



## Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013

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### Medical Review of Inpatient Hospital Claims

CMS plans to issue guidance to Medicare Administrative Contractors (MACs), *Medicare Recovery Auditors, and other review contractors (herein, “Medicare review contractors”)*. The guidance CMS issues for determining the appropriateness of inpatient hospital admission and payment language will provide further guidance on the FY 2014 Hospital IPPS Final Rule CMS-1599-F. This regulation described two distinct, although related, medical review policies: a 2-midnight **presumption** and a 2-midnight **benchmark**.

### Patient Status Reviews

Throughout this document, the term “patient status reviews” will be used to refer to reviews conducted by *Medicare review contractors* to determine the appropriateness of an inpatient admission versus treatment on an outpatient basis.

CMS will direct *Medicare review contractors* to apply CMS-1599-F and the additional guidance CMS plans to issue in conducting patient status reviews for claims submitted by acute care inpatient hospital facilities, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs) and Inpatient Psychiatric Facilities (IPFs) for dates of admission on or after 10/1/2013. CMS will direct *Medicare review contractors* NOT to apply these instructions to admissions at Inpatient Rehabilitation Facilities (IRFs). IRF patient status reviews are specifically excluded from the 2-midnight inpatient admission and medical review guidelines per CMS-1599-F.

When conducting a patient status review *in accordance with 1599-F*, CMS will instruct *Medicare review contractors* to assess the hospital’s compliance with three things:

- a) the admission order requirements,
- b) the certification requirements, and
- c) the 2-midnight benchmark

### I. Reviewing Hospital Claims for Inpatient Status: Inpatient Admission Order Requirements

CMS plans to direct *Medicare review contractors* that when they are conducting patient status reviews they should assess whether the requirements for order for inpatient admission were met. Requirements related to the inpatient order can be found at:

<http://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

### II. Reviewing Hospital Claims for Inpatient Status: The Inpatient Certification Requirements

CMS plans to direct *Medicare review contractors* that when they are conducting patient status reviews they should assess whether the requirements for inpatient certification were met. Requirements related to the inpatient *certification* can be found at:

<http://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

### **III. Reviewing Hospital Claims for Inpatient Status: The 2-Midnight Benchmark**

The 2-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.

#### **A. General Rule for Expected 0-1 Midnight Stays**

When a patient enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the patient in the hospital for 0-1 midnights, the services are generally inappropriate for inpatient admission and inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed.

Where the medical record indicates that the physician did not or could not reasonably have expected to keep the patient in the hospital for greater than 2 midnights, *Medicare review contractors* shall deny these inappropriate admissions unless the circumstances described in Section D apply.

#### **B. General Rule for Expected 2 or More Midnight Stays**

When a patient enters a hospital for a surgical procedure not on the inpatient only list, a diagnostic test, or any other treatment and the physician expects the beneficiary will require medically necessary hospital services for 2 or more midnights (including inpatient and pre-admission outpatient time), the services are generally appropriate for inpatient admission and inpatient payment under Medicare Part A. CMS will direct *Medicare review contractors* to approve these cases so long as other requirements are met.

#### **C. General Rule for Services on Medicare's Inpatient-Only List**

Medicare's "Inpatient-Only" list at 42 C.F.R. § 419.22(n) defines services that support an inpatient admission and Part A payment as appropriate, regardless of the expected length of stay. CMS will direct *Medicare review contractors* to approve these cases so long as other requirements are met.

#### **D. Short Inpatient Hospital Stays (0-1 Midnight)**

##### **1. When the Expected Length of Stay was 2 or More Midnights**

If an **unforeseen** circumstance results in a shorter beneficiary stay than the physician's reasonable expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis and hospital inpatient payment may be made under Medicare Part A. Such circumstances must be documented in the medical record in order to be considered upon medical review. Examples include unforeseen: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice care in lieu of continued treatment in the hospital.

## 2. When the Expected Length of Stay was Less Than 2 Midnights

Except for cases involving services on the “Inpatient-Only” list, CMS believes that only in rare and unusual circumstances would an inpatient admission be reasonable *and necessary* in the absence of an expectation of a 2 midnight stay.

Examples of situations that do not represent instances in which an inpatient admission would be appropriate without an expectation of a 2 midnight hospital stay include:

- **Beneficiaries admitted for telemetry.**  
CMS does not believe that the use of telemetry, by itself, is the type of rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. We note that telemetry is neither rare nor unusual, and that it is commonly used by hospitals on outpatients (ER and observation patients) and on patients fitting the historical definition of outpatient observation; that is, patients for whom a brief period of assessment or treatment may allow the patient to avoid a hospital stay.
- **Beneficiaries admitted to an Intensive Care Unit (ICU).**  
As CMS specified in the final rule, the use of an ICU, by itself, would not be the type of rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. An ICU label is applied to a wide variety of facilities providing a wide variety of services. Due to the wide variety of services that can be provided in different areas of a hospital, CMS does not believe that a patient assignment to a specific hospital location, such as a certain unit or location, would justify an inpatient admission in the absence of a 2-midnight expectation.

CMS has identified the following exception to the 2-midnight rule:

### 1. **Mechanical Ventilation Initiated During Present Visit:**

As noted above, treatment in an ICU, by itself, does not support an inpatient admission absent an expectation of medically necessary hospital care spanning 2 or more midnights. Stakeholders have notified CMS that they believe beneficiaries with newly initiated mechanical ventilation support an inpatient admission and Part A payment. CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than 2 midnights, and to embody the same characteristics as those procedures included in Medicare’s inpatient –only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, inpatient admission and Part A payment is nonetheless generally appropriate.

CMS will continue to work with the hospital industry and with *Medicare review contractors* to determine if there are any additional categories of patients or services that should be added to this list. Suggestions should be emailed to [IPPSAdmissions@cms.hhs.gov](mailto:IPPSAdmissions@cms.hhs.gov) with “Suggested Exceptions to the 2 Midnight Benchmark” in the subject line.

## E. The Need for Hospital Services

When conducting patient status reviews for services not on the inpatient-only list, CMS will direct the *Medicare review contractors* to evaluate whether, at the time of the admission order, it was reasonable for the admitting practitioner to expect the beneficiary to require medically necessary hospital services (including inpatient and outpatient services) over a period of time spanning at least 2 midnights. We note that absent rare and unusual circumstances (See D.2 above), the medical necessity assessment to be conducted by the review contractor is whether the beneficiary's clinical presentation, prognosis, and expected treatment support the expectation of the need for hospital care spanning 2 or more midnights, as opposed to care outside of a hospital facility, such as a skilled nursing facility or other less intensive services. The beneficiary's severity of illness and intensity of services are complex medical factors that CMS will instruct the *Medicare review contractors* to consider when assessing whether the physician was reasonable in forming his or her expectation that a beneficiary required hospital services for 2 or more midnights. **Note: It is not necessary for a beneficiary to meet an inpatient "level of care," as may be defined by a commercial screening tool, in order for Part A payment to be appropriate. In addition, meeting an inpatient "level of care," as may be defined by a commercial screening tool, does not make Part A payment appropriate in the absence of an expected length of stay of 2 or more midnights.**

## F. Documentation Requirements

The 2-midnight benchmark is based upon the physician's expectation of the required duration of medically necessary hospital services at the time the inpatient order is written and the formal admission begins. CMS will direct *Medicare review contractors* that in conducting patient status reviews, *Medicare review contractors* should consider complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2-midnight benchmark. Both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered. In other words, if reviewer determines that it was reasonable for the physician to expect the beneficiary to require medically necessary hospital care lasting 2 midnights, and that expectation is documented in the medical record, inpatient admission is generally appropriate, and payment may be made under Medicare Part A; this is regardless of whether the anticipated length of stay did not transpire due to unforeseen circumstances (See section D.I.)

*Medicare review contractors* will continue to follow longstanding guidance to review the reasonableness of the inpatient admission decision based on the information known to the physician at the time of admission. The expectation for sufficient documentation is well rooted in good medical practice. Physicians need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes. Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which CMS will direct the *Medicare review contractors* to expect to be documented in the physician assessment and plan of care. The entire medical record may be reviewed to support or refute the reasonableness of the decision, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission. If the physician believes the beneficiary represents a rare and unusual exception to the 2-midnight benchmark, in which the expected length of stay is less than 2 midnights but inpatient admission may be appropriate, the physician must clearly document this rationale and supporting information in the medical record for CMS review.

## G. The 2-Midnight Benchmark and Outpatient Time

### 1. General

For purposes of determining whether the 2-midnight benchmark was met and, therefore, whether a claim for inpatient admission should be approved upon review, CMS will direct the *Medicare review contractors* to consider time the beneficiary spent receiving outpatient services within the hospital prior to inpatient admission, in addition to the post-admission duration of care. This pre-admission time may include services such as observation services, treatments in the emergency department (*ED*), and procedures provided in the operating room or other treatment area.

### 2. 2-Midnight Benchmark Reviews

Whether the beneficiary receives services in the ED as an outpatient prior to inpatient admission (for example, receives observation services in the *ED*) or is formally admitted as an inpatient upon arrival at the hospital (for example, inpatient admission order written prior to an elective inpatient procedure), the starting point for the 2 midnight timeframe for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital.

For the purpose of determining whether the 2-midnight benchmark was met, CMS will direct the *Medicare review contractors* to exclude triaging activities (such as vital signs) and wait times prior to the initiation of medically necessary services responsive to the beneficiary's clinical presentation. If the triaging activities immediately precede the initiation of medically necessary and responsive services, it is the initiation of diagnostic or therapeutic services responsive to the beneficiary's condition that CMS will direct the *Medicare review contractors* to consider to "start the clock" for purposes of the 2 midnight benchmark. CMS will direct *Medicare review contractors* not to count the time a beneficiary spent in the ED waiting room while awaiting the start of treatment.

In other words, a beneficiary sitting in the ED waiting room at midnight while awaiting the start of treatment would not be considered to have passed the first midnight, but a beneficiary receiving services in the ED at midnight would meet the first midnight of the benchmark.

NOTE: While the time the beneficiary spent as an outpatient before the beneficiary is formally admitted as an inpatient pursuant to a physician order will not be considered inpatient time, it will be considered during the medical review process for purposes of determining whether the 2-midnight benchmark was met and, therefore, whether payment for the admission is generally appropriate under Part A.

## ***H. The 2-Midnight Benchmark and Transfers***

### ***1. General***

*For the purpose of determining whether the 2-midnight benchmark was met, the Medicare review contractor shall take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, the start 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 shall be excluded.*

*Medicare review contractors may request records from the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving care to ensure compliance and deter gaming or abuse. Claim submissions for transfer cases will be monitored and any billing aberrancy identified by CMS or the Medicare review contractors may be subject to targeted review. The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility.*

### ***2. Off-Campus EDs***

*If the ED is established as a provider-based/practice location of the hospital, CMS does not pay to move the patient from an off-campus location of the Medicare hospital to the campus of the same Medicare hospital. Moving the beneficiary within the hospital that participates in Medicare under a single CMS Certification Number (CCN) from a provider-based off-campus ED to a separate on-campus unit, or moving the bene from an on-campus ED to a specified floor on the same campus would be considered the same from a Medicare perspective. The provider-based or practice location (off-campus) ED is subject to all of the hospital Conditions of Participation (COPs) and is considered an integral part of the Medicare participating hospital.*

*Therefore, if a hospital ED is either an on-campus ED or an off-campus provider-based ED/practice location of a Medicare-certified hospital, the ED is considered part of that hospital for purposes of the 2-midnight rule, and therefore the total time in the hospital should be counted for purposes of the 2 midnight benchmark. On the other hand, if the ED is not established as an off-campus provider based/practice location (unrelated to that hospital's CCN), then the beneficiary movement would be considered a transfer and the rules outlined in HI are applicable.*

### ***I. Delays in the Provision of Care***

1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of reasonable and necessary medical treatment. As such, CMS expects *Medicare review contractors* will continue to follow CMS' longstanding instruction that Medicare payment is prohibited for care rendered for social purposes or reasons of convenience. Therefore, CMS will direct *Medicare review contractors* to exclude extensive delays in the provision of medically necessary care from the 2 midnight benchmark calculation. CMS will instruct *Medicare review contractors* to only count the time in which the beneficiary received medically necessary hospital treatment. Factors that may result in an inconvenience to a beneficiary, family, physician or hospital do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, CMS will direct *Medicare review contractors* to consider them in determining whether inpatient hospitalization was appropriate. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

## **J. Monitoring Hospital Billing Behaviors for Gaming**

In accordance with the 2-midnight benchmark, as further described in the document *Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013*, CMS will instruct *Medicare review contractors* to monitor inpatient hospital claims spanning 2 or more midnights after admission for evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. CMS will instruct *Medicare review contractors* to identify such trends through probe reviews and through its data sources, such as that provided by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and Program for Evaluating Payment Patterns Electronic Report (PEPPER).