



MLN Connects™

National Provider Call

Inpatient Admission and Medical Review Criteria *The 2-Midnight Rule*

January 14th 2014

1:30-3:00 PM



Medicare Learning Network®

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Agenda for Today

- CMS Introductions
- 2-Midnight Rule
- Unforeseen Circumstances and Exceptions
- Benchmark vs. Presumption Overview
- Counting 2 Midnights
- Medical Necessity
- Occurrence Span Code 72 (NUBC Code)
- Case Scenarios
- Questions & Conclusion

Speakers

- Melanie Combs-Dyer
 - Acting Director, Provider Compliance Group
- Jennifer Dupee
 - Nurse Consultant, Provider Compliance Group
- Jennifer Phillips
 - Nurse Consultant, Provider Compliance Group

Agenda Topics for Future Training Sessions

- Feedback from the MAC Reviews
 - Common Errors Identified
 - Educational Resources
- Orders /Certification
- Transfers

2-Midnight Rule

- Surgical procedures, diagnostic tests, and other treatments are generally **appropriate** for inpatient hospital payment under Medicare Part A when:
 - The physician expects the patient to require a stay that crosses at least 2 midnights, and
 - Admits the patient to the hospital based on that expectation

2-Midnight Rule

- Conversely, 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
- CMS anticipates such services should be submitted for Part B payment.

Unforeseen Circumstances

- Unforeseen circumstance may result in a shorter beneficiary stay than the physician's expectation (that the beneficiary would require a stay greater than 2 midnights)
 - Death
 - Transfer
 - Departure against medical advice (AMA)
 - Unforeseen recovery
 - Election of hospice care
- Such claims may be considered appropriate for hospital inpatient payment
- The physician's expectation and any unforeseen interruptions in care must be documented in the medical record

Exceptions to the 2-Midnight Rule

- In certain cases, the physician may have an expectation of a hospital stay lasting less than 2 midnights, yet inpatient admission may be appropriate
- Includes:
 - Medically Necessary Procedures on the Inpatient-Only List
 - Other Circumstances
 - Approved by CMS and outlined in subregulatory guidance
 - New Onset Mechanical Ventilation*
 - Additional suggestions being accepted at IPPSAdmissions@cms.hhs.gov (subject line “Suggested Exception”)

** NOTE: This exception does not apply to anticipated intubations related to minor surgical procedures or other treatment.*

Medical Review Benchmark (Review of Claims)

- Describes how CMS will review claims under the 2-midnight rule
- Contractors will include the time the beneficiary spends receiving outpatient care in their review decision
- If total time the beneficiary is expected to spend receiving medically necessary hospital care (includes outpatient care and inpatient care) =
 - **0-1 Midnight:** Review contractor will review to see if the beneficiary was admitted for an inpatient-only procedure or if other circumstances justify inpatient admission per CMS guidance (new onset ventilation).
 - **2 or More Midnights:** Review contractor will generally find Part A payment to generally appropriate



Start Clock

- 2-midnight benchmark “clock” starts:
 - When hospital care begins
 - Observation care
 - Emergency department, operating room, other treatment area services
 - The start of care after registration and initial triaging activities (such as vital signs)
 - Exclude excessive wait times
- Remember that while the total time in the hospital may be taken into consideration when the physician is making an admission decision (i.e. expectation of hospital care for 2 or more midnights), the inpatient admission does not begin until the inpatient order and formal admission occur

Medical Necessity

- What is Medically Necessary Hospital Care?
 - Care that needs to be provided during a stay at the hospital
 - Medically necessary for diagnosis & treatment (Social Security Act §1862(a)(1)(A))

- Shift in focus of review:
 - Medically necessary hospital care
 - Expected to span 2 or more midnights (absent exception)

Presumption: Selection of Claims for Medical Review

- Describes whether claims will be selected for review under the 2-midnight rule
- If a claim shows 2 or more midnights *after* formal inpatient admission begins, the contractor will **presume** for claim selection purposes that inpatient admission is appropriate. This claim will not be the focus of medical review.
- **Exception**: Will monitor claim patterns for evidence of systematic gaming or abuse, such as unnecessary delays in the provision of care to surpass 2 inpatient midnights

Occurrence Span Code 72

- NUBC redefined Occurrence Span Code 72 (12/1/2013) by allowing “Contiguous outpatient hospital services that preceded the inpatient admission” to be reported on inpatient claims (See [NUBC implementation calendar](#))
- Voluntary code, but CMS encourages hospital use
- Hospitals may use Occurrence Span Code 72 to report the number of midnights the beneficiary spent in the hospital from the start of care until formal inpatient admission

Case Scenarios

**Note that these case scenarios are being provided for educational purposes only. Compliance with the 2-midnight rule is considered on a case-by-case basis, in accordance with the information contained in the medical record.*

Scenario #1: Initial Presentation to ED

68 year-old man presents to the ED with several day history of urinary symptoms, vague intermittent abdominal discomfort, “gassy” and “feverish” feeling over the past several days, and intermittent chills and nausea without vomiting. Patient on oral medications for constipation, hypertension, cholesterol, and diabetes. Patient complains that he is not feeling like himself – no appetite, tired, “maybe a touch of the flu”. No other complaints.

10/1/2013

- 10:00 pm - Patient is triaged.
- 10:10 pm - Urine sample and glucometer reading obtained and patient sent to the waiting room.
- 11:00 pm - MD assesses patient, orders therapeutic/additional diagnostic modalities.
- 12:00 am - Patient with new complaint of chest pain – additional therapeutic/diagnostic modalities ordered.

10/2/2013

- 12:15 am – MD re-evaluates and determines a need for medically necessary hospital level of care/services for this patient to beyond midnight #2.
- 12:35 am – Formal order/admission provided.

10/3/2013

- 7:35 am: Patient is discharged home.

Hospital may bill this claim for inpatient Part A payment. 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.

Scenario #2: Initial Presentation to Physician Office

A 80 year-old woman presents to her primary care physician's office not feeling well. Past medical history is significant for chronic obstructive pulmonary disease and the patient is on multiple medications. She has experienced increasing shortness of breath for several days.

10/1/2013

- 6:00 pm - Patient is evaluated by primary and sent to the hospital for further evaluation via ambulance.
- 9:00 pm – Upon arrival at the hospital the admitting practitioner confirms the suspected diagnosis and admits the beneficiary based on the expectation that the patient's care will span at least 2 midnights.

10/2/2013 -10/4/2013

- Patient continues to receive medically necessary hospital level of care/services.

10/5/2013

- 9:00 am - Patient is discharged home.

Hospital may bill this claim for inpatient Part A payment. Claim will demonstrate 2 midnights of inpatient services. Review contractors will generally not select this claim for review as it is subject to the “presumption.”

Scenario #3: Treatment in the ICU

73 year-old male with an accidental environmental toxic exposure presents to the ED.

12/1/2013

- 9:00 am - Patient arrives by ambulance to the ED. Patient is awake and alert.
- 9:03 am - Poison control/POISONINDEX consulted, which advises that patient requires telemetry monitoring; plan to intubate if necessary. Small hospital facility, telemetry monitoring is only available in the intensive care unit.
- 9:07 am - Therapeutic and diagnostic modalities have all been ordered and initiated. Patient airway intact.
- 10:00 am - MD requests transfer to ICU for telemetry monitoring. Unclear to the physician if this patient will need medically necessary hospital level care/services for 2 or more midnights. Determination will be dependent on clinical presentation and results of diagnostic and therapeutic modalities.

12/2/2013

- 10:30am - Medical concerns/ sequelae resolving; airway remained intact absent mechanical intervention.
- 12:00pm - Physician writes orders to discharge home.

Hospital should bill for outpatient services. Location of care in the hospital does not dictate patient status. The patient's expected length of stay was unclear upon presentation and the physician appropriately kept the patient as an outpatient because an expectation of care passing 2 midnights never developed. No other circumstance was applicable.

Scenario #4: Uncertain Length of Stay

80 year-old patient presents from home to the ED on a Saturday with clinical presentation consistent with an acute exacerbation of 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.

12/7/2013

- 9:00 pm – Patient begins receiving medically necessary services in the ED. She shows evidence of fluid overload, requiring intravenous diuresis and supplemental oxygen and continuous monitoring.
- 11:00 pm – Intravenous diuretics are provided and an order for observation services is written with a plan to re-evaluate her within 24 hours for the need for continued hospital care or discharge to home.

12/8/2013

- 9:00 am - She remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis and supplemental oxygen.
- 5:00 pm – She continues to respond to diuretics but remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis for another 12 to 24 hours. 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.

12/9/2013

- 10:00 am - The patient's acute CHF exacerbation is resolved and she is discharged home.

Hospital may bill this claim for inpatient Part A payment. Providers should treat patients as outpatients until the expectation develops that the patient will require a second midnight of hospital care. When the expectation develops, an inpatient admission order should be written by the physician.

Scenario #5: Unforeseen Circumstance (after formal admission)

Disabled 50 year-old man presents to ED from home with history of cancer, now with probable metastases and various complaints, including nausea and vomiting, dehydration and renal insufficiency.

1/1/2014

- 10:00 pm - presents to the ED at which time the admitting provider evaluates and orders diagnostic/therapeutic modalities.

1/2/2014

- 4:00 am - Physician writes an order to admit. Patient is formally admitted with the expectation of medically necessary hospital level of care/services for 2 or more midnights.
- 9:00 am - Appropriate designee and the family discuss with the primary physician the desire for hospice care to begin for this patient immediately.
- 3:00 pm – Patient is discharged with home hospice.

Hospital may bill this claim for inpatient Part A payment. Claim will demonstrate 1 midnight of inpatient services. This represents an unforeseen circumstance interrupting an otherwise reasonable admitting practitioner expectation for hospital care. 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.

Scenario #6: Medical Necessity

78 year-old man with a past and current medical history of chronic illnesses that are well controlled with medications. Patient slips while shoveling and falls and sustains a closed wrist fracture.

11/9/2013 Saturday

- 11:00 pm - Beneficiary presents to the ED following fall at home. Beneficiary presents alone.
- 11:30 pm - Beneficiary arm fracture confirmed by practitioner. Pain medication provided.

11/10/13 Sunday

- 3:30 am - Beneficiary pain well controlled, stable for discharge but continues to require custodial care. No family or friends available and hospital social services are unavailable until Monday morning.
- Beneficiary held in hospital pending home care plan, no IV access, pain well controlled with oral medication.

11/11/13 Monday

- 10:00 am – Beneficiary released to home with family member. No other complications.

Outpatient services may be provided and billed to Medicare as appropriate.

Question and Answer Session

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