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THE LIVANTA CLAIMS REVIEW ADVISOR

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Short Stay Review – The "Case-by-Case" Review Process

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.

Case Scenarios as a Learning Tool

Livanta has been using composite case scenarios in the monthly Claims Review Advisor as learning tools for applying the steps in the Short Stay Claim Review Guideline ("the Guideline") to determine if Medicare Part A payment is appropriate and in compliance with the Two-Midnight Rule.

The July 2023 issue of Livanta's Claims Review Advisor generated some confusion, most specifically with the illustrative case scenarios presented. As such, the July 2023 edition of the Claims Review Advisor has been revised and reposted without the case scenarios. Livanta's intent was to use the case scenarios broadly to illustrate clinical situations where Step 4 or Step 6 of the Guideline might be met. Livanta believed that the examples used were situations where there was potential to meet Step 4 or Step 6, provided the documentation in the medical record was supportive.

The responses to these scenarios from subscribers focused on seeking a dichotomous approach to Part A payment, seeking a determination that, for example, “all diabetic ketoacidosis (DKA)” or “all cholecystitis” should be treated in the same manner. However, this does not reflect clinical reality. There are gradations in all of these conditions, requiring different resources and care, which is why these claims are reviewed on a “case-by-case” basis.

In an attempt to encourage improvement in medical record documentation to a level sufficient for Steps 4 and 6 of the Guideline, Livanta provided some hypothetical clinical scenarios. These scenarios were not meant to define new categories of “exceptions” to the Two-Midnight Rule or the Inpatient-Only List—they were truncated scenarios meant to serve as illustrative examples.

Using the Short Stay Claim Review Guideline

The Short Stay Claim Review Guideline was developed to try to fairly adjudicate the complexities of clinical medicine. There are three straightforward scenarios that will lead to Part A payment: Stays of two or more midnights from the inpatient admission order (Step 1), a procedure on the Inpatient-Only List (Step 3), and new onset of mechanical ventilation outside the operating room (Step 5). Steps 4 and 6 are more complex, and the criteria in them reflect the complexities of clinical care.

Livanta’s clinical reviews of short-stay review (SSR) cases and education sessions with hospitals demonstrate that understanding these steps remains a stumbling block. Hospitals have included generic CMS language to accompany their inpatient orders to mirror the language in the Two-Midnight Rule. This language is rarely case-specific and usually fails to adequately document the physician’s thought process. Records sometimes document the “two-midnight expectation” as a catch-all justification for any inpatient admission, even when there is conflicting documentation by the treating physician that indicates only an overnight stay with discharge after one midnight is anticipated. Early discharge is then often ascribed to “rapid recovery” when the patient has already recovered significantly or entirely prior to the admission order being written. In Livanta's experience the majority of records lack documentation of specific factors that support either a two-midnight expectation or the need for inpatient admission at the time the inpatient order is written. A recent survey of about 900 medical records received by Livanta for short stay review indicated that 59 percent of the submitted records lacked clear documentation supporting the reason for inpatient admission for these submitted Part A claims.

It remains the physician’s responsibility to assess each patient individually and develop an appropriate plan of care. For reimbursement purposes, Livanta advises that physicians document the specific aspects of the plan of care that would lead to the conclusion that Step 4 or Step 6 of the Guideline is met. The BFCC-QIO reviewers base their decisions on the presence of supporting documentation as outlined in the CMS document referenced below.[1] Livanta advises that physicians who make inpatient admission decisions familiarize themselves with the Short Stay Claim Review Guideline and document in the record how it applies for each episode of care for patients receiving Medicare benefits.

[1] Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016 (published 12/31/2015) https://www.cms.gov/Research-Statistics-Data-andSystems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/MedicalReview/Downloads/Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf

Procedures Not on the Inpatient-Only List

Since the two surgical examples in the July newsletter raised the most questions, a discussion of these two cases follows. Neither procedure in the examples is on the Inpatient-Only List, which means that performing the procedure itself does not satisfy the requirements of the Short Stay Claim Review Guideline. However, CMS does not prohibit the provision of these procedures on an inpatient basis provided the circumstances meet other steps of the Guideline: a two-midnight inpatient admission (Step 1), documentation to support a reasonable expectation of a two-midnight stay (Step 4), or circumstances that require inpatient care despite the lack of a two-midnight expectation (Step 6). As with all cases, the supporting documentation is reviewed on a “case-by-case” basis.

It was not Livanta’s intent to imply that the cases presented in the July newsletter qualify for Part A payment because the patient presented through the emergency department (ED). Many patients use the ED for non-emergent conditions and many patients are admitted to the hospital from the ED without meeting the steps of the Short Stay Claim Review Guideline. There are situations in which a patient comes to the ED with mild symptoms of cholecystitis or appendicitis, minimal risk of perioperative complications, and has an uncomplicated procedure and recovery. If documentation does not support Steps 1, 4, or 6, the inpatient claim does not meet the Guideline criteria for Part A payment. At the same time, there are patients who undergo each of these procedures in the presence of complicating factors such as evidence of sepsis or disseminated peritonitis, or who develop perioperative complications such as bleeding, peritonitis, bile leak, appendiceal stump rupture, myocardial infarction, or arrhythmia, as examples. When these conditions are present and documented, Part A payment may be justified even if a second midnight was not crossed prior to discharge.

Livanta did not intend the focus to be on the patient’s point of entry to the hospital. Rather, the intended focus was on the patient’s clinical condition and case-specific concerns of the clinician that would determine if Steps 4 or 6 were met. As in all claim reviews, Livanta recommends that these concerns be documented as clearly as possible in the record with specific reference to factors that informed the decision.

Livanta hopes this discussion clarifies any misconceptions from the July newsletter and that the readership sees this as consistent with the BFCC-QIO claim review mandate to follow the recommendations of the clinician caring for the patient, provided they are supported by documentation in the record as it applies to the steps of the Two-Midnight Claim Review Guideline.

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

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Questions?

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