at the time of inpatient admission. These circumstances do not support an expectation of a two-midnight stay.

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 documentation at the time of the inpatient admission order indicated the patient was hemodynamically stable, without CT abnormalities, unremarkable chest x-ray, with no indication for tPA/thrombectomy or other invasive interventions. Documentation indicates the patient's chronic comorbid conditions were stable and did not require intervention. The patient's clinical condition and evaluation do not indicate an increased risk of an adverse event occurring during the time period for which hospitalization is considered.

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

Scenario 2

Case Summary

This 80-year-old patient presented with one hour of left facial droop. The patient has a medical history of hypertension, hyperlipidemia, diabetes mellitus, and end-stage renal disease on dialysis. The patient was also on an anticoagulant (apixaban). On arrival, the patient's NIHSS score was 1 for facial droop without other deficits. Blood pressure was 160/70, respiratory rate 14, heart rate 60 in atrial fibrillation, and pulse oximetry 97 percent on room air. The patient's symptoms resolved while in the CT scanner. CT results were negative for hemorrhage or mass effect. Laboratory evaluation was unremarkable. Electrocardiogram (EKG) showed atrial fibrillation without ischemic changes. While in the ED, the patient experienced a second TIA. A stat carotid ultrasound was performed that showed an 80 percent carotid stenosis. The patient was admitted to inpatient status the same day with a plan for dual antiplatelet therapy, permissive hypertension, and consultation with neurology and vascular surgery to consider acute carotid intervention. The patient was discharged home the next 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?

Yes. Given the recurrence of symptoms and identification of a high grade carotid stenosis, intervention was a consideration, and a two-midnight stay could be expected.

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

No. The patient presented to the ED, was admitted the same day as presentation, and was discharged after an overnight stay.

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**

Because the patient met the two-midnight expectation at Step 4a, Step 6 does not need to be addressed to meet the requirements for Part A payment. However, the recurrence of symptoms raises the question of stroke in evolution and justifies inpatient admission regardless of length of stay expectation due to the imminent risk of an adverse event during the hospitalization.

Decision: Medicare requirements for inpatient admission under the Two-Midnight Rule, including medical necessity, were met. Part A payment is appropriate.

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's Quality Improvement Organization (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 Two-Midnight 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.

TIA: Documentation to Support the Inpatient Admission Decision

Some examples are included below of documentation that would indicate a reasonable expectation of a two-midnight stay and therefore qualify for Part A payment under the Two-Midnight Rule. Ideally, these should be specifically referenced in the medical record.

- The patient is scheduled for surgical intervention during this hospital stay
- The patient is neurologically or hemodynamically unstable at the time of the inpatient admission order
- Brain imaging suggests an unstable or evolving process
- Best medical therapy or anticoagulation cannot be transitioned to an outpatient basis in less than two midnights
- The patient is administered high-risk medications or requires intensive monitoring
- Presence of other acute medical events that will extend the length of stay

Livanta advises that patient-specific documentation be included in the medical record to support the reason for inpatient admission. As demonstrated with the case scenarios above, a favorable medical review decision is facilitated when there is documentation of the factors that support either a two-midnight expectation or the need for inpatient care. When the information to support Part A payment is lacking, appropriately deferring the decision to admit to inpatient status does not adversely affect reimbursement since the medical review decision is based on the information available when the inpatient admission order is written.

About Livanta

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.

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

Questions?

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