November 2022

# 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 10** www.LivantaQIO.com Open in browser

## The Two-Midnight Rule

The Two-Midnight Rule, which was effective October 1, 2013, provides billing guidance to hospitals for short hospital stays. Under the Two-Midnight Rule, an inpatient admission is generally appropriate for Medicare Part A payment if the physician or another 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. In assessing the expected duration of necessary care, the physician or other practitioner may take into account outpatient hospital care received prior to inpatient admission. If the patient is expected to need less than two midnights of care in the hospital, the services furnished should generally be billed as outpatient services.

In the FY2016 Outpatient Prospective Payment System (OPPS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) allowed exceptions to the two-midnight benchmark to be determined on a case-by-case basis by the physician responsible for the care of the beneficiary, subject to medical review. This Rule notes that 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.

CMS issued the following Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) Two-Midnight Claim Review Guideline that graphically depicts the tenets of the Two-Midnight Rule. As the national claims review contractor for Medicare, 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 composite case scenarios of patients who presented with congestive heart failure (CHF). Heart failure is a clinical syndrome that results from structural or functional impairment of ventricular filling or ejection. Based on clinical history and examination, diagnostic testing is geared toward evaluating the possibility of underlying secondary causes of heart failure. In the acute setting, testing for suspected heart failure may include laboratory, electrocardiogram (ECG), and chest radiography (CXR).

## Congestive Heart Failure

In the emergency setting, brain natriuretic peptide (BNP) and N-terminal pro b-type natriuretic peptide (NT-proBNP) can be useful for identifying the possibility of CHF but cannot establish the diagnosis without additional clinical support.

Causes of increased BNP and NT-proBNP can include:

- Acute coronary syndrome (ACS)
- Pericardial disease
- Atrial fibrillation (AFib)
- Toxic-metabolic myocardial insults
- Advancing age
- Anemia

- Renal failure
- Chronic obstructive pulmonary disease (COPD)
- Obstructive sleep apnea (OSA)
- Pulmonary embolism (PE)

Critical features in patients who present with CHF include evidence of hypotension, pulmonary edema, and/or oxygen desaturation. Complete and accurate documentation of the presence or absence of these symptoms will facilitate accurate assessment by the Livanta physician reviewer. Identifying precipitating factors of CHF, such as ACS, pericardial disease, cardiac arrhythmia, PE, or other acute illness is also helpful. Finally, delineating underlying factors that impact the severity and expected speed of recovery from CHF (such as COPD or renal insufficiency) is important to provide as complete a picture of the clinical situation as possible.

Uncomplicated CHF often can be treated with diuresis in the emergency department (ED) and with discharge in less than two midnights. If bilevel positive airway pressure (BiPAP) is required at the time of admission due to severe shortness of breath or hypoxia, inpatient admission is generally appropriate. Livanta advises that specific documentation be included in the medical record to support the reason for inpatient admission.

Source: *Journal of the American College of Cardiology.* Available at: **https://www.jacc.org/doi/10.1016/j.jacc.2021.12.012**

## Congestive Heart Failure Case Scenarios

### Scenario 1

#### Case Summary

The patient is an 84-year-old male who presented to the ED with several weeks of worsening shortness of breath (SOB) and orthopnea. The patient had a medical history of aortic stenosis, coronary artery disease status-post coronary artery bypass graft (CABG) of four vessels, thyroid disease, and diabetes. The patient had no previous history of CHF but was started on furosemide by his cardiologist a few days prior to presentation. Upon presentation, the patient was in no distress with stable vital signs. There were mild rales upon chest examination.

The ED work-up showed a slightly elevated troponin level without acute ECG changes, consistent with demand ischemia. Laboratory results included hemoglobin 13 g/dL, BNP 350 pg/mL, and creatinine 1.15 mg/dL. The CXR showed borderline to mild cardiomegaly without edema or evidence of failure. The patient's oxygen saturation was 96 percent on room air. The patient was diuresed in the ED with improvement in his clinical symptoms and then admitted to inpatient status with a diagnosis of CHF exacerbation on the same day of presentation. The plan of care included intravenous (IV) furosemide, a cardiology consultation, and iron studies. 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?**
*No. It was not reasonable to expect this patient to stay two midnights in the hospital based on the patient's stable condition and plan of care. The patient had been experiencing symptoms for several weeks and these symptoms improved in the ED prior to inpatient admission. The plan of care for IV furosemide, iron studies, and cardiology consultation in a hemodynamically stable patient without acute ECG changes, normal oxygenation, and no acute distress does not indicate a reasonable 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. The patient presented to the ED, was admitted the same day as presentation, and was discharged after an overnight stay. The patient was diuresed in the ED with improvement in his clinical symptoms and then admitted to inpatient status the same day of presentation with a diagnosis of CHF exacerbation.*

**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. There was no documentation in the medical record supporting the need for inpatient care in*

*the absence of a two-midnight expectation in this hemodynamically stable patient. There was no documentation supporting the risk of an adverse event during the time for which hospitalization was considered. The patient needed diuresis, which was accomplished in the ED, and he was admitted overnight for iron studies and cardiology consultation. The patient had no evidence of acute ACS or cardiac arrhythmia. There was no documentation of a diagnosis of pulmonary embolism or other acute conditions that might support a significant risk of an adverse event.*

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

## Scenario 2

### Case Summary

The patient is an 83-year-old male who presented to the ED late in the day with 24 hours of SOB, likely due to dietary indiscretion. The patient has a medical history of hypertension, hyperlipidemia, chronic CHF with an ejection fraction (EF) of 25 percent and an automatic implantable cardioverter defibrillator (AICD), diabetes, and prostate cancer. The patient has had multiple such episodes of SOB in the past.

Initial examination demonstrated a heart rate of 101, respiratory rate of 26, and oxygen saturation of 90 percent on room air. His respiratory system examination demonstrated wheezes and decreased air movement. The laboratory test results were significant for a BNP of 127 pg/mL. The BUN and creatinine were normal at 20 mg/dL and 0.97 mg/dL, respectively. A CXR showed worsening CHF.

The patient was treated in the ED with IV methylprednisolone, IV furosemide, and ipratropium/albuterol via inhalation with improvement in his SOB. There was less wheezing and work of breathing improved. Oxygen saturation after treatment in the ED was 96 percent on 2 liters. Vital signs in the ED after treatment showed a heart rate of 78 and a respiratory rate of 16. He was noted to be symptomatically improved by the ED physician, who then admitted him to inpatient status early the next morning. The plan of care included IV furosemide, check BNP, and a low-salt diet. The patient was discharged home later that same 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 documentation in the medical record was insufficient to support an expectation of a two-midnight stay. This CHF exacerbation was likely due to increased sodium intake with stable renal function and oxygenation responding to low level oxygen. This was one of multiple episodes of CHF for this patient as a result of dietary indiscretion in the face of normal renal function. As such, it would be expected to resolve rapidly and there was objective evidence of such resolution shortly after initiation of appropriate therapy in the ED prior to the inpatient order for admission. Further improvement sufficient to allow discharge after an overnight stay would be expected. There is nothing documented in the record that could justify the expectation of the patient spending at least two midnights in the hospital. There was no mention of concern for an acute event that would likely extend the patient's 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. There were no new cardiovascular events. Although the patient had reduced EF and an AICD, these were chronic conditions and no documentation indicated they would influence the duration or intensity of care. The patient's creatinine was at baseline. Troponin level and ECG did not demonstrate acute ischemia. There was no concern for a pulmonary embolism. The patient had decreased oxygen saturation on room air but normalized on 2 liters (96 percent). The patient was treated with steroids, diuretics, and inhalers, followed by improved oxygenation. There was no documentation in the medical record supporting the need for inpatient care despite not meeting the two-midnight benchmark expectation for this patient or supporting the risk of an adverse event 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.**

# SSR Review Steps and Considerations

Livanta evaluates each sampled claim using the Two-Midnight Claim Review Guideline featured herein to determine if the payment was appropriate under Medicare Part A. If the Part A payment is deemed inappropriate, 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 supporting 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. Livanta is restricted to the written documentation in making its determination.

It is important to note that although the QIO may use evidence-based clinical guidelines and other relevant clinical decision support materials as components of the review activity, these are not considered authoritative. 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 may file an appeal with the Medicare Administrative Contractor (MAC) that processed the claim for payment.

## Documentation to Support the Inpatient Admission Decision

Congestive Heart Failure: The following are some examples of documentation that might help support an expectation of a two-midnight stay and therefore qualify for Part A payment under the Two-Midnight Rule.

- Bilevel positive airway pressure (BiPAP) is required at the time of admission due to severe shortness of breath or hypoxia
- Myocardial infarction (MI)
- Constrictive pericarditis
- Pulmonary embolism
- Evidence of significant hypoxia, arrhythmia, or hypotension that did not respond to intervention prior to the admission order
- Underlying comorbidities such as acute kidney injury (AKI) or severe chronic kidney disease (CKD) or cor pulmonale that would require more complicated care or extend the expected recovery period
- Other acute event that would result in a two-midnight stay or create concern for the risk of an adverse event

Source: *Journal of the American College of Cardiology.* Available at: **https://www.jacc.org/doi/10.1016/j.jacc.2021.12.012**

Livanta advises that specific documentation be included in the medical record to support the reason for inpatient admission. As demonstrated with the case scenarios above, documentation of the physician's reasons supporting inpatient admission is critical to a good review outcome. Clear documentation of the factors that support the two-midnight expectation or the need for inpatient care absent a two-midnight expectation will avoid the need for a medical reviewer to infer the physician's thought process.

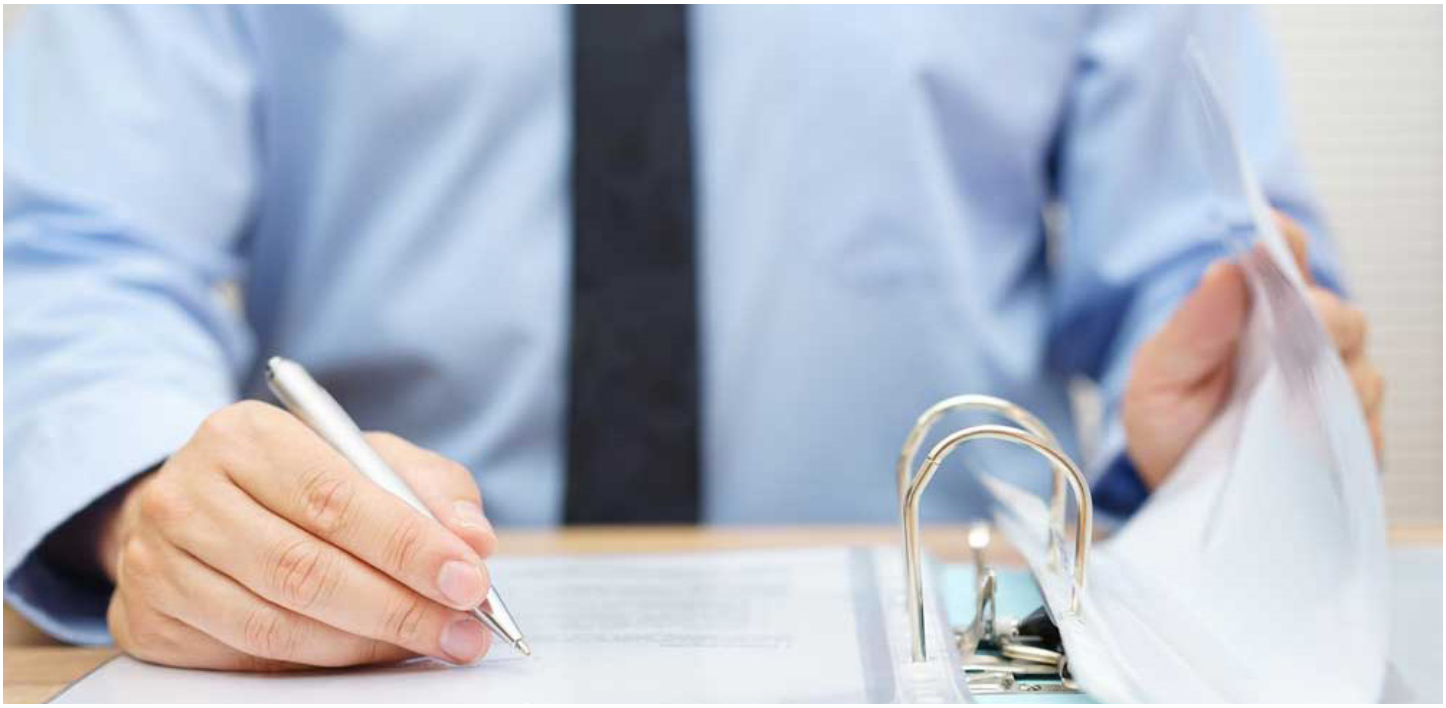
## Resources

Final Rule 78 FR 50495 – 51040
**https://www.govinfo.gov/content/pkg/FR-2013-08-19/pdf/2013-18956.pdf**

Final Rule 80 FR 70297 – 70607
**https://www.govinfo.gov/content/pkg/FR-2015-11-13/pdf/2015-27943.pdf**

## About Livanta

Livanta is the Medicare 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 under CMS-1599-F, as revised by CMS-1633-FC.

## Questions?

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

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