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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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Exploring Short-Stay Claim Review Guidelines

In this issue of The Livanta Claims Review Advisor:

- History and Background of Short-Stay Claim Reviews
- Short Stay Medical Review
- Step-by-step Guideline for Short-Stay Determinations
- Documentation Features

Brief History of Short-Stay Claim Reviews

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 would generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported 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 supported the determination that the patient required inpatient hospital care. The Two-Midnight Rule does not apply to procedures on the Inpatient-Only List.

Under CMS direction, Livanta is the Beneficiary and Family Centered Care -Quality Improvement Organization (BFCC-QIO) conducting 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 also issued a BFCC-QIO Two-Midnight Claim Review Guideline that graphically depicts the tenets of the Two-Midnight Rule.

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

FY 2014 IPPS Final Rule - 78 FR 50938 – 50954 (Medical Necessity Review on Inpatient Admissions)
https://www.govinfo.gov/content/pkg/FR-2013-08-19/pdf/2013-18956.pdf

FY2016 Outpatient Prospective Payment System (OPPS) Final Rule - 80 FR 70297 – 70607
https://www.govinfo.gov/content/pkg/FR-2015-11-13/pdf/2015-27943.pdf

Short-Stay Medical Review

Two-Midnight Presumption
Inpatient hospital claims with lengths of stay two midnights or greater after formal inpatient admission are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, unless there is evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the two-midnight presumption. Therefore, these inpatient claims are not subject to sampling under the Short Stay Review (SSR) program. This presumption is explained in Livanta's Step-by-Step Guideline for Short-Stay Review Determinations.

Two-Midnight Benchmark
The two-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. This guidance is consolidated in the graphic Two-Midnight Claim Review Guideline issued by CMS, noted below. Livanta follows these steps when making SSR determinations for sampled inpatient claims of less than two midnights.

Applying the Claim Review Guideline
The Two-Midnight Rule does not set a standard of care or dictate what kind of care physicians should be providing for patients. The rule is designed to determine how claims will be paid. In most cases, physicians should generally treat patients expected to require medically necessary hospital care for less than two midnights under outpatient care or observation services.

Support for a stay expected to be two midnights or longer
CMS acknowledges that there are circumstances where the patient's length of stay may be less than that initially estimated at the time of admission. Physician estimates of length of stay should be made based on data, clinical judgment, and plans of care. Documentation of these factors is reviewed specific to the admission and to support of the two-midnight expectation. Generic statements accompanying inpatient orders in many electronic medical records do not provide sufficient clarity to support such decisions.

For those hospital stays in which the physician cannot reliably predict the beneficiary to require a hospital stay of two midnights or more, the physician should continue to treat the beneficiary as an outpatient and then admit as an inpatient if and when additional information suggests a longer stay or the passing of the second midnight is anticipated.

Support for admission without a two-midnight expectation
At the time of admission, if a physician believes that the situation is one of the infrequent situations where inpatient care is required—despite the fact that such care is not expected to span at least two midnights—then he or she should explicitly document the reason the specific case requires inpatient care as opposed to hospital services in an observation status. Upon review, CMS and its contractors retain the discretion to determine whether the documentation is sufficient to support the medical necessity of the inpatient admission.

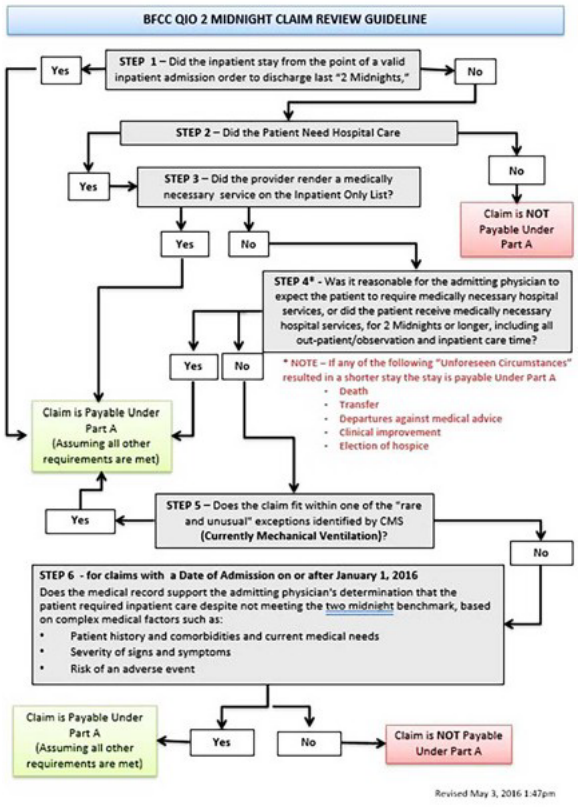
The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

The use of telemetry, by itself, is not considered a service that would justify an inpatient admission in the absence of a two-midnight expectation

CMS also specified in the Final Rule that treatment in an intensive care unit should not be an exception to this standard, as the two-midnight benchmark policy is not contingent on the level of care required or the placement of the beneficiary within the hospital.

Potential quality of care issues noted during a review for payment of a short stay are referred to the appropriate Regional BFCC-QIO for follow up.

Step-by-Step Guideline for Short-Stay Review Determinations



Livanta includes a copy of the Guideline here, for convenience. The file was last accessed March 29, 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/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimReviewGuideline.%20508.pdf

Livanta operationalizes this Guideline issued by CMS for claim reviews to approve or deny the sampled claims, using the documentation in the medical record associated with the claim. There are three potential final outcomes of a Short Stay Review:

- Approved: the claim is appropriate for Medicare Part A payment.
- Excluded: the claim meets one or more of the exclusion criteria outlined in the Rule.
- Denied: the claim is not appropriate for Medicare Part A payment.

Hospitals can check on the status of their claim reviews at Livanta's Claim Review Services website: https://livantaqio.com/en/ClaimReview/Provider/case_lookup.html

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

- Yes to this step leads to the claim being Approved
- No to this step sends the review onto Step 2

Step 1 is related to the Two-Midnight Presumption and only counts time after the inpatient admission order. Outpatient time is taken into consideration at Step 4b.

Step 2: Did the patient need hospital care?

- Yes to this step leads the review onto Step 3
- No to this step requires physician review for a potential denial

Part A payment is not appropriate for purely custodial care. Part A payment is generally not appropriate in the following circumstances: Care rendered for social purposes; care rendered for convenience only; delays in providing medically necessary care (generally, delays greater than 24 hours for consultations, testing, care plan documentation).

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

- Yes to this step leads to the claim being Approved as an exclusion
- No to this step sends the review onto Step 4

In implementing the CMS Guideline, Livanta samples with the goal to avoid claims with procedure codes associated with a procedure on the applicable Inpatient-Only List. Due to crosswalk complexities, an occasional sampled claim procedure may be on the Inpatient-Only List. The medical record for such a claim is reviewed by a certified coder to ascertain whether or not the actual procedure performed is a procedure on the Inpatient-Only List. If it is determined that the procedure performed is on the Inpatient-Only List, the claim is approved for payment under Medicare Part A as an exclusion. If the patient presents for a scheduled procedure on the Inpatient-Only List and the procedure is aborted or cancelled, the claim is also approved for payment as an exclusion

Step 4: Was it reasonable for the admitting physician to expect the patient to require medically necessary hospital services, or did the patient receive medically necessary hospital services for two midnights or longer, including all outpatient/observation and inpatient care time?

Livanta breaks this step down into three components.

4a: Was it reasonable for the admitting physician to expect the patient to require medically necessary hospital services?

- Yes to Step 4a sends the review onto Step 4b
- No to Step 4a requires physician review for a potential denial, if Steps 4b, 4c, and 5 are also answered No

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

- Yes to Step 4b leads to the claim being Approved
- No to Step 4b sends the review onto Step 4c

For patients who are transferred from one facility to another, the BFCC-QIO considers pre-transfer time and care provided to the beneficiary at the initial hospital. 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 are excluded.

4c: Did any of the following "unforeseen circumstances" result in a shorter stay? (select from Death, Transfer, Departures against medical advice, Election of hospice, Clinical improvement)

- Selection of any option at Step 4c leads to the claim being Approved as payable under Medicare Part A.

Generic statements such as "I anticipate a 2 midnight stay" are not sufficient to meet Step 4. The physician documentation of the evaluation and plan of care must indicate a reasonable expectation of a two-midnight stay. If determination of the length of stay will be based on results of further testing, the decision for inpatient admission should await these test results.

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

- Yes to this step leads to the claim being Approved
- No to this step sends the review onto Step 6

This involves newly initiated mechanical ventilation when medically necessary and excluding anticipated intubations related to minor surgical procedures or other treatment.

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, or risk of an adverse event?

- Yes to this step leads to the claim being Approved
- No to this step leads to a potential denial of the claim

The decision on this step is always the result of physician review. The physician's documentation must indicate the reason the patient needs inpatient admission without a two-midnight expectation. The care provided along with the reason for the admission must represent a risk above the patient's baseline risk. The "patient risk" that qualifies under this category is not the patient's baseline risk but the risk of the treatment provided that recognizes the patient's comorbidities. In general, the patient's comorbidities are only relevant to this decision in so far as they influence the management of the condition that required admission. This influence should be documented in the record.

Documentation is Key

For Medicare payment purposes, both the decision to keep the patient at the hospital and the expectation of needed duration of the stay must be supported by documentation in the medical record based on factors such as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event during hospitalization.

Document case-specific features that would support the expectation of a two-midnight stay at the time of admission, such as a complex plan of care, need for frequent monitoring, impact of comorbidities, likelihood of an adverse event, or specific services that can only be provided in the hospital. Be as specific as possible. 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 two-midnight expectation.

There are three ways that a patient can meet medical necessity for Part A payment:

- Services that required hospital services for at least two midnights;
- Documented reasonable expectation of two midnights of hospital care, supported by the plan of care at the time of admission; or
- Documented need for inpatient care despite the lack of a two-midnight expectation, including specific services needed and provided; the likelihood of an adverse event based on the patient's circumstances; or a service that can only be provided on an inpatient basis.

The more explicit a physician's documentation of his or her thought process, the more accurate the QIO determination will be.

DOCUMENTATION remains the best way to ensure appropriate reimbursement. Physicians should explain the need for a two-midnight stay or inpatient services in the absence of a two-midnight expectation. The attending physician should describe what services are uniquely inpatient services or require two midnights of hospital care. Documentation need not be exhaustive but should be specific to the case.

Questions?

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

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