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THE LIVANTA CLAIMS REVIEW ADVISOR

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Short Stay Review – Syncope

This month's edition of the *Livanta Claims Review Advisor* focuses on the diagnosis and payment of syncope considering the CMS Two-Midnight Claim Review Guideline.

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 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.

Syncope

Syncope is often defined as a sudden temporary loss of consciousness. The person regains consciousness without a significant period of altered mental status or confusion after the event. It is important to distinguish syncope from sleeping or seizures due to the differing causes of each.

Merriam-Webster dictionary defines syncope as: “loss of consciousness resulting from insufficient blood flow to the brain.”**[1]** Although this definition seems simple enough, evaluation of a patient who presents after a loss of consciousness can be quite challenging. The term “syncope” is sometimes applied inappropriately when the patient feels lightheaded, faint, or dizzy but does not experience loss of consciousness. It is important for clinicians to differentiate between these conditions and true syncope.

When a patient presents after an episode of loss of consciousness, the history surrounding the event is paramount to help risk-stratify the patient. The patient’s medical history can help differentiate syncope from other pathologies as well as help distinguish the type of syncope. Loss of bladder control is not a defining characteristic of seizure that provides any useful stratification information.

Syncope can be categorized as orthostatic syncope or non-orthostatic syncope.**[2]**

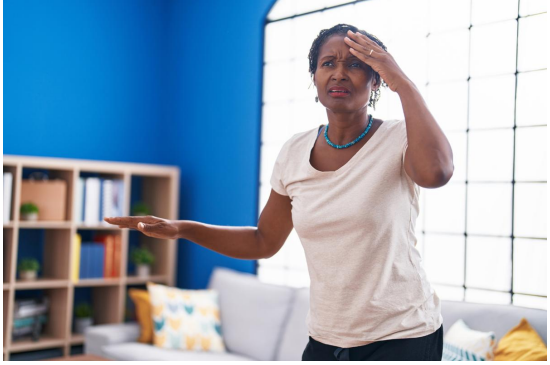
[1] https://www.merriam-webster.com/dictionary/syncope

[2] Helmon, A. Best Practices for Emergency Department Syncope Risk Assessment ACEP Now, December 2022. https://www.aafp.org/pubs/afp/issues/2017/0301/p303.html#:~:text=The initial assessment for all, immediate short-term risk stratification.

Hypovolemic (Orthostatic) Syncope

Orthostatic syncope occurs with postural changes, usually upon standing. Orthostasis is usually associated with loss of five to ten

percent of intravascular volume. On examination, orthostatic syncope is documented by a change in blood pressure of greater than 20 mmHg systolic or 10 mmHg diastolic with positional change.



Orthostatic syncope is usually associated with reflex tachycardia, although this may be blunted in patients taking beta blockers. Orthostatic syncope can be caused or exacerbated by certain medical conditions that affect the autonomic nervous system (such as multiple sclerosis or Parkinson's disease) or drugs (such as, antihypertensives, diuretics, opioids, some illicit drugs, or alcohol). Volume depletion due to dehydration, bleeding, or pregnancy, can also cause or exacerbate orthostatic syncope.

Orthostatic hypotension may also occur in patients with normal intravascular volume but altered autonomic response to positional change. Orthostatic hypotension usually results in lack of peripheral vasoconstriction when assuming an upright position, leading to venous pooling in the lower extremities and decreased preload. This effect can occur after drug ingestion or in association with certain neurological diseases. This group of neurological diseases also includes postural orthostatic tachycardia syndrome (POTS).

Evaluation of the patient begins by establishing the presence or absence of changes in blood pressure and pulse related to position. If orthostatic change is identified, the clinical focus shifts to identifying the relative roles that volume depletion and autonomic dysfunction play in the patient's symptoms. This involves a history designed to identify underlying diseases that may affect vasomotor function, estimating any intravascular volume deficits, quantifying renal and hepatic function, and identifying potentially offending drugs or intoxicants. Treatment is generally directed at repleting blood volume, holding antihypertensive medications, and eliminating intoxicants that affect vasomotor tone.

When syncope is caused by acute conditions such as drugs or dehydration, the length of stay is usually less than two midnights and dependent on the time it takes for the drug to be metabolized or the intravascular deficit to be corrected. Cases of pure autonomic dysfunction may be more difficult to treat but rarely represent a threat to life. These cases often require slow adjustments in medications and vascular volume or behavioral modification as an outpatient over time.

Normovolemic (Non-Orthostatic) Syncope

With normovolemic syncope, there is not an absolute or relative intravascular volume deficit. This category consists of both reflex syncope and cardiac syncope.

Reflex syncope occurs when there is an exaggerated or inappropriate response from the autonomic nervous system that leads to bradycardia and consequent hypotension. This is not positional, and while hypotension is

present, there is bradycardia rather than tachycardia. Reflex syncope is the most common cause of syncope and can occur due to benign etiologies such as fear, coughing, pain, or defecation. Vasovagal syncope is a typical example. Treatment efforts should be directed at identifying the triggering event and determining whether the syncope was an isolated incident or whether an underlying condition may require treatment.

Cardiac syncope is the most dangerous syncope since it may indicate a serious underlying cardiac condition. As a type of normovolemic syncope, typical orthostatic changes and evidence of volume depletion are absent with cardiac syncope. The goal of evaluation is to identify such conditions. Cardiac syncope can occur due to dysrhythmias, obstructive cardiomyopathy, structural heart disease, or valvular disease.

The history and physical examination should be used to identify reversible causes of syncope, diagnosis of syncope, and probable prognosis. Family history is important to identify any history of sudden death that could lead to a concern for structural abnormalities. A detailed neurologic examination is important to identify any focal neurologic deficits or the presence of neurological conditions, including cerebral vascular occlusive disease that might result in cerebral hypoperfusion.

Characteristics most often associated with cardiac etiologies of syncope include the list below.

- Age of 60 years or older
- Male sex
- Presence of known ischemic heart disease, structural heart disease, previous arrhythmias
- Syncope during exertion or in the supine position
- Abnormal cardiac examination
- Family history of inheritable conditions
- Presence of known congenital heart disease**[1]**

Disposition after initial evaluation can depend on available resources and patient-specific characteristics when determining outpatient evaluation or the need for hospital-based evaluation. Although guidelines do not take the place of a physician's clinical judgment, the American Heart Association has made some recommendations. These guidelines mention "inpatient" evaluation; however, the terminology is used to recommend in-hospital evaluation. This does not necessarily equate to Part A payment as defined by the Two-Midnight Rule.

As noted in *A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society*, "Hospital evaluation and treatment are recommended for patients presenting with syncope who have a serious medical condition potentially relevant to the cause of syncope identified during initial evaluation."**[2]** Serious conditions including arrhythmic causes may require pacemaker placement. These conditions include sustained or symptomatic ventricular tachycardia, conduction system disease, symptomatic bradycardia, or inheritable cardiac conditions. Other serious conditions can include severe anemia, cardiac ischemia, pulmonary embolism, acute decompensated congestive heart failure, or aortic dissection.

It should be clear from the preceding statement that many of these conditions will not routinely require a two-midnight stay and may not require inpatient admission (that is, evaluation and care may be performed as an outpatient, including emergency department or observation unit).

[1] Shen WK, Sheldon RS, Benditt DG, Cohen MI, Forman DE, Goldberger ZD, Grubb BP, Hamdan MH, Krahn AD, Link MS, Olshansky B, Raj SR, Sandhu RK, Sorajja D, Sun BC, Yancy CW. 2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients With Syncope: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol. 2017 Aug 1;70(5): e39-e110. doi: 10.1016/j.jacc.2017.03.003. Epub 2017 Mar 9. Erratum in: J Am Coll Cardiol. 2017 Oct 17;70(16):2102-2104. PMID: 28286221.

Documentation Recommendations

Livanta advises that when admitting patients for hospital evaluation of syncope, the documentation at the time of the admission should reflect the patient specific concerns and medical needs. The Two-Midnight Rule does not utilize any proprietary guidelines or risk stratification tools to determine Part A payment.

There have been several syncope rules developed including the Canadian Syncope Risk Score.**[1]** However, these risk stratification tools do not address the steps of the Short Stay Guideline such as expected length of stay. When risk stratification tools recommend “inpatient admission,” this does not imply compliance with the rules for Part A payment. Risk stratification tools attempt to identify those patients at risk of significant morbidity or mortality in a 7 to 30 day timeframe, not the risk of an adverse event in the 24 to 48 hours following admission or the length of stay the evaluation should take. In general, these kinds of rules should not be relied upon as justification for inpatient admission and Part A payment.

When applying the Two-Midnight Rule to syncope cases, it is important to document the plan of care, keeping in mind how long that plan of care will take. Most orthostatic causes of syncope will resolve with timely volume repletion and drug metabolism in less than two midnights. Most syncope “rule out cardiac dysrhythmia” cases do not require two midnights of hospital care. If the particular case has any other reasons to justify an extended hospital stay, these reasons should be specifically documented. Patient- and case-specific risks should also be documented at the time of the inpatient admission to ensure a clear understanding and documentation of the plan of care.

[1] Moussa, Bassant Sayeda, * ; Ali, Mohamed Aminb; Ali, Ahmed Abd El-Nasserc; Abou Zeid, Ahmed EL Sayed Mohammedd Assessment of Canadian Syncope Risk Score in the prediction of outcomes of patients with syncope at the Emergency Department of Suez Canal University
STROBE compliant Medicine 101(25):p e29287, June 24, 2022. | DOI: 10.1097/MD.0000000000029287

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