DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Revised product from the Medicare Learning Network® (MLN)

- "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet, ICN 006847, downloadable

MLN Matters® Number: MM8586

Related Change Request (CR) #: CR 8586

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Implementation: February 25, 2014

Occurrence Span Code 72; Identification of Outpatient Time Associated with an Inpatient Hospital Admission and Inpatient Claim for Payment

Note: This article was revised on April 8, 2014, to add a reference to SE1403 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1403.pdf**) that alerts providers that a focused prepayment review strategy for MACs is being implemented to review inpatient hospital Part A claims with dates of admission between October 1, 2013, and March 31, 2014, for appropriateness of inpatient admission under the revised 2-midnight benchmark. All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for hospitals submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8586 to provide clarification to hospitals regarding the billing of inpatient hospital stays and the 2-Midnight Rule, codified under the Fiscal Year 2014 Inpatient Prospective Payment System Final Rule CMS-1599-F.

The 2-Midnight Rule allows hospitals to account for total hospital time (including outpatient time directly proceeding the inpatient admission) when determining if an inpatient admission order should be written based on the expectation that the beneficiary will stay in the hospital for 2 or more midnights receiving medically necessary care. Because currently the inpatient claim only permits CMS to accurately track inpatient time after formal inpatient order and admission (i.e., utilization days/midnights), CMS would also like to use Occurrence Span Code 72 to track the total, contiguous outpatient care prior to inpatient admission in the hospital. This will enable CMS to identify claims in which the beneficiary received care as an outpatient for 1 or more midnights and was subsequently admitted as an inpatient based on the expectation that the beneficiary would require 2 or more midnights of hospital care.

Background

The change in billing instruction is associated with CMS-1599-F, in which CMS clarifies and modifies its guidance regarding the proper billing of inpatient hospital stays. Under the rule, surgical procedures, diagnostic tests, and other treatments (not specifically designated as inpatient-only) are generally appropriate for inpatient hospital payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least 2 midnights and admits the beneficiary to the hospital based on that expectation.

The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status and time, but permits the physician and the medical reviewer to consider all time a beneficiary has already spent in the hospital receiving outpatient services (including observation services and treatment in the emergency department, operating room, or other treatment area) in guiding their 2-midnight expectation. This rule is available in the Federal Register on Page 50508 at **http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf** on the Internet.

The redefinition of occurrence span code 72 allows providers to voluntarily identify those claims in which the 2- midnight benchmark was met because the beneficiary was treated as an outpatient in the hospital prior to the formal inpatient order and admission. In other words, it permits providers and subsequently review contractors to identify the "*contiguous outpatient hospital services* [midnights] *that preceded the inpatient admission*," as well as the total number of midnights after formal inpatient order and admission, on the face of the claim.

While MACs may still select this claim type for medical review, the use of occurrence span 72 will help support the medical record and the MAC's review decision. Since the 2 midnight benchmark allows hospitals to account for *total* hospital time in determining if the beneficiary is expected to meet the 2 midnight benchmark, CMS has provided examples scenarios below, to illustrate circumstances in which an outpatient midnight was pertinent to the inpatient admission decision. In the future, occurrence span 72 may also be used to guide the claim selection process at CMS' discretion.

Examples in which the 2-Midnight Benchmark was met based on *total* (outpatient and inpatient) hospital time. CMS would like to track the outpatient time on an automated basis, using occurrence span code 72, so we may focus medical review as needed:

Example 1: Beneficiary is an outpatient and is receiving observation services at 10PM on 12/1/2013, and is still receiving observation services at one minute past midnight on 12/2/2013 and continues as an outpatient until admission. Beneficiary is admitted as an inpatient on 12/2/2013 at 3 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on 12/3/2013 at 8AM. Total time in the hospital meets the 2 midnight benchmark.

Example 2: Beneficiary having arrived at the hospital and begun treatment in the ED at 8PM on 12/11/2013 is still in the Emergency Department (ED) at one minute past midnight on 12/12/2013 and continues as an outpatient until admission. The beneficiary is admitted as an inpatient on 12/12/2013 at 2 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. The beneficiary is discharged on 12/13/2013 at 8AM. Total time in the hospital meets the 2-midnight benchmark.

Example 3: Beneficiary in an outpatient Surgical Encounter at 6PM on 12/21/2013 is still in the Outpatient Encounter at one minute past midnight on 12/22/2013 and continues as an outpatient until admission. Beneficiary is admitted as an inpatient on 12/22/2013 at 1 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on 12/23/2013 at 8AM. Total time in the hospital meets the 2 midnight benchmark.

Additional Information

The official instruction, CR8586, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1334OTN.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.