



# MLN Connects™

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services**  
**2-Midnight Benchmark for Inpatient Hospital Admissions**  
**MLN Connects National Provider Call**  
**Moderator: Charlie Eleftheriou**  
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**Operator:** At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Charlie Eleftheriou. You may begin.

## Announcements and Introduction

Charlie Eleftheriou: This is Charlie Eleftheriou from the Provider Communications Group here at CMS, and as today's moderator I'd like to welcome everyone to this MLN Connects National Provider Call on the 2-Midnight Benchmark for Inpatient Hospital Admissions. MLN Connects calls are part of the Medicare Learning Network.

During this call, CMS subject-matter experts will provide an overview of the inpatient hospital admission and medical review criteria, also known as the 2-Midnight Rule, that was released on August 2nd, 2013, in the Fiscal Year 2014 Inpatient Prospective Payment System Long-Term Care Hospital Final Rule, CMS-1599-F. CMS will present case scenarios on the application of the rule to sample medical records. A question-and-answer session will follow the presentation.

Before we get started, there are just a few items I'd like to cover. First, you should have received a link to this slide presentation for the call in the email today. If you have not seen this email, you can find today's presentation on the Call Details webpage at [www.cms.gov/npc](http://www.cms.gov/npc). That's *N* as in national, *P* as in provider, *C* as in call. Again that's [cms.gov/npc](http://cms.gov/npc). On the left side of that page, select "National Provider Calls and Events," then select today's call by date from the list to access the Call Details page. The slide presentation is located there in the Call Materials section.

Second, please note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Call Details page when available. When it is available, an announcement will be placed in the CM – in the MLM Connects Provider eNews.

And finally, registrants were given the opportunity to submit questions in advance of today's call. We thank those of you who took the time to do so, and will address some during the call today. But while we will not be able to get to all of them, they may be used in future presentations or to develop frequently asked questions and other educational materials. If you have additional questions following the call, please visit the inpatient hospital review website, as your question may be answered there.

The website address is [go.cms.gov/InpatientHospitalReview](http://go.cms.gov/InpatientHospitalReview), without any spaces, and the *I*, *H*, and *R* all must be capitalized. Again that's [go.cms.gov/inpatient](http://go.cms.gov/inpatient) with a capital *I*, hospital capital *H*, review with a capital *R*. If you can't find the answer to your question there, you may email your question to [IPPSAdmissions@cms.hhs.gov](mailto:IPPSAdmissions@cms.hhs.gov). Again, that's [IPPSAdmissions@cms.hhs.gov](mailto:IPPSAdmissions@cms.hhs.gov).

At this time I'd like to turn the call over to Melanie Combs-Dyer, Acting Director of the Provider Compliance Group here at CMS.

## **Presentation**

Melanie Combs-Dyer: Thank you, Charlie. This is Melanie and I am on slide 5. I'm going to review our agenda for today. We're going to start with the CMS introductions, and we won't be introducing everyone in the room today, just some of our primary speakers. Then we'll be talking about the 2-Midnight Rule, unforeseen circumstances and exceptions, the benchmark versus the presumption overview, how to count 2 midnights, medical necessity, Occurrence Span 72 (which is an NUBC code), then we're going to be talking about some case scenarios, and finally, we'll be taking your questions and sort of wrapping up at the end.

I do want to do a quick disclaimer on those case scenarios: I think it's important for everyone to recognize that these are just examples; we actually don't have individualized medical records in front of us. But we've laid out these scenarios because we think that they are real-world examples, and they'll be helpful to people who are on the call.

So now on slide 6, we're going to have the three primary speakers say their names and their titles just so that you can hear our voices. My name is Melanie Combs-Dyer, and I am the Acting Director of the Provider Compliance Group.

Jennifer Dupee: My name is Jennifer Dupee, and I'm a nurse consultant in the Provider Compliance Group.

Jennifer Phillips: And I'm Jennifer Phillips. I'm also a nurse consultant in the Provider Compliance Group.

Melanie Combs-Dyer: On slide 7 you can see some agenda topics for future training sessions. These are things that we are not going to cover today, but we will be covering in future calls. The first is feedback from our Medicare administrative contractors, the MACs. We want to be able to share with you what they are learning in their reviews, what common errors they're identifying, and what educational resources are available to providers. We'll also be scheduling a training session on orders and certification, and finally on transfers. So those are all the future topics that are going to be covered.

So on to today's presentation. We're going to – I'm going to turn it over now to Jennifer Dupee to talk about the 2-Midnight Rule.

## **2-Midnight Rule**

Jennifer Dupee: Hi, good afternoon, everybody. We're now on slide 8. For the presentation here we first just wanted to start by going over the actual language that was published as part of the Fiscal Year 2014 Inpatient Prospective Payment System Final Rule. And that language states that surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital payment under Medicare

Part A when (first) the physician expects the patient to require a stay that crosses at least 2 midnights, and (second) admits the patient to the hospital based on that expectation.

On slide 9, you can see the converse to this rule, which is that surgical procedures, diagnostic tests, and other treatments are generally inappropriate for inpatient hospital payment under Medicare Part A when the physician expects to keep the patient in the hospital for only a limited period of time that does not cross 2 midnights. In these cases, we anticipate that such services would be submitted for Part B payment.

### **Unforeseen Circumstances and Exceptions**

Now, you can see from this language that this is highly based on the physician's expectation. And as such we recognize that there can be circumstances that interrupt an unforeseen – an otherwise appropriate expectation. So on page – slide 10, we go over what we consider to be the unforeseen circumstances—basically, just saying that unforeseen circumstances may result in a shorter beneficiary stay than the physician's expectation that the beneficiary would require a stay greater than 2 midnights.

We enumerate some examples here, but keep in mind that this is not an all-inclusive list. We would anticipate that most of the cases would fall into one of these categories, however. For example, unforeseen death, unforeseen transfer to another hospital or facility, an unforeseen departure against medical advice—another part of that also is even if they're not discharged against medical advice but they just decide to leave the hospital—unforeseen recovery, and an unforeseen election of hospice care that results in their discharge before the 2 midnights have passed.

In these cases, such claims may be considered appropriate for hospital inpatient payment. The physician's expectation in any of these unforeseen interruptions in care, however, must be documented in the medical record to be taken into account upon review.

On slide 11, we want to talk a little bit about the exceptions to the 2-Midnight Rule. And I do just want to point out what the difference is between what we consider to be exceptions from the previous topic, which were the unforeseen circumstances. With the unforeseen circumstances, there is an expectation that the patient will require a 2-midnight stay when the inpatient order is written. With these exceptions, we are saying that an inpatient hospital admission will be appropriate even if the physician does not have an expectation that the patient may require a 2-midnight stay. So this patient could stay for either no midnights or 1 midnight, and it would still be an appropriate inpatient admission.

So this includes medically necessary procedures on the inpatient-only list, and also other circumstances that will be approved by CMS and outlined in sub-regulatory guidance. You may have heard of this referred previously as one of our rare and unusual circumstances. As of today's date, we have identified one such circumstance, which is the New Onset Mechanical Ventilation. As a note, this exception does not apply to anticipated intubations that are related to minor surgical procedures or other treatments.

So we are currently in – in talks with the public and also through the reviews about other exceptions that may be appropriate for an inpatient admission for these short inpatient stays, and we are inviting feedback from the public in our IPPS Admissions mailbox that you can see on slide 9. You can refer back to this slide as well for other topics in which we do request that you submit feedback to this email address. So again, that's [IPPSAdmissions@cms.hhs.gov](mailto:IPPSAdmissions@cms.hhs.gov), and we just ask that for our ease of trying to go through these, that you use the subject line "Suggested Exception."

### **Medical Review Benchmark**

Now, going on to slide 12, we wanted to talk a little bit about what we call the medical review benchmark. And this is basically describing how we actually review claims based on the 2-Midnight Rule. Contractors will include the time the beneficiary spends receiving care in the hospital. So this can include both inpatient and outpatient time: The outpatient time meaning before the inpatient order and admission occurs, and the inpatient time after the inpatient order and admission.

So if the total time the beneficiary's expected to spend receiving medically necessary hospital care, which includes both outpatient and inpatient, is either zero or 1 midnight, the review contractor will review to see if the beneficiary was admitted for an inpatient-only procedure, or if the other circumstance justified inpatient admission per CMS guidance. If not, this would generally be inappropriate for inpatient payment.

For 2 or more midnights, the review contractor will generally find that Part A payment is appropriate upon review.

### **Counting 2 Midnights**

Now going on to slide 13, we wanted to talk about the start clock, and we have received quite a few questions in the last few weeks about when the clock actually starts under the 2-Midnight Rule. And basically, the basic rule is that the 2-midnight benchmark clock starts when hospital care begins. So this can include observation care, care received in the emergency department, operating room, or other treatment areas.

And our basic rule is that the start of care, in the case particularly when they come in through the emergency department, starts after registration and the initial triaging activities, such as vital signs. We do ask to exclude excessive wait times when determining the start clock.

Now remember that while the total time in the hospital can be taken into consideration when the physician is making the admission decision based on the expectation of hospital care for 2 or more midnights, the inpatient admission itself does not begin until the inpatient order and formal admission occurs.

### **Medical Necessity**

Now going on to slide 14, we wanted to discuss medical necessity in terms of how it is applied under the 2-Midnight Rule. And as we have alluded to, this is based on the need

for medically necessary hospital care. So the basic definition of that is care that needs to be provided during the stay at the hospital.

Medicare rules do dictate that for payment purposes all treatments need to be reasonable and necessary, and that's provided in the Social Security Act, Section 1862. There is a shift with the medical necessity determination from what the context used to be under our previous rules, which were highly focused on the inpatient versus outpatient level of care depiction. We can get into this a little bit more later as well, but basically what we are saying is that if the beneficiary requires medically necessary services in the hospital for 2 or more midnights, that is an appropriate inpatient admission.

So our shift in focus of review, again, is medically necessary hospital care expected to span 2 or more midnights, absent an exception that we previously described.

### **Presumption: Selection of Claims for Medical Review**

Slide 15 talks about what we call – what – the other part of our benchmark. We have two concepts in this rule that are interrelated: The benchmark, which describes how we do review; and what we call *presumption*, which is essentially the selection of claims for medical review. And so this concept describes whether the claims will be selected for review under the 2-Midnight Rule.

The rule is – the rule of the presumption is that if a claim shows that 2 or more midnights have occurred after the formal inpatient admission begins, meaning after the inpatient order and admission start, the contractor will presume for claims selection purposes that the inpatient hospital admission is appropriate. And therefore the claim will not be the focus of medical review. However, this is not an across-the-board rule; we do have exceptions that we will be monitoring for any patterns, for evidence of systematic gaming or abuse, such as unnecessary delays in the provision of care to surpass the 2 midnight – to surpass the 2 midnights.

We have previously stated that data that we can be used – that we can use for these purposes include CERT data, which is the Comprehensive Error Rate Testing data; our First-Look Analysis for Hospital Outlier Monitoring, or FATHOM, report; and our Program for Evaluating Payment Patterns Electronic Reports, also known as our PEPPER reports.

### **Occurrence Span Code 72 (NUBC Code)**

Moving on to slide 16, it may have come to your attention recently that the National Uniform Billing Committee redefined Occurrence Span Code 72, and this change was effective on December 1st of 2013. The new definition allows “contiguous outpatient hospital services that preceded the inpatient admission” to be reported on the inpatient claims. On our slide there we do have a link to the NUBC implementation calendar. This is a voluntary code, but we do encourage its use because it can be used by the contractors in the future when selecting claims for reviews.

At this point, we're going to start getting into our case scenarios, and I'm going to hand the reins over to my colleague, Jennifer Phillips.

## Case Scenarios

Jennifer Phillips: Good afternoon, everyone. I'll firstly go over the case scenarios. These are sample case scenarios that apply the 2-midnight benchmark and presumption as described in CMS 1599-F.

As Melanie noted earlier, these case scenarios are being provided for educational purposes only. Compliance with the 2-Midnight Rule will be considered on a case-by-case basis. The information in the medical record needs to support the claim for payment. If you have any questions about these case scenarios, of course we will respond to these at the end of the call.

### *Case Scenario 1: Initial Presentation to ED*

So moving on to slide number 18, the first case scenario is entitled "Initial Presentation to the ED." And in this case scenario we have a 68-year-old male who presents the ED with several days' history of urinary symptoms, vague intermittent abdominal discomfort, he had gassy and feverish feeling over the past several days, and intermittent chills and nausea without vomiting. This patient is on oral meds for constipation, hypertension, cholesterol, and diabetes. The patient complains that he is just not feeling like himself, he has no appetite, he's tired, and may have a touch of the flu. No other complaints are noted.

This patient presents on October 1st at 10:00 p.m. and is triaged. At 10:10 p.m., a urine sample and glucometer reading are obtained, and the patient is sent back to the waiting room. At 11 o'clock p.m., the MD assesses the patient and orders therapeutic and additional diagnostic modalities. At 12:00 a.m., the patient has a new complaint of chest pain. Additional tests and treatments are provided.

On October 2nd at 12:15 a.m., the MD reevaluates the patient after the new complaint and determines that they will need to stay in the hospital for at least 2 midnights of medically necessary hospital services. At 12:35 a.m., a formal order and inpatient admission are provided. The patient indeed stays overnight, and on 12 – excuse me, on 10/3 at 7:35 a.m., the patient is safe for discharge home.

The hospital may bill this claim for inpatient Part A payment because this claim will demonstrate 1 midnight of outpatient services and 1 midnight of inpatient services. This claim may be selected for medical review but will be deemed appropriate for inpatient Part A payment so long as the documentation and other requirements are met. As you can see, this slide provides an example of how to calculate the 2-midnight benchmark as described in our Frequently Asked Questions document at 2.1.

For those of you who may not be aware, the Frequently Asked Questions document is on our website, and our website is available at [go.cms.gov/InpatientHospitalReview](http://go.cms.gov/InpatientHospitalReview). And each of those words—inpatient, hospital, and review—are capitalized, just the first letter.

And so our 2-midnight benchmark states that a physician may account for the total time in the hospital when determining whether the beneficiary's expected to stay for 2 or more midnights of medically necessary hospital care.

Medical reviewers will assess the physician's expectation as well as the need for hospital care and other payment requirements, such as the order and certification, during the 2-midnight curve and educate process. Per Frequently Asked Question 1.2, medical review contractors will continue to base their review decisions based on the physician's expectation at the time it was made and the information that was available to the admitting practitioner.

***Case Scenario 2: Initial Presentation to Physician Office***

Moving on to our next slide, slide number 19, and our second scenario, this is a beneficiary who presents initially to the physician's office. We have an 80-year-old female who presents to her primary care physician's office not feeling well. She has a past medical history significant for chronic obstructive pulmonary disease and is on multiple medications. She has been experiencing increased shortness of breath for the last several days. On October 1st at 6 o'clock p.m., she's evaluated by her primary and sent to the hospital for further evaluation. She's sent via ambulance.

At 9 o'clock p.m. upon arrival at the hospital, the admitting practitioner confirms the suspected diagnosis and admits the beneficiary based on his expectation that the patient's care will span at least 2 midnights. The patient indeed continues to receive medically necessary hospital services from October 2nd through October 4th. On October 5th at 9:00 a.m., the patient is discharged home.

The hospital may bill this claim for inpatient Part A payment. This claim will demonstrate 2 midnights of inpatient services and review contractors will generally not select this claim for review as it is subject to the 2-midnight presumption. Again, our Frequently Asked Questions document, question number 1.1, discusses the 2-midnight presumption, excuse me, as described in our rule. This states that if a beneficiary is in the hospital for 2 or more midnights after formal inpatient admission from following the physician's order, they will not be subject to medical review absent systematic gaming or abuse.

For more discussion on what we will be looking at to evaluate claims and determine if any type of systematic gaming or abuse to surpass the 2-midnight presumption is being employed, you can refer to question 5.1.

And this scenario also provides a good opportunity to discuss the ambulance time. As we describe in Frequently Asked Question 2.1, the clock starts when the beneficiary arrives at the hospital and begins receiving medically responsive services, excluding the initial triage, vital signs, and wait times. Therefore, ambulance time prior to arrival at the hospital should *not* start the clock for the purposes of the physician calculating the 2-midnight benchmark.

***Case Scenario 3: Treatment in the ICU***

Moving on to slide number 20 and our third case scenario, this is treatment in the ICU. In this case scenario, we have a 73-year-old male with an accidental environmental toxic exposure presents – presenting to the ED. On December 1st at 9:00 a.m., the patient arrives via ambulance and is awake and alert. At 9:03, Poison Control is consulted, and they advise that the patient will require telemetry monitoring and a plan to intubate as needed. This is a small hospital facility, and therefore telemetry monitoring is only available in their intensive care unit. At 9:07, therapeutic and diagnostic modalities have all been ordered and initiated, and the patient’s airway remains intact.

At 10:00 a.m., the physician requests transfer to the ICU for telemetry monitoring. It is unclear to the physician at this time if the patient will need medically necessary hospital-level care or services for 2 or more midnights. This determination will be dependent on their clinical presentation and the results of their diagnostic tests.

On December 2nd at 10:30 a.m., their medical concerns are resolving, and the airway continues to remain intact. At 12 o’clock p.m., the physician determines that the beneficiary’s safe for discharge home. This should be billed as an outpatient claim for services. Location of care in the hospital does not dictate the patient’s status. This is discussed further in Frequently Asked Question 4.4. Therefore, despite the placement in the intensive care unit, the decision still should be centered around whether or not the physician expects the beneficiary to remain in the hospital for medically necessary services for 2 or more midnights.

Of course, this excludes procedures on the inpatient-only list and very unusual circumstances. But otherwise, this decision must still center around whether or not the physician expects the beneficiary to remain in the hospital for 2 or more midnights. When a physician is making this decision, he should account for several factors, which are mapped out in Frequently Asked Question 4.2. Such complex medical decision factors include the beneficiary’s age, their disease processes, their comorbidities, and the potential impact of sending the beneficiary home.

In Frequently Asked Question 4.3, I do want to mention, since we did discuss a moment ago the rare and unusual circumstances, at this time CMS has only identified one rare and unusual circumstance, which is Newly Initiated Mechanical Ventilation. But as Jen mentioned earlier, we continue to accept submissions and will continue to evaluate such suggestions at the [IPPSAdmissions@cms.hhs.gov](mailto:IPPSAdmissions@cms.hhs.gov) mailbox.

***Case Scenario 4: Uncertain Length of Stay***

Moving on to our next slide, slide number 21, and our fourth scenario, this scenario represents a beneficiary who upon presentation has an uncertain length of stay in the physician’s mind. So we have an 80-year-old patient who presents from home to the ED on Saturday with a clinical presentation consistent with acute exacerbation of their chronic congestive heart failure. She is short of breath and hypoxic with ambulation. The physician determines that she will require hospital care for diuresis and monitoring.

However, it is unclear at presentation whether she will require 1 or 2 midnights of hospital care.

On December 7th at 9 o'clock p.m., the patient begins receiving medically necessary services in the emergency department. She does show evidence of fluid overload and is requiring IV diuresis and supplemental oxygen and continuous monitoring. At 11 o'clock p.m., IV diuretics are provided and an order for observation services is written with a plan to reevaluate within 24 hours. At 9 o'clock a.m. on December 8th, she remains short of breath and hypoxic with ambulation, requiring additional IV diuretics and supplemental O<sub>2</sub>. At 5 o'clock p.m., she is reevaluated. She continues to respond to the diuretics but remains short of breath and hypoxic with ambulation. She will require another 12 to 24 hours of IV diuresis.

At this time, an inpatient admission order is written based on the expectation that the patient will require at least 1 more midnight in the hospital for medically necessary hospital care. The beneficiary's discharged the following day at 10 o'clock a.m.

This case scenario demonstrates that if it is clear at the time of presentation whether the beneficiary's expected length of stay will surpass 2 or more midnights in the hospital receiving medically necessary services, then the physician should continue to treat the beneficiary as an outpatient until such time as they develop a clear and reasonable expectation that the beneficiary will require 2 or more midnights of medically necessary hospital care. So for this claim, the hospital may bill this claim for inpatient Part A payment, but providers should treat the beneficiary as outpatient until such time that an expectation is developed.

***Case Scenario 5: Unforeseen Circumstance after Formal Admission***

Moving on to the next case scenario in slide number 22, we're on case scenario number 5. This case scenario discusses unforeseen circumstances as CMS addressed in CMS 1599-F for final rule, and in subsequent open-door forums and educational materials.

We have a disabled 50-year-old male who presents to the ED from home with a history of cancer, now with probable metastases, and various complaints including nausea and vomiting, dehydration, and renal insufficiency. On January 1st at 10 o'clock p.m., he presents to the ED, at which time the admitting provider evaluates and orders diagnostic and therapeutic modalities. On January 2nd at 4 a.m., the physician writes an order to admit. The order to admit is based on his expectation that this beneficiary will need to stay in the hospital for at least 2 midnights. At 9 o'clock a.m., however, an appropriate designee and the family members discuss his desire to move this beneficiary into hospital treat – hospice care, excuse me. Therefore, they discussed with the physician their desire to begin hospice care immediately. At 3:00 p.m., the patient is discharged with home hospice.

The hospital may bill this claim for inpatient Part A payment. This claim will demonstrate 1 midnight of inpatient services and represents an unforeseen circumstance

interrupting an otherwise reasonable admitting practitioner expectation for hospital care for 2 or more midnights. Upon review, this would be appropriate for inpatient admission and payment so long as the physician expectation and unforeseen circumstance were supported in the medical record.

In our Frequently Asked Questions document, question number 4.7, CMS describes some unforeseen circumstances that we anticipate may interrupt otherwise physician's sound opinions and expectations for 2 or more midnights. These may – should include – or may include, excuse me, unforeseen beneficiary death, unforeseen transfers, unexpected refusals of continuing treatment, unexpected clinical improvements, or unexpected hospice. We do reiterate that they must be included in the medical record in order to be considered by medical review contractors and to support the claims for Part A payment.

***Case Scenario 6: Medical Necessity***

Moving on to the final case scenario in slide number 23. In this case scenario, we have a 78-year-old male with a past and current medical history of chronic illnesses that are well controlled with medication. This patient slips while shoveling and falls, sustaining a closed wrist fracture. On Saturday, November 9th, the beneficiary presents to the ED following a fall from home. The beneficiary presents alone at 11 o'clock p.m. At 11:30, the beneficiary's arm fracture is confirmed by the practitioner and pain medication is provided.

The following day, Sunday, 11/10, at 3:30 a.m., the beneficiary's pain is well controlled, and they are stable for discharge, but they continue to require custodial care. No family or friends are available, and hospital social services are unavailable until Monday morning. The beneficiary is therefore held in the hospital pending a home care plan, has no IV access, and their pain is well controlled with oral medication.

On Monday morning at 10 o'clock a.m., the beneficiary is released to home with a family member. No other complications are noted. For this claim, outpatient services may be provided and billed to Medicare as appropriate. However, as noted in our Frequently Asked Questions document 3.1, 1862 (a)(1)(A) of the Social Security Act requires medically necessary services in order for Medicare to provide payments.

CMS will not pay for social and custodial, excuse me, for factors of convenience, and therefore we cannot count excessive wait times or custodial care when calculating the 2-midnight benchmark. The patient must be receiving medically necessary hospital care, and if a beneficiary is kept in the hospital beyond 2 midnights, but it appears that the beneficiary is kept solely for purposes of systematic gaming or abuse in order to surpass the 2-midnight presumption, this claim that may be reviewed by Medicare review contractors.

With that, we will go ahead and discuss some of the frequently asked questions that we received prior to the call and also open it up to questions. And I think first, I'm going to go ahead and turn it back over to Charlie for a minute.

## Keypad Polling

Charlie Eleftheriou: Yes, thank you. Before we move into question and answers, we're going to pause for a moment to complete keypad polling. This is so CMS has an accurate count of the number of participants on the line with us today. If you just would note that there's going to be a couple moments of silence on the line while we tabulate the results. We're ready to start polling.

**Operator:** CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you. I would now like to turn the call back over to Mr. Eleftheriou.

## Frequently Asked Questions

Charlie Eleftheriou: Thank you. We're now going to move into the question-and-answer portion of the call. But before taking your live questions, our subject-matter experts are going to address some common questions submitted during the call registration period. I'll turn it over to the subject-matter experts now.

Jennifer Dupee: Sure, thank you so much, Charlie. This is Jennifer Dupee. We did just want to mention again that a lot of the questions we have received are pertaining to subjects that we are planning on addressing in future training sessions. For example, the order and certification requirements will be later addressed and also how to be – how to treat beneficiary transfers from hospital to hospital. So thank you all for the questions you did submit regarding those – regarding those topics, and hopefully we'll be able to get those answers to you quickly here.

One question that we have received a lot, and we did receive from – from many of you, was the question of how does level of care, meaning the inpatient level of care, factor into the 2-Midnight Rule. And we did briefly touch on that during the presentation, but I did want to expand on it a little bit here. So basically, whether the patient needs to meet an inpatient level of care as provided, for example, in a commercial screening tool.

Our answer to that is, under the 2-Midnight Rule the admission decision is based on the need for medically necessary hospital care. Now we recognize that that may fall into what was previously considered to be an outpatient level of care *and* an inpatient level of care. So it is true that patients do not need to necessarily meet an inpatient level of care via one of these screening tools. We are not saying that they – that these screening tools

cannot be used by the hospitals; in fact, we said – it's our understanding that from what we've heard from providers is that oftentimes these screening tools are helpful when you are doing your care planning and also making the decision of whether the beneficiary actually needs to stay in the hospital versus being discharged.

So the need for hospital care is really – really centered around the question of whether the beneficiary needs to be in the hospital to receive those services, and if such, if the expectation is that they will need to be in the hospital receiving that care for 2 or more midnights. That is an appropriate inpatient admission even if it does not reach an inpatient level of care versus one of these screening tools.

Also, other factors that can be taken into consideration when making this decision of how long the patient will stay or whether they will need to – or whether they can be discharged are the factors that Jennifer Phillips went over previously, and these can be such things as the severity of the signs and symptoms, the beneficiary's history and comorbidities, current medical needs, the risk of an adverse event during the period in which hospitalization is considered. And these factors we ask – we ask that these are documented well in the medical record so that when we are conducting review, we can see – this will help us make the decision – make the determination that the expectation of a 2-midnight stay was reasonable.

Another question that we have received frequently are whether any of the elective surgeries could ever be appropriate for an inpatient admission. Many of you may be familiar with the Medicare manual provisions, in the benefit policy manual in particular, that speak about these minor surgical procedures, which are almost never appropriate for inpatient admission and were often denied under the old inpatient admission rules. These are – we find that these are often 1-night stays where the beneficiary comes in for the procedure, just stays overnight, and is discharged the next day.

So in the past, we've said that those are always appropriate for outpatient – as long as it's a reasonable and necessary procedure, those are appropriate for outpatient payment, not inpatient payment. That does not change under these new rules, however what we are saying at this time is that if there is an unexpected circumstance that comes up, that it becomes clear during – at the second day that the beneficiary actually will require a second midnight in the hospital, such as if there's a complication or other such circumstance—in those cases, as long as the beneficiary needs medically necessary hospital care for that second midnight, that would – that would be an appropriate inpatient admission.

And I think that that was the most frequently asked questions that we did want to cover today. And we'll be happy to take more questions. I just want to reiterate as well that if there are any that we're not able to answer today or that if we did not get to your question, that we do ask that you first visit our website, and we'll go over that before we complete the call. I apologize, I don't have that in front of me. But go there first and if you feel like it's not answered there, then please feel free to submit your question to the

IPPS mailbox. Again, that's [IPPSAdmissions@cms.hhs.gov](mailto:IPPSAdmissions@cms.hhs.gov). And that's, again, also on slide 11, and we'll be addressing those questions as they come in.

Melanie Combs-Dyer: Thank you, Jen. This is Melanie, and I'd like to turn it over to the operator now to explain how you can communicate that you have a question to ask.

## Question-and-Answer Session

Charlie Eleftheriou: So – I'm sorry. So, if you do have a question – well, I guess – I'm sorry. We're going to be starting the actual live question-and-answer session now, where our subject-matter experts will take our callers' questions. I just want to remind everyone one more time that the call is being recorded and transcribed, so before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions as possible, we ask that you limit to just one at a time, one question per – per caller. If you have more than one question you can press star 1 after your first question is answered to get back into queue, and we'll address additional questions as time permits. We're now ready to take our first question from our callers.

**Operator:** To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

Your first question is from Beth Aldridge.

Beth Aldridge: Hi, my question is about the skilled nursing facilities. Right now, the way the rules work is the patient cannot qualify for a SNF stay unless they've had an inpatient stay of a certain number of days. Does this new rule change the requirements for patients to qualify for a SNF stay?

Jennifer Dupee: That rule does not change under the 2-Midnight Rule, meaning that the inpatient time after the inpatient order and formal admission is the time that counts towards the 3-day inpatient stay requirement for skilled nursing facilities.

Beth Aldridge: OK. And is there any consideration to change that? I had read in the media that that rule may be changing.

Melanie Combs-Dyer: You don't have the right people in the room to answer that question, I don't think.

Beth Aldridge: OK, well, thank you.

Melanie Combs-Dyer: But thank you very much for your interest.

Beth Aldridge: OK.

Charlie Eleftheriou: OK, we'll take our next call.

**Operator:** Your next question is from Donna Crawford.

Donna Crawford: Hi, I just wanted to go over one thing. On scenario number 3, where you're talking about the patient that was treated in the ICU, and the patient's discharged the next day, there's nothing in there that says whether the patient was put in observation or whether they were put in as an inpatient. So doesn't the way you bill the patient or bill – for whether you bill outpatient services or inpatient services have to be backed up with the order?

Melanie Combs-Dyer: We're just taking a quick look. Just give us one minute, please.

Donna Crawford: OK.

Jennifer Phillips: Hi, this is Jennifer Phillips. Thank you for your question. And so, just, we went back and looked to make sure—there's no order written for inpatient admission in scenario 3. And that's correct, actually, under the 2-midnight benchmark. The 2-midnight benchmark states that unless the physician has an expectation of hospital care for 2 or more midnights, inpatient admission would not be appropriate.

So it doesn't really matter which unit in the hospital the beneficiary is placed within for continuing treatment. The benchmark really focuses on whether or not the beneficiary will require continued treatment for 2 or more midnights. Does that help? And that is also why this is marked as a claim appropriate for billing on the outpatient side.

Donna Crawford: Well, the decision has to be made at the time the patient's brought in. So in the ER, we're going to decide whether it's observation or inpatient when they're talking to the attending before putting the patient on the floor. Supposing the physician has thought, "Yes, he's probably going to be here for 2 days," and put him in as an inpatient, and then he still leaves the next day. Do we bill for outpatient?

Jennifer Phillips: So there's kind of two different scenarios you walked through, and then I'll turn it over to our order colleagues to see if there's anything else to add. I think this really probably focuses mostly on the 2-midnight piece, and so what we really have been trying to stress is that unless the physician has a reasonable expectation at the time they present that the beneficiary will be there for 2 more midnights, it's appropriate to continue to go ahead and treat them in outpatient status. And then at such time, if they do develop an expectation, you know, if the tests come back, and they realize, you know, "Yes, this beneficiary will need to be here for the second midnight," at that time, it would be appropriate to do the order for inpatient admission.

If the physician is unsure at the time of admission, it would not be appropriate. Only once the physician has reasonable expectation would it be appropriate. And that's what

happened here: The physician just was not clear based on this poisoning, you know, where this beneficiary's tests and treatment would come out. And so I'm just – I'm looking at – Dan Schroder's here to see if there's anything else and ...

Daniel Schroder: Yes, I agree, what you said. You mentioned that the decision has to be made on –when the patient presents. And I believe what we're saying through the 2-Midnight Rule is when there is no clarity on whether a 2-midnight benchmark would be met, something like observation services could be ordered under the outpatient benefit, and then when it becomes apparent that the patient will meet the 2-midnight benchmark, at that point an inpatient order can be written.

Melanie Combs-Dyer: And this is Melanie. I want to remind folks that it is – you're looking at that time that you're maybe going to write that inpatient order. You're not looking for an *additional* 2 midnights. You're looking for that second midnight. That's – that's just a distinction I wanted to make sure that people were catching. Donna, was that – was that helpful information?

Donna Crawford: Well, here's my scenario from yesterday. Sunday, the patient comes in with a TIA, meets the criteria for inpatient, so the ER physician places the patient as an inpatient. Actually this was Friday, sorry. Saturday – and I leave a little note saying according to InterQual, you have to have an ultrasound of the carotids and an echo, because I use the criteria because I thought that's what we were supposed to do.

So the attending comes in later and decides to discharge the patient because he doesn't want to hold the patient up in the hospital through the weekend waiting for tests, which is appropriate. So he discharges the patient, but then the patient's only here 1 night, you know, so we can't really bill for observation now because there's been an inpatient order written. At the time of admission, they thought the patient would be here, I guess, for 2 midnights. So I don't know how to deal with these cases.

Melanie Combs-Dyer: This is Melanie. And one thing that I could suggest is that you keep in mind that the rule here is the physician's expectation of a 2-midnight stay. That's sort of the rule, rather than what does InterQual say or what does Milliman say. That's really, I think, the key takeaway for you.

Donna Crawford: So then when I meet with the ER physicians Thursday morning, I can tell them, "Don't worry about InterQual that I was going to teach you about, it's whether they need to be here 1 midnight or 2 midnights or more"?

Melanie Combs-Dyer: Let me have Dr. Handrigan, an ER physician himself, address that part of your question.

Michael Handrigan: So this is Dr. Handrigan. In the case that you laid out, where the physician has a reasonable expectation at the time of admission that the beneficiary's going to be there beyond the second midnight and writes an admission order based on

that expectation, that's an appropriate inpatient admission, and we would expect to see a Part A claim for that patient as opposed to a Part B claim.

Now even if the patient leaves the following day because it turns out that, you know, after an evaluation they are unexpectedly better than they thought they would be at the time of admission, that's still OK. That's still a Part A payment, and we would expect a Part A claim for that beneficiary. Does that help?

Donna Crawford: Yes. So I just need to get the attending to put an addendum on the discharge summary that says, "Patient recovered unexpectedly quickly"?

Michael Handrigan: It would be more relevant to have good documentation around the admission decision to support the medical necessity and reasonableness of the admission decision at the time of admission.

Melanie Combs-Dyer: And the care that was going to be received on Friday night and Saturday and Sunday. It sounds like, perhaps, maybe the decision was that there was going to be no hospital-level care provided on Saturday and Sunday, that perhaps the patient was just waiting for a test on Monday, and in that case, it would not be appropriate to count that additional time.

Michael Handrigan: And I just want to wait and make one more point with respect to this case and Milliman, as you indicated you use Milliman. Those kind of guidelines can be very helpful in determining whether you should keep the beneficiary at the hospital for hospital care. They will help you in designing your decision at the time of admission and whether you can let the patient go home or if they need to remain at the hospital for continued care. You're certainly welcome to use any guidelines that you think are useful, but we wouldn't look to those guidelines here at CMS in determining the validity of the benchmark or the expectation of the 2-midnight stay.

Melanie Combs-Dyer: Operator, let's take our next question, please.

**Operator:** Your next question is from Charles Locke.

Charles Locke: Yes, just thank you for taking my call. In scenario 1, can you specify exactly when the time of care begins? I'm not sure whether it's 10 – 10:00 p.m. or 11:00 p.m. in the example that you gave, or 10:10. So if CMS looked at this claim, when would they – or the MACs – when would they consider in this case that the time of care began?

Jennifer Dupee: We're going to just take a quick look and put you offline for just a second. Thanks.

Charles Locke: Sure.

Charlie Eleftheriou: Thanks for holding.

Jennifer Dupee: OK, thank you, everybody. So, taking another look at this, we would say that the care begins for the benchmark purposes at 10:10 p.m., and just remember that we do exclude wait times.

Charles Locke: OK, thank you very much for that clarification.

Jennifer Dupee: Thank you.

Jennifer Phillips: Thank you.

**Operator:** Your next question is from Mary Jane Allenbof.

Mary Jane Allenbof: Yes, thank you for taking my question. I just need some clarification here; we are going around and around. On scenario 4, where the 80-year-old gentleman is admitted and for the first 24 hours appears to be observation and then necessitates medical necessity to be made into inpatient— will that be billed totally as 2 days inpatient, or would it be part outpatient for the first 24 and inpatient the second? This has been a question we are really going around and around about. Thank you.

Charlie Eleftheriou: Give us one quick second to confer, please.

Dan Schroder: Hi, this is Dan Schroder in the Division of Acute Care. For a IPPS hospital—I mean, this would be an inpatient single DRG payment. The outpatient – any outpatient procedures performed before the actual day of admission would all be bundled into the original payment. So whether you want to conceptualize this as being 1 day of outpatient and 1 day of inpatient, it would still be a single Part A claim.

Melanie Combs-Dyer: And this is Melanie. Am I correct that there would some NUBC codes that could be put on the claim to indicate which days or which midnights were outpatient midnights and which were inpatient midnights?

Jennifer Dupee: Yes. So the Occurrence Span Code 72 that we spoke of would encompass the time that the beneficiary spent as an outpatient, that first midnight as an outpatient. So when we are doing claims selection, it's possible that the review contractors would be able to take a look at the claim and see that the beneficiary was actually in the hospital for 2 midnights; one was spent as an outpatient and one was spent as an inpatient.

Previously – or right now we're in the implementation phase, but we could only do that when we actually get the medical record and take a look and see that they were in the hospital as an outpatient for 1 midnight.

Jennifer Phillips: And just to piggyback on what everyone else said, I just want to remind you that while the physician can take the total time in the hospital into consideration when determining whether or not the beneficiary's expected to remain for 2 or more

midnights, the formal order for inpatient admission still starts inpatient time, and so that is just something to keep in mind with your questions.

Charlie Eleftheriou: OK, I think we'll take the next call now.

**Operator:** Your next question is from CoLette Morgan.

CoLette Morgan: Hi, this is Dr. Morgan. I just wanted to kind of springboard off of Donna's question. If you have a patient admitted on Saturday, you – they're coming with chest pain. You expect for them to meet the 2-midnight benchmark; however, for whatever reason, you cannot provide the stress testing or whatever modality you want to use to evaluate the cardiac function until Monday. So they end up staying—you can't safely discharge them—but I wasn't sure if they would truly meet medical necessity and meet the 2 to midnight benchmark that they are staying 2 midnights. But one part of that is waiting on the test that can't occur until the following day.

Jennifer Phillips: Hi, this is Jennifer Phillips, thank you for your question. So we do realize that there are inherent delays in hospital practice and in the way hospitals operate. However, when you do have extended wait times, as we stated in our presentation, we would expect that those are not considered for purposes of whether the 2-midnight benchmark is met. And so just be cognizant of those when determining whether or not inpatient admission's appropriate.

CoLette Morgan: So if you're continuing to monitor that patient, maybe providing PRN nitroglycerin and other treatments like PRN morphine, giving IV, you still would not count that time since truly what that patient is waiting on is for a test to be done?

Jennifer Phillips: Well, I think it's going to be a beneficiary-by-beneficiary circumstance (inaudible). If you have a particular question—it sounds like you may have a very facts- and clinical-specific question. For those types of questions, I think it would probably be best to send the details to the IPPS Admissions mailbox, and that way we can, you know, get back to you that way after we have time to review them.

CoLette Morgan: Thank you guys so much.

Jennifer Phillips: Thank you.

Melanie Combs-Dyer: You're welcome. Operator, let's take our next call.

**Operator:** Your next question is from Assadula Khan.

Assadula Khan: In regards to scenario 6, if we change a bit and we say that this patient required emergency surgery and was on IV medication, but the surgery wouldn't be done till Monday morning, would we be able to bill this as inpatient for the whole stay?

Melanie Combs-Dyer: They require emergency – you find out on a Friday that they require emergency surgery and you waited for Monday to do the surgery?

Assadula Khan: On the Saturday. The patient came in Saturday night at 11:30, 11:00.

Melanie Combs-Dyer: Dr. Handrigan, do you want to take that one?

Michael Handrigan: Yes, could you explain that scenario a little bit better?

Assadula Khan: This patient came in at 11:00 p.m., the orthopedic physician came to see the patient early morning—3:00 a.m., 3:30, or 4 o'clock in the morning—and decides this patient needs emergency surgery, but the surgery couldn't be scheduled till Monday morning. Now this patient's inpatient with IV pain medication. Will this be billed inpatient or outpatient?

Michael Handrigan: I guess I am stumbling over somebody that shows up on Saturday requiring emergency surgery that gets sort of electively scheduled for Monday for the convenience of the hospital. I'm not sure that that would satisfy the benchmark per se. It would be akin to someone who needs a diagnostic CAT on Saturday morning or Friday evening and the hospital doesn't provide CAT services until Monday. If it's an emergency procedure, why would you not transfer that patient to an appropriate facility?

Assadula Khan: This is an orthopedic procedure, so it can be done on Monday, and the patient's on IV pain medication.

Michael Handrigan: As Jennifer noted earlier, each patient will be a little bit different. And in this scenario that you're laying out, the patient may need pain management, and that's a different question than whether they need to stay in a particular spot awaiting a scheduled procedure next week. So if your question is, does the patient who requires 24 hours or 48 hours of pain management satisfy the benchmark, then the answer would be a potential yes, depending on their current situation. But if your question is simply because the hospital doesn't provide a service, does that satisfy the benchmark, then the answer would be no. Is that clearer than it was before?

Melanie Combs-Dyer: He may have dropped off. Operator, let's take our next call.

**Operator:** Your next question is from Nassau University.

Roman Zeltser: This is Dr. Roman Zeltser, and who actually interprets what's considered to be reasonable physician expectation?

Melanie Combs-Dyer: This is Melanie Combs-Dyer, and as we always have, we leave it up to our Medicare administrative contractors to review the medical record and really focus on the documentation of the physician. And in this case, we're talking about the physician's documentation of an expectation of a 2-midnight stay. They'll certainly

consider all the entries in the medical record, but that physician's documentation is probably the most important.

Roman Zeltser: So as long as the physician is documenting that they reasonably expect the patient to stay for 2 midnights; however, the patient receives a test earlier or the test comes back as normal, which was not – let's say, not expected. That would still be acceptable under the 2-Midnight Rule as an inpatient stay?

Michael Handrigan: So long as on review it is a reasonable expectation, yes, and that is exactly the rule. If the expectation is such that the physician expects the patient, based on their presentation, to require greater than 2 midnights of hospital care—and that needs to be documented—then that would be an appropriate Part A payment, and they would have met the benchmark. Now, the medical necessity of those services still need to be reviewed by the Medicare administrative contractor to ensure that it indeed was a reasonable expectation.

Roman Zeltser: Thank you.

Charlie Eleftheriou: All right, thank you. We'll take the next question.

**Operator:** Your next question is from Jeanine Gerlach.

Jeanine Gerlach: Hi, I have a question in regards to the unforeseen circumstances as relates to death or a transfer. If we know a patient is coming into the facility and they are in extremis, and there's a potential that this patient is not going to survive, and we know that, do they not qualify as an inpatient because we can't say that they're going to require 2 midnights? Of course, we don't know exactly when they might expire, but it's a potential. How do we address those?

Michael Handrigan: This is Dr. Handrigan, and these are difficult cases to manage, for sure, and we recognize that. It is a near impossibility to predict the amount of time a patient who is expectant will survive in your facility. It's certainly reasonable to assume that unless it's very obvious that they will expire within minutes or hours, for them to require hospitals care beyond the second midnight in most cases. I don't think most reviewers would object to that use of the benchmark, so I would encourage you to not try to be too predictive in the demise of the beneficiary when they're expectant.

Melanie Combs-Dyer: Operator, let's take our next call, please.

**Operator:** Your next question is from Karen MacFadden.

Karen MacFadden: Hello. I'm calling as a provider office, and my question is, when a patient is admitted initially as observation because there is no expectation for 2 over-midnights and then does get admitted as an inpatient, I'm – from what I'm hearing, that whole hospital stay then becomes inpatient if – if it meets the criteria for the inpatient admission. As consultants that get called in a lot—we're a heart – heart doctors—do we

bill the first part as observation from our office as out-person – outpatient consultation services and the second part as inpatient following the patient, or is it all inpatient services then?

Melanie Combs-Dyer: This is Melanie. I just want to clarify your question. Your question is from the perspective of a physician in their office who comes to the hospital to perform a hospital visit. And the question is, is it an inpatient hospital visit, or is it an outpatient hospital visit? Is that your question?

Karen MacFadden: Exactly. Yes, we have so much trouble with this, especially because now, especially, you're saying because the hospital could initially bill it as observation or whatever, and then it could be turned into an inpatient stay, and we've already billed it as observation. And then it all gets denied, etcetera, etcetera, so ...

Melanie Combs-Dyer: I apologize, we may not have the right CPT experts here about the E&M visit codes. I'm not sure that there is a separate hospital – a separate code for inpatient hospital visit versus outpatient hospital visit, or whether it's just a hospital visit. So we may have to take that question.

Karen MacFadden: Well, when we bill – when we bill for a consultation at the hospital, if the person is in under observation care, it gets billed as the CPT code for office or other outpatient visit. So there's only – it's billed almost as if the patient was in the office for a code. I'm just – my question – I guess maybe I'll even backtrack a bit and say if the person is initially admitted under observation and then an inpatient order is put in place, does the inpatient order start the day that the person came in and started their observation stay, or does it start the 2 days hence, when the inpatient order is written? Is the whole thing then an inpatient stay, or is it half and half?

Daniel Schroder: I can answer that. This is Dan Schroder.

Karen MacFadden: OK.

Daniel Schroder: The inpatient stay, we're – nothing is changing under the 2-midnight policy; it's still the same guidance, that the inpatient stay begins with the formal admission after an admission order. So in cases where they come in, observation is ordered for a day, and then the next day they are admitted, under the 2-midnight policy that observation services are still observation, which is an outpatient service. For the hospital billing, those services are all bundled together under a single DRG, but for your case of physician billing, I would say nothing would change. It would still remain an observation service, and then whatever other ...

Karen MacFadden: So it would remain an observation service for maybe the patient's first 2 days. So we'd bill the way we would normally bill observation, and then if the patient became inpatient and we were still following them, we'd then start billing as under the inpatient codes.

Daniel Schroder: I would think so. I'm not an expert in physician billing, but...

Karen MacFadden: You're not an expert on this, so possibly I should...

Daniel Schroder: ...nothing has changed as far as I know.

Karen MacFadden: OK.

Melanie Combs-Dyer: And this is Melanie. We will take that question and make sure that we write it up and get it up to our FAQ page, because that might be one that other physicians have as well.

Karen MacFadden: OK. All right.

Melanie Combs-Dyer: Operator, we'd like to take our next call please, our next question.

**Operator:** Your next question comes from the line of Vanessa Jenkins.

Vanessa Jenkins: Yes, good afternoon. I'm Vanessa Jenkins from Mountain States Health Alliance. The question I have is, is there any plan to change the conditions of participation related to utilization review, which does require non-physician reviewers to look at that initial inpatient screening, since we are moving away from total reliance upon a commercial screening criteria? So are there plans to change the COPs related to utilization management? Because everything we've seen has said that utilization review requirements stay intact.

Jennifer Dupee: Hi, this is Jennifer Dupee. We actually do not have the correct people in the room for that. So if you could please submit that question to our email box, [IPPSAdmissions@cms.hhs.gov](mailto:IPPSAdmissions@cms.hhs.gov), we will forward that appropriately.

Vanessa Jenkins: Thank you.

Charlie Eleftheriou: Thank you.

Melanie Combs-Dyer: Operator – I'm sorry, Charlie, go ahead. Operator, we'd like our next question.

**Operator:** Your next question is from Fadi Hammami.

Fadi Hammami: Thank you, my question has been asked already. Thank you.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question is Emilie Reinoehl.

Emilie Reinoehl: Yes. We would like to know if our inpatient statement needs to reflect the expected dates of inpatient confinement, such as we validate the patient will be here an expected 3 to 5 days.

Daniel Schroder: This is Dan Schroder. We are working on a little additional guidance to what we sent out in September 5th. And I think it will address this question directly as far as what you need and expected length of stay for a certification statement.

Melanie Combs-Dyer: So check back to our – check back to the website in the next few days, and you should see some clarified guidance on that point, Emilie.

Emilie Reinoehl: Thank you.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question is from Sam West.

Charlie Eleftheriou: Hello, Sam?

Sam West: Yes, our question's already been answered.

Charlie Eleftheriou: OK, great, we'll take the next one.

**Operator:** Your next question is from Helen Cortez.

Paz: Hi, this is Paz from Southwest, and I'm with Helen. My question is, can we bill inpatient Part A if it met inpatient criteria for the medical necessity; second, met the 2-midnight benchmark requirements, but the documentation of this decision does not have the expected the length of stay being documented? Can you still bill Part A without the expected length of stay?

Melanie Combs-Dyer: This is Melanie. I'll first start by saying when you talk about the inpatient criteria, I hope you're not talking about Milliman or InterQual, because that is not relevant to the Medicare determination about an inpatient stay. It's really the physician's documentation of whether or not he or she expects the patient to require 2 or more midnights of hospital care that's really the deciding point right now. Does that answer your question?

Paz: Not really, because the doctors are not documenting the expected length of stay. Some, you know – we have a physician that does not document the expected length of stay for – that's going to be 20 – you know, 2 midnights, greater than 2 midnights. Can we still bill the inpatient even if it met the benchmark, but the doc...

Michael Handrigan: This is Dr. Handrigan. The clarification that (inaudible) Medicare is going to be posting hopefully soon will help you answer this question more directly. But in order to satisfy the benchmark, that documentation has to appear in the medical record.

So in the case that you described, if the physician doesn't document their expectation that the individual will require more than 2 midnights of care, then that will be problematic for you. It will be particularly problematic if you are trying to submit a claim for a Part A payment for a stay that's less than 2 midnights. I hope that's helpful.

Paz: Thank you very much. OK.

Charlie Eleftheriou: You're welcome. Next question, please?

**Operator:** Your next question comes from the line of Linda Jo Spencer.

Jill Tierney: Yes, this is Jill Tierney speaking. We have a concern. When a patient gets admitted, obviously we're not applying the InterQual or Milliman if we expect that they're greater than 2 midnights. How do we qualify that third midnight to get a patient to a skilled nursing facility? It's kind of nebulous for us what actually qualifies that third midnight.

Michael Handrigan: This is Dr. Handrigan, and nothing in the 2014 rule changes that requirement.

Daniel Schroder: Yes, and I believe for the long-term care it's not a third midnight, it's a 3-day stay. And kind of off the top of my head, I don't believe the day of discharge counts. So this isn't necessarily documenting an expectation of a crossing any midnight threshold, it's just there's a length of stay requirement in order to qualify for that benefit, and it's counted in days.

Melanie Combs-Dyer: So this is Melanie, and I just want to clarify that nothing in this rule changes the rule for the SNF admissions. However, it may clarify in some cases when a physician should be writing an order for inpatient, which could have an impact on some patients.

I saw a news story the other day talking about a patient who had a 4- or 5-day stay and then a skilled nursing facility admission. And only after the fact did she learn that that 4- or 5-day hospital stay was an outpatient stay. She never was admitted as an inpatient and so the skilled nursing facility care was her liability; it was not paid for by Medicare.

We anticipate that those kinds of situations will be fewer now that we have this 2-midnight benchmark in place. But the rules for skilled nursing facility admission and how you count that time really has not changed with this rule. May be impacted by this rule, but has not changed.

Jill Tierney: But we apply – we always apply the continued – the criteria for continued stay using – we use InterQual for the, you know, the second and the third midnight. It is 3 midnights that a patient has to stay in order to get ...

Melanie Combs-Dyer: And what we're saying is we just don't have the experts in the room for skilled nursing facility stays. This is the 2-midnight inpatient hospital review experts.

Jill Tierney: OK.

Melanie Combs-Dyer: Thanks, Jill.

**Operator:** Your next question comes from the line of Pam Groshong.

Charlie Eleftheriou: Hello, Pam? We'll move on to the next question.

**Operator:** Your next question comes from Joan Hanson.

Joan Hanson: Yes, this is Joan. So let me give you a scenario: The patient comes into the emergency room at 10 o'clock at night, gets active treatment through the midnight. The doctor isn't quite sure; Grandma's not doing great, but isn't really sure that's going to need inpatient, so places in observation. In the afternoon, clearly Grandma's not doing well, going to stay another midnight. OK, so from what I understand, we need at that point in time to do an inpatient admission.

So when the RAC and MAC auditors come and see the 1-midnight rule – that 1-midnight stay, because that's what's – how they're selecting their audits, and they look at it, are they going to – are they going to then start applying criteria to say, "Well, they're really observation, they didn't meet criteria," and then we're going to get the whole thing denied? How – is Medicare going to make sure that the fairness factor for the audits are facilitated for the hospitals?

Jennifer Dupee: Hi, Joan, this is Jennifer Dupee. And what the situation you described is the perfect encompass – perfectly encompasses what we say by – what we're trying to explain by the benchmarks. So if it's not clear at the time that the beneficiary presents whether they will need to stay in the hospital for 2 or more midnights, in your case they were appropriately kept as an outpatient for the first midnight. And then when it became clear on the second day that they would require another midnight, I'm assuming in this case that this would be medically necessary hospital services, meaning that – that this particular patient actually did need to be in the hospital receiving services for that second midnight, an inpatient admission order could be written.

When we are conducting reviews you're correct that because in the system at this particular time, that is a 1-day inpatient stay. So it does not fall under the presumption, which is that we will not select claims for review except for in special circumstances when the inpatient length of stay was 2 or more midnights.

However, when we do look at the claim and look at the record, we will see that there was 1 night that was spent as an – as an outpatient. And so we will see therefore that – that in fact the beneficiary was in the hospital for the 2 midnights and that based on that and that

all the other requirements were met, that would be an appropriate inpatient admission. And this would be the case even if the patient did not meet one of these inpatient level of care criteria with these commercial screening tools.

Again, you know, hospitals can feel free to use those screening tools as they find them to be appropriate for their purposes. But for Medicare purposes, upon review, that will not be a factor any longer. It really is the fact that they needed that medically necessary hospital care for 2 or more midnights. And we also, with the NUBC's Occurring Span Code 72 that we talked about earlier, that will be the information that will be able to be – be able to entered on the inpatient claim now. So the hospitals will have the option of putting that time in that code so that when Medicare contractors are selecting their claims, they will also have the option of using that information when selecting their claims for review.

Melanie Combs-Dyer: And Jennifer, this is Melanie. When does that NUBC code go into effect? When can people start using it?

Jennifer Phillips: December 1st, so it's actually in effect, and CMS is working on additional instruction that should be out shortly—you know, very shortly—on that code. And just also following up on the review guidelines that Jen described, this is a question that we've received quite a few times, and so we did want to put providers' minds at ease that review contractors are receiving the same instruction as providers. And so we have actually posted our review guidelines that are – that came with those. We've shared with the review contractors through our website at [go.cms.gov/capital](http://go.cms.gov/capital) I for inpatient, capital H for hospital, and capital R for review. And review is singular, not plural. And so those are available there until we are able to update the program integrity manual in its entirety.

Charlie Eleftheriou: OK, thank you. We'll take next question.

**Operator:** Your next question comes from the line of Heath Whaley.

Heath Whaley: Hi, the question that we had was around the placements and timing guidelines for the inpatient stay. Specifically, in clinical scenarios coming from an ...

Charlie Eleftheriou: I think we may have lost our caller. Are you still there?

**Operator:** They removed themselves from the queue.

Charlie Eleftheriou: OK.

**Operator:** And your next question is from Kim Lalamandier.

Kim Lalamandier: Hi, this is Kim from St. Genevieve County Memorial Hospital. And my question is kind of a repeat about the scenario number 4. But in this question, we are a critical access hospital and we don't bill DRG. So our question is, you know, if they're observation and then – one day and then change to inpatient the second day, are – we've

been, you know, splitting our bills, obs and ins, and because we're critical access, is that what we still need to do? Because with the DRG hospitals that you explained earlier that you could bill this all as Part A.

Daniel Schroder: Again, this is something that didn't – doesn't necessarily change under the 2-midnight policy that was just implemented. But I am not a CAH billing policy expert; Renate Dombrowski might be. If you wanted to submit this question to the IPPS Admissions mailbox, I think we could direct this to the correct person very quickly.

Kim Lalamandier: OK, thank you.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question comes from the line of Betty Johnson.

Betty Johnson: Good morning. I have a question about the definition of hospital care. Just a simple definition of – from CMS of what hospital care is defined as.

Michael Handrigan: This is Dr. Handrigan, and we're not trying to be tricky here. Hospital care would be care that can only be delivered in the hospital.

Betty Johnson: That's not being tricky, that's actually very clear. That makes it so that we are saying that it's care that requires an acute setting, cannot be delivered as an outpatient in a skilled nursing facility, et cetera.

Michael Handrigan: Yes, if you can't discharge the patient from your hospital and you need to keep your inpatient at the hospital to receive the care that you're going to deliver, then we would consider that hospital care.

Betty Johnson: OK, great. Thank you.

**Operator:** Your next question comes from the line of Lindsay Rowe.

Kelly: Hi, this is Kelly. I had a quick question for clarification. If a patient – there's an order for observation services is written, and the patient decompensates and has to stay a second or even a third midnight. It says when the expectation develops an inpatient admission order should be written by the physician. My question is, is what happens if that order gets missed, and it never is written by the physician? How are we then supposed to bill?

Daniel Schroder: This is Dan again. We'll be touching on this in the upcoming guidance that I referenced. But just to reiterate, I mean, we have – we would consider this a case where an inpatient order is missing or defective. We do have guidance on that previously that is essentially the same in that there is some contractor discretion if an inpatient stay is clearly intended, and there's no question that, you know, services were provided and an inpatient stay was intended. Contractors would have discretion to go ahead and make that

payment. But in general, our guidance remains the same that an inpatient stay begins when there is an inpatient order. And if that inpatient order is missing, it is problematic.

Kelly: OK, thank you.

Melanie Combs-Dyer: And this – this is Melanie. I will just remind you that we do intend to have a whole 'nother one of these training sessions focused on these order and certification issues. So stay tuned to future opportunities to come back for more training.

Kelly: OK, thank you.

Charlie Eleftheriou: I'd like – before we take our next call, I'd like to just let the callers know that if you are in queue to have your question asked, and your question has already been asked and answered, please remove yourself from the queue so we can address as many questions as possible. We currently still have over 100 people in queue. We appreciate it, thank you. We'll take the next question.

**Operator:** Your next question comes from the line of Rita Cowan.

Rita Cowan: Hi, this is Rita Cowan at Palmetto Health. My question is regards to the – when the order is written, so if the patient comes in as observation, and it's determined later that...

Charlie Eleftheriou: I'm sorry, Rita, could I interrupt you one second? Do you mind speaking up, we're having a hard time hearing you.

Rita Cowan: OK, can you hear me now?

Charlie Eleftheriou: Oh, much better, thank you.

Rita Cowan: Is that better?

Charlie Eleftheriou: Yes.

Rita Cowan: OK, we've got a patient scenario: They're observation. We look, they stay overnight in the ER, the physician reexamines them. Now, they definitely meet the inpatient, and they're going to stay more than the second midnight. At that point he writes the order for inpatient. Do we still have to do the code 44?

Daniel Schroder: You mean the condition code 44?

Rita Cowan: Yes.

Daniel Schroder: Condition code 44 is to essentially undo an inpatient order and make it outpatient. How is that – that wouldn't apply in this case.

Rita Cowan: OK, wouldn't apply because he wouldn't be considered an inpatient until the inpatient order?

Daniel Schroder: Correct, yes.

Rita Cowan: OK.

Daniel Schroder: You're an outpatient essentially by default until there is an inpatient order. Condition code 44 would be in cases where there is an inpatient order, but upon another review, the physician doesn't feel it's appropriate to be inpatient. And there's a process in which you can convert that patient to an outpatient status.

Rita Cowan: OK. And my next question is, if they are to remain past 2 midnights, whatever the rule says, are we still going to be able to use the InterQual criteria for those continued stays? I know someone said we're not going to use the commercial product.

Melanie Combs-Dyer: This is Melanie, and we are anticipating that most hospitals will choose not to use InterQual or Milliman to make the decision about whether or not to write the inpatient order. Instead, we're expecting that most hospitals are going to look to the guidance in this rule about the physician's expectation of a – of 2-midnight or more stay in the hospital requiring that hospital-level care.

Rita Cowan: I understand that. I'm taking about a continued stay level, so they're there the third midnight, the fourth midnight.

Jennifer Dupee: Right. Rita, this is Jennifer Dupee. As Dr. Handrigan mentioned earlier, we're not saying that hospitals cannot use these criteria, and we – and actually it can be very helpful in making the decision of whether or not the beneficiary actually needs to stay at the hospital or can be discharged. So you can feel free to use it for that purpose, for deciding whether they need to stay for a third, fourth, fifth midnight.

Rita Cohen: OK.

Jennifer Dupee: There's no rule saying that you cannot use it in that way.

Rita Cowan: OK, that was my question, thank you.

Jennifer Dupee: You're welcome.

**Operator:** Your next question comes from the line of Case Ronan.

Tom McCarter: Hi, this is Tom McCarter. We are currently processing several denials made by CMS contractors for beneficiary admissions after October 1st of 2013. As discussed in the last open-door forum, one of these cases is a TURP with a 2-midnight stay. Another case is a fall with a fracture and a subsequent neurological deficit that

actually crossed a 13-midnight stay. And the third is a beneficiary presenting with multiple seizures and a 3-midnight stay.

Each case has a valid inpatient order, each case has the expectation of a 2-midnight stay. All the elements of certification are documented, yet all cases were denied by contractors for a lack of medical necessity. How has CMS instructed its contractors to determine whether care reflects medically necessary hospital services, even when the 2-midnight presumption has been met?

Melanie Combs-Dyer: This is Melanie, and I will ask that you, if you believe that your – the contractor has denied your claim inappropriately, and it sounds like that’s what you think in these three cases, I would encourage you to use the appeal process. We have instructed our contractors using the same slide deck that we’re presenting to you today. The same kind of materials that are out on our website are the materials that we have given to our contractors in terms of what they are supposed to be considering when they are reviewing claims.

And we will certainly be picking samples of claims that we will re-review—we’ll double-check. We’ll look over the shoulder of the Medicare administrative contractors. We’ll certainly be watching what’s happening in the appeal process and providing feedback to our MACs. So thank you for your comments today and please know that we’re going to be watching the MACs very carefully. But they have received the same guidance and the same instruction that you all have received.

Tom McCarter: I appreciate your answer, but I also don’t want to rely on an appeals process that’s currently backlogged 2 years in order to get these questions remedied. We are seeing these denials today from the MACs, and I think we need a more expeditious process than the current delayed appeals process. Thank you for your time.

Melanie Combs-Dyer: Yes, and if you can feel free to, without including any PHI, you can send us the case numbers, the claim numbers, or any other information that would help us find those cases, to those – the mailbox that has been mentioned several times, and we will certainly look into it from that perspective.

## **Additional Information**

Charlie Eleftheriou: And unfortunately, I think we’ve run out of time for calls today. I just want to close by saying that we’re obviously sorry we couldn’t get to every single call. But if we didn’t get to your question, please visit the inpatient hospital review website, as your question may be answered there. The web address again is [go.cms.gov/InpatientHospitalReview](http://go.cms.gov/InpatientHospitalReview), all capitals on inpatient, hospital, and review. If you can’t find the answer to your question there, then again, the email address is [IPPSAdmissions@cms.hss.gov](mailto:IPPSAdmissions@cms.hss.gov).

On slide 25 of the presentation, you’ll find information and a website to evaluate your experience with today’s call. Evaluations are anonymous and confidential and voluntary. We do hope you’ll take a few moments to evaluate today’s call. Again, my name is

This document has been edited for spelling and punctuation errors.

Charlie Eleftheriou, and I'd like to thank our subject-matter experts and all participants who joined us for today's MLN Connects call. Have a great day.

**Operator:** This concludes today's call. Presenters, please hold.

**-END-**

