



Clarifying Medical Review of Hospital Claims for Part A Payment

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Note: This article was revised on January 9, 2019, to add a link in the Additional Information section to MLN Matters article [SE19002](#), which has information regarding the "Two-Midnight Rule" as it relates to total knee arthroplasty. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Article is intended for providers that submit institutional claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10080 clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the "Two-Midnight" Rule) for MACs, Supplemental Medical Review Contractors (SMRC), Recovery Audit Contractors and the Comprehensive Error Rate Testing (CERT) contractors. (Note, such reviews are currently, mainly overseen by Quality Improvement Organizations). Make sure that your staffs are aware of these policies.

BACKGROUND

CR 10080 updates the Medicare Program Integrity Manual (PIM), Chapter 6, Section 6.5.2, to ensure consistency with recent regulations, as published by the Centers for Medicare & Medicaid Services (CMS). It clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the "Two-Midnight" Rule) status.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors will conduct reviews of medical records for inpatient acute Hospital Inpatient Prospective Payment System (PPS) hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) claims, as appropriate and as 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.

These updates apply to MACs, as well as Medicare's SMRC, Recovery Audit Contractors, and the CERT contractor. The following describes the updates:

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. “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.

Medicare contractors will conduct such reviews in accordance with two distinct, but related medical review policies:

1. A **Two-Midnight presumption** which helps guide contractor selection of claims for medical review

Per the Two-Midnight presumption, Medicare contractors will presume hospital stays spanning two or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Generally, Medicare contractors will 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 Two-Midnight presumption. (Due to its function, the CERT contractor would not exclude such claims from its review and calculation of the improper payment rate).

2. A **Two-Midnight benchmark** which helps guide contractor reviews of short stay hospital claims for Part A payment

Per the Two-Midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning two 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 two midnights.

If a stay is not reasonably expected to span two or more midnights, Medicare contractors will assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

1. If the procedure is on the Secretary’s list of “inpatient only” procedures (identified through annual regulation)
2. If the procedure is a CMS-identified, national exception to the Two-Midnight benchmark
3. If the admission otherwise qualifies for a case-by-case exception to the Two-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 Two-Midnight expectation. Medicare contractors will note CMS’ expectation that stays under 24 hours would rarely qualify for an exception to the Two-Midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The Two-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.

Reviewing Hospital Claims for Patient Status: The Two-Midnight benchmark determines if the stay involved an “Inpatient Only” procedure

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor will 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. Section 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

MACs will 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 will 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 Two-Midnight benchmark.

Calculating Time Relative to the Two-Midnight Benchmark

Per the Two-Midnight benchmark, Medicare contractors will assess short stay (that is, 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 2 midnights.

Medicare review contractor reviews will assess the information available at the time of the original physician/practitioners’ decision as follows:

1. 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/her plan of care, treatment orders, and progress notes.
2. Medicare contractors will 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.

3. 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 will take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission.
 - a. 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.
 - b. If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the Two-Midnight benchmark at the recipient hospital, the Medicare contractors will take into account the time and treatment provided to the beneficiary at the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor may 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.
 - c. Medicare contractors will 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 will exclude extensive delays in the provision of medically necessary care from the Two-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 will 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 the Medicare Benefit Policy Manual, [Chapter 1](#), Section 10 for additional information regarding the formal order for inpatient admission.)

Unforeseen Circumstances Interrupting Reasonable Expectation

The Two-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 will, 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 will 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 two 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.

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. Section 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than two 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 will 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.

Exceptions to the Two-Midnight Rule:

1. Medicare's Inpatient-Only List

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 Two-Midnight Rule

If a general exception to the Two-Midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor will 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 Two-Midnight rule:

a. Mechanical Ventilation Initiated During Present Visit:

CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than two 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 two 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 Two-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 will 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
- The risk of an adverse event

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

ADDITIONAL INFORMATION

The official instruction, CR10080, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R716PI.pdf>.

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

More information regarding the “Two-Midnight Rule” as it relates to total knee arthroplasty is available in MLN Matters article SE19002 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19002.pdf>. The CMS Fact Sheet: Two-Midnight Rule is available at <https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0>.

DOCUMENT HISTORY

Date of Change	Description
January 9, 2019	The article was revised to add a link in the Additional Information section to MLN Matters article SE19002, which has information regarding the “Two-Midnight Rule” as it relates to total knee arthroplasty. All other information remains the same.
May 15, 2017	Initial article released.

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