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THE LIVANTA CLAIMS REVIEW ADVISOR

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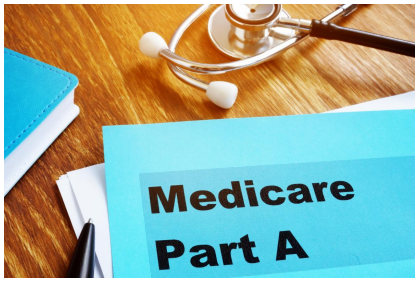
Short Stay Review: Procedures and the Two-Midnight Rule

The Two-Midnight Rule



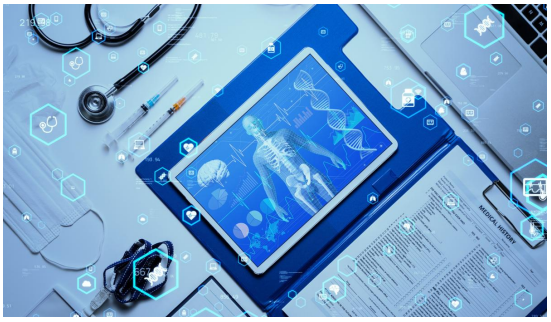
The Centers for Medicare & Medicaid Services (CMS) implemented the Two-Midnight Rule in Fiscal Year 2014 (FY2014) to help determine when inpatient admission is appropriate for payment under Medicare Part A. Medicare Part A covers inpatient hospital services. Under the Two-Midnight Rule, an inpatient hospital admission is generally appropriate for Medicare Part A payment if the physician or other qualified practitioner admits the patient as an inpatient based upon the expectation that the patient will need hospital care that crosses at least two midnights. The medical record must also support that expectation.

The Two-Midnight Rule includes two distinct, related medical review standards: (1) a two-midnight presumption; and (2) a two-midnight benchmark. The two-midnight presumption applies to hospital claims with lengths of stay that span two or more midnights from the time of inpatient admission to the time of discharge. In general, these claims are appropriate for Medicare Part A payment, and thus, are not the focus of medical review efforts. In contrast, the two-midnight benchmark applies to claims with inpatient lengths of stay less than two midnights. For these claims, the Rule defines conditions that would meet Part A payment requirements.

In the FY2016 Outpatient Prospective Payment System (OPPS) Final Rule, CMS amended the Two-Midnight Rule to clarify that Medicare would allow exceptions to the two-midnight benchmark. These exceptions are determined on a case-by-case basis by the physician responsible for the care of the patient and are subject to medical review.

The Two-Midnight Rule does not apply to procedures on the Inpatient-Only List.

Advances in Technology



Technology advances and other improvements in healthcare have improved periprocedural recovery in recent decades. These advances, such as the use of minimally invasive techniques, increased focus on streamlining periprocedural care, and better pain management, have led to improved patient outcomes. Overall, these changes have resulted in reduction of hospital stays for most procedures, as well as policy changes to allow many procedures to be performed in an outpatient setting such as an ambulatory surgical center. In large part, today's surgical patients have improved patient experience, equivalent or better health outcomes, and, typically, there are reduced costs associated with the care. These changes, which have had a significant impact on Medicare reimbursement for many commonly performed procedures, are the focus of this month's *Claims Review Advisor*. Read on to learn more.

The Inpatient-Only List

CMS has chosen a time-driven methodology to determine the eligibility for Part A (inpatient) versus Part B (outpatient) payment. Admissions that span two midnights or more are presumed to qualify for Part A payment, while CMS has stated that they expect it to be "unusual" to require inpatient admission after minor surgical procedures not expected to have at least an overnight stay. CMS developed the Two-Midnight Claim Review Guideline to identify those unusual circumstances. The following discussion explores Step 3 of the Guideline (procedures on the Inpatient-Only List) and how it relates to Part A payment.

> *"In addition, as previously stated in this final rule, we continue to expect it to be rare and unusual for a beneficiary to require inpatient hospital admission after having a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for only a few hours and not at least overnight …"*
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> Source: Federal Register/Vol. 80, No. 219/Friday, November 13, 2015/Rules and Regulations/70545/page 249 of 311

The Medicare Inpatient Only (IPO) list is a definitive list of elective procedures that Medicare will only cover as inpatient care. CMS updates and publishes the list annually, and it includes Healthcare Common Procedure Coding System (HCPCS) codes and descriptions. This list does not pertain to emergency procedures. The list is developed through a process that involves input from clinicians and professional societies. Procedures that are on this list will not be reimbursed by Medicare if they are performed in an outpatient setting.

However, this does not mean that a procedure not on this list must be performed in an outpatient setting. CMS realizes there are clinical situations where it is in the patient's best interest to have procedures not on the IPO list performed in an inpatient setting. CMS expects that clinicians will use their best judgment to make those decisions. It is important to remember that outpatient procedures can be performed both in a hospital setting and at a free-standing center. Furthermore, outpatient procedures performed in a hospital setting do not necessarily entail a same day discharge but may include an overnight stay for extended recovery services.

Procedures on the IPO list automatically qualify for Part A payment when performed in a hospital setting (Step 3 of the Guideline). However, all other procedures must meet one of the other Steps of the Guideline to qualify for Medicare Part A payment (Steps 1, 4, 5, or 6). The medical record should provide sufficient documentation to support Guideline compliance. Livanta continues to review and deny claims for procedures not on the IPO list where the documentation in the medical record does not support the need for inpatient care. Livanta's physician reviewers and professional staff have identified several common errors surrounding these claims.

Common Errors

A common error occurs when a particular procedure is inaccurately identified as being on the Inpatient-Only List. In some cases, this results from failure to appreciate the differences between minimally invasive procedures and those performed by more traditional open surgery. When a procedure is performed using laparoscopic, robotic, endoscopic, or other less invasive techniques it is important not to use the code for more traditional "open" techniques. In other cases, the coder appears to rely on the presence of an inpatient order associated with the procedure. To qualify for Part A payment, such orders must be supported by documentation of compliance with one of the Guideline Steps. Proceduralists may not always consider either the Inpatient-Only List or the Guideline when assigning inpatient status. It does not influence the professional component of the reimbursement. The provider should develop procedures to ensure accurate billing for the hospital component of care.

Another common misconception pertains to the identification of increased perioperative

risk and its influence on Steps 4 and 6 of the Guideline. All procedures are associated with some degree of periprocedural risk. This is particularly true in the Medicare population where the majority of patients have one or more comorbidities. While many patients have multiple comorbidities, standard of care requires these risks to be mitigated as much as possible in the preoperative preparation for elective surgery. When an extended length of stay or inpatient admission is anticipated despite such mitigation, the rationale for the need for inpatient care should be documented in the medical record.

The American Society of Anesthesiologists Physical Status classification (commonly known as “ASA class”) is frequently cited as reflecting “increased risk” of a perioperative complication to justify inpatient status. ASA class reflects the level of anesthetic risk associated with the procedure. There are no data that correlate ASA class alone with either length of stay or the need for inpatient care. The complexity or extent of the procedure is another factor often cited in support of inpatient admission. Fortunately, many complex procedures can be safely performed with minimal impact on the overall length of stay. Moreover, the duration of anesthesia–while it may be associated with extended recovery–does not automatically translate into a two-midnight expectation or the need for inpatient (as opposed to extended recovery) care. As with ASA class, the record must document how the complexity of the procedure results in either a two-midnight expectation or the need for inpatient care.

Lastly, providers are encouraged to remember that procedures not on the Inpatient-Only List do not inherently require inpatient admission. Therefore, routine periprocedural care would not qualify for inpatient admission. Requirements for Part A payment would not be met if that routine care results in an overnight (but not a two-midnight) stay, if no justification supporting either Step 4 or Step 6 is documented.

Proper Coding and Documentation are Key

In summary, proper coding for procedural admissions requires attention to both the Inpatient-Only List and the Two-Midnight Claim Review Guideline. It is important to recognize the impact of minimally invasive approaches and new treatment algorithms on procedures traditionally billed as inpatient that are often still performed in a hospital setting. While procedures on the Inpatient-Only List are approved for Part A payment, all other procedures must have documentation to support compliance with one of the other Guideline Steps before Part A payment can be authorized.

About Livanta

Livanta is the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) conducting post-pay fee-for-service claim reviews of acute care inpatient hospitals, long-term acute care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims. These claims are reviewed in accordance with the Two-Midnight Rule published in FY

2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rule CMS-1599-F, as revised by CMS-1633-F.

CMS issued the following BFCC-QIO Two-Midnight Claim Review Guideline that graphically depicts the tenets of the Two-Midnight Rule. Livanta utilizes this Guideline when making payment determinations for SSR claims.

CMS Two-Midnight Claim Review Guideline
https://www.cms.gov/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimReviewGuideline.%20508.pdf

Questions?

Should you have questions, please email **ClaimReview@Livanta.com**, or visit the claim review website for more information:
https://www.livantaqio.cms.gov/en/ClaimReview/index.html