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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 Chest Pain Case Scenarios

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 expects the patient to require a hospital stay that cross two midnights and the medical record supports that reasonable 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 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 downloads as a PDF file)
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 chest pain case scenarios. Second only to injuries, chest pain is a common reason for adults to present to the emergency department in the United States. Chest pain can have many etiologies. The most common diagnostic focus for patients with chest pain is evaluation for acute coronary syndrome (ACS).

In sharing these case scenarios, Livanta describes 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 shine a light on the reasoning, the clinical considerations, and the necessary documentation related to compliance with the Two-Midnight Rule.

Evaluation of ACS in Patients with Chest Pain

The characteristics of the pain are critically important. Timing, duration, relation to exercise, response to treatment all can help distinguish chest pain of cardiac origin from other causes such as reflux, pulmonary conditions, or musculoskeletal pain. The patient's physical findings and these pain characteristics help determine the potential severity of the presenting event. Although the clinical presentation is important to document, it is often insufficiently specific to conclude a diagnosis of ACS.

Diagnostic studies support the clinical impression and serve as important documentation. The common diagnostic modalities applicable in the emergent setting to evaluate cardiac etiology of chest

pain include diagnostic algorithms such as Heart Scores and interpretation of electrocardiograms (ECGs) and biomarkers (i.e., troponin levels).

Interpretation of a current ECG is a critical diagnostic tool. Evidence of ECG changes consistent with acute ischemia (ST segment elevation or depression) may support the diagnosis of ACS. Comparison to old ECGs as well as clinical context are critical and should be documented when possible. Adult patients without evidence of ST-elevation ACS can be risk-stratified to predict the incidence of 30-day major acute cardiac event (MACE). Although Heart Scores may be used as a clinical prediction instrument for risk stratification, they are not a tool for predicting length of stay and are not designed to determine the need for inpatient status.

Read more: Clinical Policy: Critical Issues in the Evaluation and Management of Emergency Department Patients With Suspected Non–ST-Elevation Acute Coronary Syndromes (opens as downloaded PDF from the American College of Emergency Physicians)
https://www.acep.org/globalassets/new-pdfs/clinical-policies/nste.acs.2.2018.final.pdf

Laboratory results offer insight to the clinical diagnosis as well. A sensitive and specific indication of cardiac myonecrosis, troponin released from myocytes into the systemic circulation can result in an elevated level; however, an elevated troponin is nonspecific relative to the etiology of cardiac myonecrosis it represents. Although troponin is more specific than other cardiac markers it can still be elevated in other conditions and should always be interpreted in the context of the clinical presentation and pre-test likelihood that it represents myocardial infarction (MI).

Most patients presenting with chest pain can be evaluated with ED or short stay observation using a combination of symptom and electrocardiographic monitoring, laboratory testing, cardiac imaging, stress testing, or related diagnostic evaluations. Invasive testing and further hospital care can be determined after initial evaluation, pre-test risk stratification, and expert cardiology consultation.

Reference

ACCF 2012 Expert Consensus Document on Practical Clinical Considerations in the Interpretation of Troponin Elevations: A Report of the American College of Cardiology Foundation Task Force on Clinical Expert Consensus Documents. L. Kristin Newby, Robert L. Jesse, Joseph D. Babb, Robert H. Christenson, Thomas M. De Fer, George A. Diamond, J Am Coll Cardiol. 2012 Dec, 60 (23) 2427–2463

Chest Pain Case Scenarios

Scenario 1

Case Summary

This 73-year-old male with a history of five-vessel coronary artery bypass graft and prior percutaneous coronary intervention developed chest pain radiating to his neck and arms that was relieved with nitroglycerin after 45 minutes. On presentation to the emergency department (ED), his chest pain had resolved, but he complained of “soreness.” His blood pressure was 135/85, and he was stable. His examination was unremarkable, and an ECG showed normal sinus rhythm without any ST changes. The initial troponin was negative. His blood urea nitrogen (BUN) and creatinine were mildly elevated at 6 mg/dL and 143 mL/min respectively. The patient was admitted for serial troponins and a stress test in the morning. He did well overnight, troponins remained negative, and there was no recurrence of his chest pain. The BUN/creatinine improved with intravenous fluids. His stress test was negative for cardiac issues. The patient was discharged after a one-midnight stay to follow up with his outpa-tient providers.

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 patient had chest pain without any other features associated with acute coronary syndrome

(ACS) such as hypotension, ECG changes, or elevated troponin. The chest pain had resolved with the exception of "soreness" at the time of ED presentation. Chest pain is a common and non-specific complaint. While the patient had an episode of chest pain with response typical for angina, his pain was almost completely resolved, and his vital signs were stable on presentation. This may have been an isolated anginal episode but at this point it does not qualify as ACS. The negative troponins and normal ECG speak against active ischemia. Therefore, additional testing would be required to determine whether ACS is present. Absent additional evidence of ongoing ischemia, the patient would not be expected to stay two midnights. His BUN and creatinine would be expected to respond to hydration in less than two midnights.

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. Nothing was documented about the patient's history, comorbidities, medical needs, signs, symptoms, or risk of an adverse event that supported the need for inpatient care without a two-midnight expectation. The patient did not receive treatment associated with a "code heart" or ACS. The patient's evaluation did not indicate an increased risk (probability) of an adverse event occurring during the time period 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 68-year-old male presented with post-prandial chest pain at an outside facility, where he was given aspirin and nitroglycerin. Then, on the same day, he was transferred to the current facility for

further evaluation. His chest pain was resolved at the time of transfer, and he was pain-free on arrival. He was hemodynamically stable with a mild troponin elevation at 0.10 ng/ml and no ECG changes. The patient has a medical history of coronary artery disease and a recent cardiac catheterization with stent placement. The patient also has gastroesophageal reflux disease (GERD) and moderate chron-ic kidney disease (CKD). The record indicated a low likelihood of a new cardiac event in light of the recent angiogram and stent placement. The patient was admitted to evaluate for ACS with Cardiology consultation the morning after admission. It was determined that he did not have an acute cardiac event, and he was discharged home after one midnight to continue follow-up with a cardiologist as an outpatient.

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 expected length of stay at the time of inpatient admission was pending the cardiology consultation.

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. The patient did not have an "unexpected clinical improvement" since he was asymptomatic with stable vital signs on arrival to the ED.

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 was admitted to obtain further diagnostic testing and to monitor for the possibility of ACS. He was not treated for ACS. The patient was not seen as an emergency by cardiology, but consultation was deferred to the morning, again consistent with the need to obtain further information before arriving at a diagnosis of ACS. While the patient was transferred from an outside institution, the receiving institution has the responsibility of determining the patient's diagnosis and plan of care. When a transfer patient is accepted, the receiving hospital must independently determine the need for hospitalization, services required, and the likelihood of a two-midnight stay. Nothing was documented about the patient's history, comorbidities, medical needs, signs, symptoms, or risk of an adverse event that supported the need for inpatient admission without a two-midnight expectation. The patient's evaluation did not indicate an increased risk (probability) of an adverse event occurring during the period of time for which hospitalization was considered.

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

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, they 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

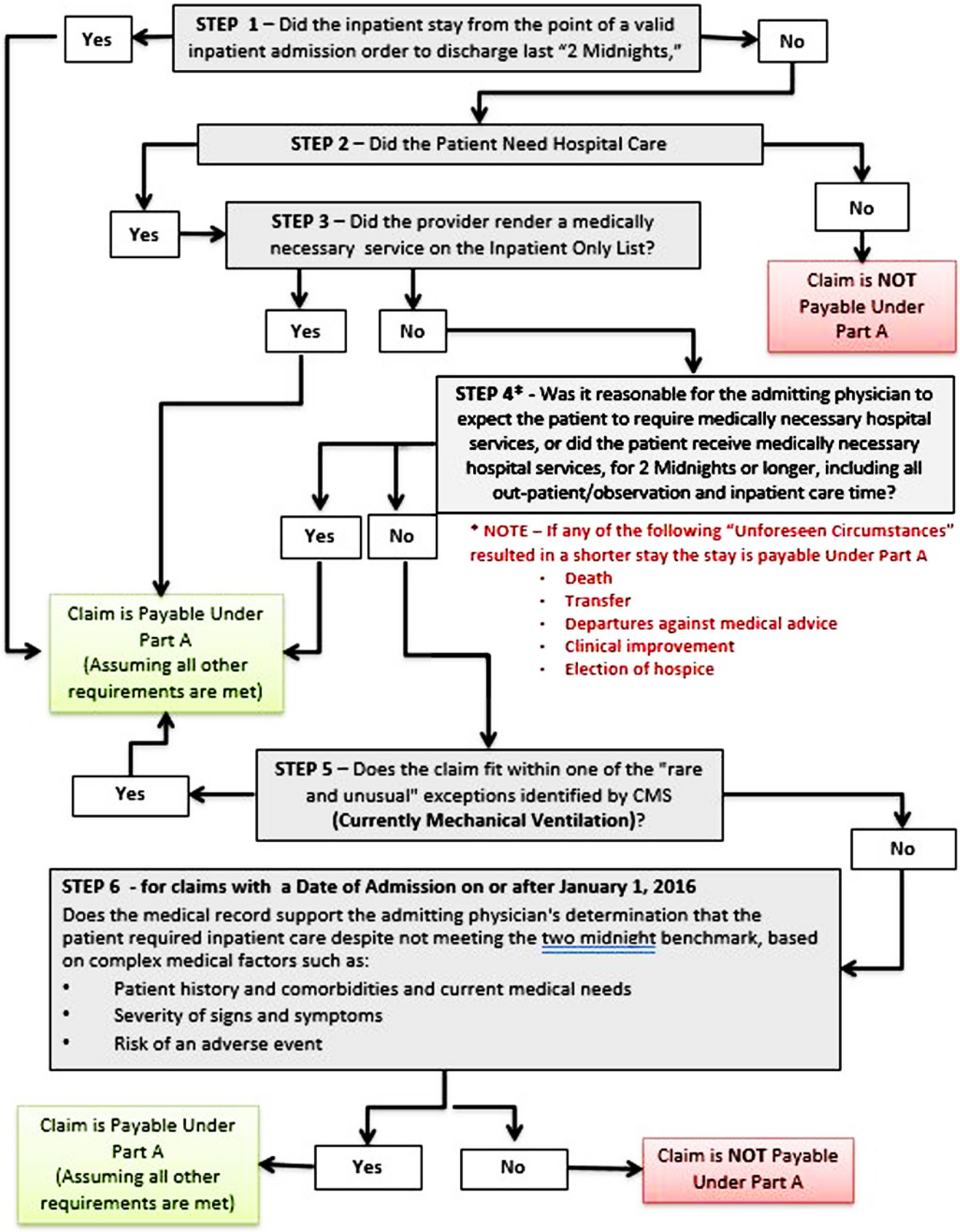
As demonstrated with the case scenarios above documentation of the physician's reasons supporting inpatient admission is critical to a good review outcome. Denial may be avoided if the inpatient admission decision is delayed until there is sufficient information available to support a plan of care that 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.

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. The file was last accessed July 28, 2022. 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

BFCC QIO 2 MIDNIGHT CLAIM REVIEW GUIDELINE



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Questions?

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

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