CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 716	**Date: May 12, 2017**
	Change Request 10080

SUBJECT: Clarifying Medical Review of Hospital Claims for Part A Payment

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify the instructions for conducting medical reviews of hospital claims for Part A payment.

EFFECTIVE DATE: June 13, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 13, 2017
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row*.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/TOC
R	6/6.5/Medical Review of Hospital Claims for Part A Payment
R	6/6.5/6.5.2/Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-08	Transmittal: 716	Date: May 12, 2017	Change Request: 10080

SUBJECT: Clarifying Medical Review of Hospital Claims for Part A Payment

EFFECTIVE DATE: June 13, 2017
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I. GENERAL INFORMATION

A. Background: This CR updates chapter 6 of Pub. 100-08 to ensure consistency with recent regulations, as published by the Centers for Medicare & Medicaid Services (CMS), clarifying the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the "Two-Midnight" Rule).

B. Policy: Final Rules CMS-1599-F and CMS-1633-F.

- CMS 1599-F is entitled Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status

- CMS 1633-F is entitled Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System; Provider Administrative Appeals and Judicial Review

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10080.1	Medicare contractors shall conduct reviews of inpatient acute IPPS hospital, Critical Access Hospital, Inpatient Psychiatric Facility, and Long Term Care Hospital claims, as appropriate and so directed by CMS, in accordance with the policies and	X								CERT, RACs, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	procedures provided in revised Chapter 6, Section 6.5 of Pub. 100-08.									
10080.1.1	Medicare contractors shall conduct patient status reviews in accordance with two distinct, but related, medical review policies: a 2-midnight presumption, which helps guide contractor selection of claims for medical review, and a 2-midnight benchmark, which helps guide contractor reviews of short stay hospital claims for Part A payment. Note: The term "patient status review" refers to reviews conducted by Medicare contractors to determine a hospital's compliance with Medicare requirements to bill hospital claims for Medicare Part A payment.	X								CERT, RACs, SMRC
10080.1.2	Per the 2-midnight presumption, Medicare contractors shall presume hospital stays spanning 2 or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment, and shall not focus their medical review efforts on stays	X								RACs, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.									
10080.1.3	Medicare contractors shall review all other stays per the 2-midnight benchmark, which states that hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights, and such reasonable expectation is supported by the medical record documentation.	X								CERT, RACs, SMRC
10080.1.3.1	Medicare contractors shall make the initial determination of whether the procedure is on the Secretary's list of "inpatient only" procedures (identified through annual regulation), prior to assessing it in accordance with the 2-midnight benchmark.	X								CERT, RACs, SMRC
10080.1.3.2	Medicare contractors shall, if not an inpatient only procedure and not expected to span 2 or more midnights,	X								CERT, RACs, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	determine whether the procedure is a CMS-identified, national exception to the 2-midnight benchmark. Note: As of the date of this instruction, CMS has only identified one national or general exception to the 2-midnight rule: Mechanical Ventilation Initiated During Present Visit.									
10080.1.3.3	Medicare contractors shall, if not an inpatient only procedure and not expected to span 2 or more midnights, determine whether the admission otherwise qualifies for a case-by-case exception to the 2-midnight benchmark because the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Note: Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark.	X								CERT, RACs, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10080.1.3.3.1	Medicare contractors shall consider, when assessing the physician's decision, complex medical factors including but not limited to: • The beneficiary history and comorbidities; • The severity of signs and symptoms; • Current medical needs; and • The risk of an adverse event.	X								CERT, RACs, SMRC
10080.1.4	Medicare contractor reviews shall assess the information available at the time of the original physician/practitioners' decision.	X								CERT, RACs, SMRC
10080.1.5	Medicare contractors shall consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay, including but not limited to: • The beneficiary's medical history and comorbidities,	X								CERT, RACs, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• 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.									
10080.1.6	Medicare contractors shall take into account, when assessing the practitioner's reasonable expectation of care spanning 2 or more midnights, the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission, which may include: • Pre-admission time may include services such as observation services, • Treatments in the emergency department, and • Procedures provided in the operating room or other treatment area.	X								CERT, RACs, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10080.1.7	Medicare contractors shall, if the beneficiary was transferred from one hospital to another, take into account the time and treatment provided to the beneficiary at the initial hospital (and accordingly request documentation authored by the transferring hospital to support the medical necessity of the service and verify when the beneficiary began receiving hospital care) when assessing the reasonableness of the practitioner's expectation of care spanning 2 or more midnights.	X								CERT, RACs, SMRC
10080.1.8	Medicare contractors shall exclude extensive delays in the provision of medically necessary care from the 2-midnight benchmark calculation; factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission.	X								CERT, RACs, SMRC
10080.2	Medicare contractors shall, in determining the reasonableness of the practitioner’s original expectation, determine if an unforeseen event or circumstance	X								CERT, RACs, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	interrupted the practitioner's otherwise reasonable expectation of a stay spanning 2 or more midnights, such as: unexpected: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10080.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jennifer Phillips, 410-786-1023 or Jennifer.Phillips@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services

Table of Contents
(Rev.716, Issued: 05-12- 17)

Transmittals for Chapter 6

6.5 - Medical Review of Hospital Claims *for Part A Payment*
*(Rev**716, Issued: 05-12- 17**, Effective 06-13-17: Implementation 06-13-17)*

6.5.2 – *Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions*
(Rev716, Issued: 05-12- 17, Effective 06-13-17: Implementation 06-13-17)

This section applies to Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Audit Contractors and the Comprehensive Error patient Rate Testing (CERT) contractor.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors shall conduct review*s* of medical records for inpatient acute IPPS hospital*, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF)* and *Long Term Care Hospital (*LTCH*)* claims, as appropriate *and as so permitted by CMS*, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay*, and that the stay was appropriate for Medicare Part A payment*.

A. Determining *the* Appropriateness *of Part A Payment*

The term "patient status review" refers to reviews conducted by Medicare contractors to determine a hospital's compliance with Medicare requirements to bill for Medicare Part A payment. Medicare contractors shall conduct such reviews in accordance with two distinct, but related, medical review policies: a 2-midnight presumption, which helps guide contractor selection of claims for medical review, and a 2-midnight benchmark, which helps guide contractor reviews of short stay hospital claims for Part A payment. "Patient status reviews" may result in determinations that claims are not properly payable under Medicare Part A; "patient status reviews" do not involve changing a beneficiary's status from inpatient to outpatient.

*Per the **2-midnight presumption**, Medicare contractors shall presume hospital stays spanning 2 or more midnights **after** the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Medicare contractors shall not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.*

*Per the **2-midnight benchmark,** hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights, and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than 2 midnights. If a stay is not reasonably expected to span 2 or more midnights, Medicare contractors shall assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:*

- *If the procedure is on the Secretary's list of "inpatient only" procedures (identified through annual regulation);*
- *If the procedure is a CMS-identified, national exception to the 2-midnight benchmark; or*
- *If the admission otherwise qualifies for a case-by-case exception to the 2-midnight benchmark because the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-*

midnight expectation. Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The 2-midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

I. Reviewing Hospital Claims for Patient Status: The 2-Midnight Benchmark

A. Determine if the stay involved an "Inpatient Only" procedure

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor shall determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the Secretary as an "inpatient only" procedure is performed. "Inpatient only" procedures are so designated per 42 C.F.R. § 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

Medicare contractors shall review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are present, then the Medicare review contractor shall deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay.
If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the 2-midnight benchmark.

B. Calculating Time Relative to the 2-Midnight Benchmark

Per the 2-midnight benchmark, Medicare contractors shall assess short stay (i.e., less than 2 midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor identifies information in the medical record supporting a reasonable expectation on the part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least two midnights.

Medicare review contractor reviews shall assess the information available at the time of the original physician/practitioners' decision. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner's standard medical documentation, such as his or her plan of care, treatment orders, and progress notes. Medicare contractors shall consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary's 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.

For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning 2 or more midnights at the time of admission, the Medicare contractors shall take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission. 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. If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the 2-midnight benchmark at the recipient hospital, the Medicare contractors shall take into account the time and treatment provided to the beneficiary at the initial hospital. That is, the start clock for

transfers begins when the care begins in the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor shall request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.

Medicare contractors shall continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors shall exclude extensive delays in the provision of medically necessary care from the 2-midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors shall consider them in determining whether Part A payment is appropriate for an inpatient admission.

NOTE: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not qualify as inpatient time. (See Pub. 100-02, Ch. 1, Section 10.2 for additional information regarding the formal order for inpatient admission.)

C. Unforeseen Circumstances Interrupting Reasonable Expectation

*The 2-midnight benchmark is based on the **expectation** at the time of admission that medically necessary hospital care will span 2 or more midnights. Medicare contractors shall, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span 2 or more midnights, Medicare contractors shall look to see if there was an intervening event that nonetheless supports the reasonableness of the physician/practitioner's original judgment. An event that interrupts an otherwise reasonable expectation that a beneficiary's stay will span 2 or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.*

D. Stays Expected to Span Less than 2 Midnights

When a beneficiary 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 beneficiary in the hospital for less than 2 midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor shall assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.

E. Exceptions to the 2-Midnight Rule

1. Medicare's Inpatient-Only List

As discussed above, inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for Part A payment regardless of expected or actual length of stay.

2. Nationally-Identified Rare & Unusual Exceptions to the 2-Midnight Rule

If a general exception to the 2-midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor shall consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met.

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

Mechanical Ventilation Initiated During Present Visit

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, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.

3. Physician-Identified Case-by-Case Exceptions to the 2-Midnight Rule

For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors shall consider, when assessing the physician's decision, complex medical factors including, but not limited to:

- *The beneficiary history and comorbidities;*
- *The severity of signs and symptoms;*
- *Current medical needs; and*
- *The risk of an adverse event.*

Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark, and as such, may be prioritized for medical review.

B. Determining Whether Covered Care Was Given at Any Time During a Stay in a PPS Hospital

Medicare contractors shall utilize the medical record to determine whether procedures and diagnoses were coded correctly. If the medical record supports that they were, pay the claim as billed. If the medical record supports that they were not, then utilize ICD-9-CM *or ICD-10-CM* coding guidelines to adjust the claim and pay at the appropriate DRG. See section 6.5.4 of this chapter for further details on DRG validation review. When you determine that the beneficiary did not*, at the time of admission, have an expected length of stay of 2 or more midnights, or otherwise meet CMS standards for payment of an inpatient* admission, but that the beneficiary's condition changed during the stay and *Part A payment became appropriate*, you shall review the case in accordance with the following procedures:

- The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission;
- The deemed date of admission applies when determining cost outlier status (i.e., days or services prior to the deemed date of admission are excluded for outlier purposes); and
- The diagnosis determined to be chiefly responsible for the beneficiary's need for covered services on the deemed date of admission is the principal diagnosis.

- Adjust the claim according to the diagnosis determined to be responsible for the need for medically necessary care to have been provided on an inpatient basis.

When you determine that the beneficiary did not *meet the requirements for Part A payment* at any time during the admission, deny the claim in full.