Centers for Medicare & Medicaid Services
Questions and Answers
Open Door Forum: Hospital
Tuesday, September 6, 2023

1. Question: I have two questions. The first is considering Livanta's recent publication, who is a CMS contractor that reviews short hospital stays under Medicare's Two-Midnight Rule—in their recent publication they opened up the door to the greater use case-by-case exception, and it seems that they have a more generous view of inpatient admission than in its previous audits, including that for urgency appendectomies and emergency gallbladder removals, according to their 2023 July publication, and that prompts the following question. Livanta says that every emergent appendectomy is appropriate for inpatient regardless of the patient's comorbidities. Does CMS agree with this, and does it also apply to the MA plans as a part of the 2024 rule? Second question is, CMS has already incorporated the Two-Midnight Rule, applicable to MA plans under 42 CFR 422.101(b)(2). Since that is current, shouldn't the MA plans have to abide by the Two-Midnight Rule and all provisions as described currently? And how can they ignore an active federal regulation?
    a. Answer: CMS' standard when reviewing claims under the two-midnight rule is to follow the Hospital Outpatient Regulations and Notices (OPPS) and Inpatient Prospective Payment system (IPPS) rules including annual updates, revisions, guidelines, and amendments as published. CMS has not deviated from these standards and has no intention to do so. CMS expects Livanta and all providers and practitioners to apply these standards. To that end, CMS issued the following memo in April 2022 reiterating the standards and guidelines: https://www.cms.gov/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimReviewGuideline.%20508.pdf

       Livanta's August 2023 Claim Review Advisor is part of a larger communication plan required under contract. This communication plan included newsletters such as the one Livanta issued which included newsletters targeting various audiences and was reviewed and approved by CMS' designated Contract Officer Representative (COR). The purpose of these newsletters is to educate providers about compliance with the 2-midnight rule and its requirements by illuminating issues and themes that regularly arise during short stay reviews. The specific topics covered in these newsletters are at the discretion of the contractor so that if emerging trends give rise to novel issues, they can be addressed timely.

Your concerns have been discussed with Livanta and all issues raised will be addressed. Livanta has been instructed to retract the publication of the "Livanta Claims Review Advisor for July 2023", until CMS internal review of the publication is completed. Please feel free to email the CMS Short Stay Review mailbox at: Shortstayreview@cms.hhs.gov should you require additional clarification.

2. Question: The question is, with the IPPS payments of standard and neutral, a patient who comes to us with wounds [inaudible] is not considered standard, there's no way somebody can finish the treatment in eight days or seven days. As for the PPS payment, we are looking at maximum of eight to 10 days. You can't even have done the treatment plans and everything else for stage 3, stage 4 wounds, which we are seeing more in this hospital, to take care of it. I think that CMS needs to consider those rules, not only when [inaudible] but also the people with the stage 3, stage 4 wounds can be considered at a higher level, that they can get more days up here, for up to 25–30 days to get these things—to take care of it instead of the seven to eight days. We are now rotating on these patients; we're not helping the patients. the IPPS payment plan for—on a standard and the [inaudible] is too different. So, what we are asking you is you have considered only standards for those people who are in ICU, who have been on a vent, and those ones, the question comes about, why is the standard [inaudible] on those business only not also on the wound perspective also?
    a. Answer: The criteria for what constitutes a standard rate payment is statutory. So that's the primary reason. It's in the law so when the law was set up about what constitutes a standard rate case, that's—those are the criteria that we apply.
        i. Question: And that is what the hospital does there because there's no changes to it so, you know, it's one way in and one way out within seven to eight days. Is this written on the wall, can't be changed? How do we make these things? Because all the medical directors and everybody else who are the caretakers of the patients, this is not what we think is right for the patient.
            1. Answer: So, in terms of CMS, we don't have the ability to change the law unilaterally. You know, we can implement the law, were it to change, and we would do so, but we don't have the ability to change the law.
3. Question: The Hospital Value-Based Purchasing for severe sepsis and sepsis shock—I have the specifications for the current sepsis program. The Hospital-Based Value Purchasing specifications sheet, has that been released? I did get the information on the

percentage of patients who received the severe sepsis protocol within the three hours, but will that actually—will this particular measure have a spec sheet that we can pull from CMS?

a. Answer: Short answer is yes. If you want to send in your question in writing, I can send you a direct link, but the Hospital Value-Based Purchasing Program version of the measure is the same as the hospital IQR version, which is what I'm guessing you have pulled. So, the specifications are the same across both.
    i. Question: With the PC-01 removal measure, that will be January 1, 2024. I'm asking this because this is my first year in quality and this is…I'm not fully understanding how this works. When a measure gets retired, if it gets retired January 1, 2024, will that—the quarter that is due—like, the October quarter—will that be the last data that we submit, or will it be whatever quarter is due January 1 or December 3?
        1. Answer: No problem at all. There's a bunch of resources I can send that we have for new quality stuff, but to answer your specific question, when we remove something, we remove it starting with the reporting period. So, when we say we are finalizing PC-01 for removal beginning with the Calendar Year 2024 reporting period, that would mean the last data that we required to be collected would be that quarter for 2023. That data does get reported in 2024. And we're running on a three-month behind actual data.