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Guidance for Medicare Administrative Contractors (MACs) Processing Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIO) Two-Midnight (2MN) Short Stay Review (SSR) Determinations

MLN Matters Number: MM10600
Related Change Request (CR) Number: 10600
Related CR Release Date: August 10, 2018
Effective Date: September 11, 2018
Related CR Transmittal Number: R2109OTN
Implementation Date: September 11, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article highlights the rules for inpatient admission under the Two Midnight rule for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities submitting short-stay, inpatient claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10600 clarifies MAC follow up actions when they receive the BFCC-QIO Short Stay Review Denial Determinations.

Be aware that CR10600 provides clarification that:

- Your MAC will adjust the BFCC-QIO SSR denial decisions as an overpayment (a full claim denial)
- Clarifies how your MAC is notified of the BFCC SSR denial decisions
- Clarifies that appeals rights for BFCC-QIO SSR denial determinations are provided through your MAC issuing a demand letter.

BACKGROUND

The BFCC-QIOs conduct post-pay audits, or SSRs, per 42 Code of Federal Regulations Section 405.980, on a sample of Medicare Part A claims for appropriateness of inpatient admission under the Two Midnight rule for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities impacted by FY 2016 Outpatient Prospective Payment System (OPPS) Final Rule, CMS-1633-F, effective January 1, 2016. The 2016 interpretive guidance (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-

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FFS-Compliance-Programs/Medical-Review/Downloads/Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf) states that the BFCC-QIO will conduct patient status reviews for adjudicated claims for dates of admission within the previous 6 months.

The BFCC-QIO develop a detailed results letter, which includes individualized, claim-by-claim denial rationales for all providers after the completion of the medical record review and the opportunity for providers to provide additional information for consideration. Upon completion of its review, the BFCC-QIO submits to the MAC copies of the final decision letters sent to the provider, listing their SSR determination along with their rationale for any Part A claims denial(s). The BFCC-QIO sends a hard copy of the letter to the MAC.

The SSR denial categories include:

1. Denied as a result of a post-payment review of the medical record
2. Denied for non-response to the BFCC-QIO request for medical records (also known as Technical Denial).

CR10600 provides clarification that SSR denial determinations rendered by the BFCC-QIOs are considered Non-Medicare Secondary Payer (Non-MSP) provider overpayments, therefore adjustments to these claims must follow the existing guidelines outlined in Medicare Financial Management Manual, Chapter 4, Section 10. The MACs will also follow Chapter 4 Section 20 when adjusting SSR determinations. As stated in the Manual, the purpose of the overpayment demand letter is to notify the providers of the existence and amount of an overpayment, and to request repayment.

When the MAC receives the copy of the BFCC-QIO Final SSR letter, they shall identify the denied claims by the beneficiary name, Medicare Identifier (HICN or MBI), BFCC-QIO claim key number and dates of service. The MAC shall adjust the denied claims as an overpayment and issue a demand letter informing the provider of the overpayment as a result of the BFCC-QIO's determination. By instructing that these determinations are to be adjusted as overpayments, CR10600 clarifies that the MAC issues a 935 demand letter. The initial demand letter includes language to request the provider or supplier to submit a refund or arrange for immediate recoupment, or file an appeal. Clarification that this established guidance applies to SSR denial determinations will ensure that providers are notified of their appeal rights, and will be allowed the applicable timeframe to appeal.

As detailed above, these SSR denials are considered 935 overpayments. Therefore, MACs are responsible for conducting a redetermination when the request is a result of a BFCC QIO SSR denial. As such, MACs shall follow redeterminations guidance in the Medicare Claims Processing Manual, Chapter 29. When the MAC receives an appeal request for a BFCC QIO SSR technical denial (SSR technical denials are defined as a denial due to a provider's non-response to a BFCC-QIO's request for documentation) which includes the medical records, the MAC must return the claim and medical records to the BFCC-QIO for a reopening. The MAC should view the reopening as a remedial action taken to revise the previous [binding] decision, thereby allowing the BFCC-QIO the opportunity to perform the SSR as intended, and prior to the non-response denial.

Note: Through the reopening process the BFCC-QIO will: (1) reverse its Technical Denial issued against the provider; (2) process the appeal request as a reopening and conduct the SSR; and (3) then issue a revised SSR final decision letter to the provider and notify the MAC if the revised decision is a denial.

ADDITIONAL INFORMATION

The official instruction, CR10600, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2109OTN.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
December 21, 2018	Initial article released.