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Submitted via e-mail (IPPSAdmissions@cms.hhs.gov)

September 18, 2013

Jonathan Blum
Deputy Administrator and Director for the Center of Medicare
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Comments, General Principles, Admission Scenarios and Specific Instructions for inclusion in CMS guidance related to the admission and review criteria set forth in the FY 2014 hospital inpatient prospective payment system final rule

Dear Mr. Blum:

The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, urges the Centers for Medicare & Medicaid Services (CMS) to issue subregulatory guidance on the agency's inpatient admissions and review criteria that were finalized in the fiscal year (FY) 2014 hospital inpatient prospective payment system (PPS) final rule. With the policy's Oct. 1 implementation date fast approaching, the hospital field needs clear, detailed and precisely written guidance to ensure that providers and Medicare contractors alike can operationalize this new policy appropriately.

The FY 2014 final rule provides clarification of admission and medical review criteria, including a two-midnight benchmark, which serves as guidance for admitting practitioners to identify when an inpatient admission is generally appropriate for payment. It also includes a two-midnight presumption, which instructs review contractors to presume that hospital claims with lengths of stay greater than two-midnights after a physician order for admission are reasonable, necessary and generally appropriate for Part A payment.

The AHA recognizes that the creation of the two-midnight presumption, along with several directives in the rule which, if set forth clearly and precisely in guidance to providers and contractors, could be helpful in reducing some number of appeals of Part A claims denials. These elements should be implemented on Oct. 1. However, other elements of this policy need



significant further guidance and provider education from CMS and additional time for hospitals, physicians and review contractors to operationalize. We question whether CMS is able to issue sufficient and clear guidance before Oct. 1 and ask for a delay of at least three months in the enforcement of the two-midnight benchmark and the physician order requirements. Many questions remain related to the application of the benchmark and other requirements, and clear guidance is essential so that providers and contractors are abiding by the same rules.

As CMS acknowledged in the final rule's preamble, the guidance should promote consistent application of the inpatient admissions and review requirements and result in repeatable and reproducible decisions on individual cases for both providers and reviewers. Your staff suggested that it would be helpful for the AHA and others in the field to provide scenarios to CMS that could possibly be included in the guidance. Accordingly, the AHA has prepared the attached document with comments, general principles and specific inpatient admission scenarios that we believe are fundamental for the guidance to include.

With respect to implementation of the new inpatient admission and review criteria on Oct. 1, the AHA encourages CMS to move forward with the following provisions:

- Direct Medicare review contractors to apply the two-midnight presumption – that is, contractors should not select inpatient claims for review if the inpatient stay spanned two midnights from the time of admission.
- Direct Medicare review contractors reviewing inpatient stays that do not span two midnights from the time of admission to recognize that the physician's decision to admit may be based upon the time the beneficiary spends receiving outpatient services (including observation services, treatment in the emergency department, and procedures provided in the operating room or other treatment areas); the patient's medical history, comorbidities, severity of signs and symptoms, and current medical needs; the types of facilities available to inpatients and outpatients; the hospital's bylaws and admission policies; the relative appropriateness of treatment in each setting; the risk (probability) of an adverse event occurring during the period of hospitalization; and the health risks presented by a decision to send a beneficiary home rather than admit him or her.
- Limit a review by a Medicare contractor to only the information available to the admitting practitioner at the time of admission.

The AHA does not seek delayed enforcement of these provisions and believes these provisions should be implemented on Oct. 1, 2013.

To date, CMS has provided limited guidance to hospitals regarding implementation of the inpatient admission and review criteria. Our members tell us that many questions remain unanswered by CMS. Moreover, modifying Medicare rules regarding when inpatient hospital admissions are appropriate, as well as medical review of those admissions, is complicated and has proven to be difficult logistically for hospitals. Many internal policies and procedures need to be re-evaluated and potentially changed and extensive education of the hospital staff

undertaken. As a result, it is not feasible for hospitals to operationalize these policies before the Oct. 1, 2013 effective date. Moreover, review contractors should not be permitted to deny claims that fail to meet the two-midnight benchmark or lack a physician order unless the inpatient stay occurs *after* CMS issues additional subregulatory guidance. And even when a stay occurs after such guidance is issued, if it does not meet the benchmark, it may still be reasonable and necessary based upon the range of medical factors a physician may consider in making the admission decision.

Lastly, based on feedback from our members, the AHA would like to begin discussions with CMS to determine a long-term payment solution. We continue to believe that the 0.2 percent reduction to the PPS market basket update was unjustified and ask that CMS work with us to develop a payment solution to address those intense, inpatient-level services provided by hospitals to Medicare beneficiaries that are reasonable and necessary but do not appear on the inpatient-only list and are not expected to span two midnights.

The AHA appreciates the opportunity to comment on this matter and offers our comments and insights to improve the operation, fairness and accuracy of the Medicare program for its beneficiaries. If you have any questions concerning our comments, please feel free to contact me or Priya Bathija, AHA senior associate director, at (202) 626-2678, or Lawrence Hughes, AHA assistant general counsel, at (202) 626-2346.

Sincerely,

/s/

Linda E. Fishman
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American Hospital Association

**COMMENTS, GENERAL PRINCIPLES, ADMISSION SCENARIOS AND
SPECIFIC INSTRUCTIONS FOR INCLUSION IN CMS GUIDANCE
RELATED TO INPATIENT ADMISSION AND REVIEW CRITERIA**

TABLE OF CONTENTS

OVERVIEW OF NEW POLICIES RELATED TO INPATIENT ADMISSION AND REVIEW CRITERIA	4
GENERAL COMMENTS FOR GUIDANCE	5
GENERAL PRINCIPLES & SPECIFIC SCENARIOS	7
APPLICATION OF THE TWO-MIDNIGHT PRESUMPTION	7
EVALUATION OF THE ORDER FOR ADMISSION	10
APPLICATION OF THE TWO-MIDNIGHT BENCHMARK	11
DOCUMENTATION TO BE CONSIDERED IN APPLYING THE TWO-MIDNIGHT BENCHMARK	31

OVERVIEW OF NEW POLICIES RELATED TO INPATIENT ADMISSION AND REVIEW CRITERIA

CMS has adopted new guidelines for hospitals, physicians and Medicare review contractors regarding the criteria for determining whether the admission of a Medicare beneficiary for inpatient hospital services is reasonable and necessary and the documentation that must be included in a patient's medical record to support a reasonable and necessary inpatient admission. CMS established two distinct, although related, policies to guide the review of the medical necessity of an inpatient admission:

- a two-midnight *presumption*, which directs Medicare review contractors not to select inpatient claims for review if the inpatient stay spanned two midnights from the time of admission, absent evidence of gaming or abuse; and
- a two-midnight *benchmark*, which instructs admitting practitioners and Medicare review contractors that an inpatient admission is generally appropriate when the admitting practitioner has a reasonable and supportable expectation, documented in the medical record, that the patient would need to receive care at the hospital for a period spanning two-midnights.

In addition, in order for payment to be made under Medicare Part A to a hospital (including a critical access hospital) for an inpatient admission, there must be an inpatient admission order by a physician or other qualified and licensed practitioner with admitting privileges at the hospital and who is knowledgeable about the individual's hospital course, medical plan of care and current condition, that is furnished at or before the time of admission and that is present in the medical record and supported by the admission and progress notes.

The two-midnight presumption provides that an inpatient stay is generally presumed to be reasonable and necessary when the patient receives medically necessary items and services furnished over a period that spans at least two midnights. A Medicare review contractor should not review such claims to evaluate whether the inpatient admission was reasonable and necessary unless there is substantial evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the two-midnight presumption. On the other hand, an inpatient stay lasting less than two midnights is not presumptively reasonable and necessary. A Medicare contractor may review that claim to determine whether payment may be made under Medicare Part A. A Medicare provider may nevertheless demonstrate that the admission was reasonable and necessary by showing that the two-midnight benchmark was satisfied at the time of admission. Each of the grounds for establishing that an inpatient stay lasting less than two midnights is reasonable and necessary is outlined below.

For inpatient admissions lasting less than two midnights, a Medicare contractor may review the claim to evaluate (1) the physician order for inpatient admission, along with the other required elements of the physician certification, (2) the medical documentation supporting the physician's expectation that the patient would need care spanning at least two midnights, and (3) the medical documentation supporting the physician's expectation that it was reasonable and necessary to

keep the patient at the hospital to receive such care. An inpatient stay spanning less than two midnights is reasonable and necessary and payment is appropriate under Part A if there is a physician order for inpatient admission in the patient's medical record *and* the procedure performed is on the CMS inpatient-only list; *or* the admitting practitioner had a reasonable and supportable expectation at the time of admission that patient would need care at the hospital spanning at least two midnights – i.e., the two-midnight benchmark is satisfied – even though the actual length of stay was shorter than two midnights; *or* based on the physician's complex medical judgment of the specific facts and circumstances of a particular patient's condition, it is medically necessary for the patient to receive services at the hospital for a period of time that is expected to last less than two midnights (and that service is not on the CMS inpatient-only list).

To evaluate the physician order, a Medicare review contractor should determine only whether an order by a physician or other qualified and licensed practitioner with admitting privileges at the hospital and who is knowledgeable about the individual's hospital course, medical plan of care and current condition, is furnished at or before the time of admission and is present in the medical record and supported by the admission and progress notes. The Medicare review contractor should not evaluate whether the admitting practitioner is licensed to admit patients under state law or whether the practitioner has admitting privileges at the particular hospital.

The inpatient admission decision has been and remains a complex medical judgment that may be based on any one of a number of medical factors, or combination of those factors, that are documented in the beneficiary's medical record, including but not limited to: the patient's medical history, comorbidities, severity of signs and symptoms, and current medical needs; the types of facilities available to inpatients and outpatients; the hospital's bylaws and admission policies; the relative appropriateness of treatment in each setting; the risk (probability) of an adverse event occurring during the period of hospitalization; and the health risks presented by a decision to send a beneficiary home rather than admit him or her. To evaluate whether the two-midnight benchmark is satisfied, meaning that the admitting practitioner had a "reasonable and supportable" expectation that the patient would need care spanning at least two midnights and that it is necessary to keep the patient at the hospital to receive such care, the Medicare review contractor should consider documentation related to any one of these factors. The Medicare review contractor need not find documentation in the medical record for all or even most of these factors. To the contrary, documentation in the medical record related to only one of these factors may be sufficient to support the admitting practitioner's reasonable expectation. The Medicare review contractor may consider only information that was available to the admitting to the practitioner at the time of the admission, and must not consider information that becomes available only after the admission, such as the patient's actual length of stay and outcome.

GENERAL COMMENTS FOR GUIDANCE

Before discussing specific general principles and inpatient admission scenarios, the AHA would like to highlight several fundamental issues that CMS must address as the agency works to develop and release additional guidance related to its the new inpatient admissions and review criteria. Our comments are discussed below in more detail.

Collaboration: We recommend that CMS begin with the same precise set of principles and consider the same inpatient admissions scenarios when drafting guidance across the many different issue areas affected by this policy. We also recommend that CMS internally partner across relevant divisions during drafting to ensure that, as reflected in our recommendations that follow, the final guidance includes appropriate parallel or complementary instructions for both participating providers and Medicare review contractors. Drafting without collaboration separate guidance documents for the different intended audiences of providers and review contractors is likely to hinder achievement of the expressed objective of reducing claims denials and minimizing rebilling.

Continuous monitoring: It is important that CMS use its existing monitoring and audit authority, such as the Comprehensive Error Rate Testing (CERT) program, to ensure that Medicare contractors' review efforts are in fact focused properly only on those subsets of claims with the highest error rates, while simultaneously reducing the administrative burden for the subsets that have demonstrated compliance with the clarified and modified guidance issued. For example, as CMS suggests, Medicare contractor reviews initially can be expected to shift review to one-day stays. However, as facilities are found to be correctly applying the two-midnight benchmark, these reviews should shift away from one-day stays to areas with persistently high improper payment rates. CMS can utilize such benchmarks in its monitoring and oversight of contractors' performance to evaluate how well the new inpatient admissions and review criteria are working and to determine what additional guidance and instruction might improve the clarity and enhance the usefulness of the policy.

Real-time feedback for hospitals: We appreciate that the additional CMS guidance is intended to provide appropriate directions for Medicare review contractors, including the Recovery Audit Contractors (RACs), about the types of claims and specific medical documentation that should be reviewed. However, given the lookback period during which Medicare contractors may audit claims (e.g., a three-year lookback period for RACs), it may take many years for any hospital to know whether the claims they submitted for payment under Medicare Part A will be determined by the RACs or another contractor to have ultimately met these new inpatient admissions requirements. **Therefore, we request that CMS provide prompt and continual real-time information to help hospitals understand and properly apply the requirements in the interim.** Helpful educational information would include feedback on "common mistakes" or "lessons learned" from claims that are under or through the audit process.

Ongoing communication: The AHA also urges CMS to maintain its current email address at IPPSAdmissions@cms.hhs.gov and continue to accept comments from the field as implementation of the two-midnight requirements, including use by Medicare review contractors in post-payment claims reviews, continues to evolve. Appropriate implementation of the inpatient admissions and review criteria by providers and Medicare contractors alike will likely require iterative steps to ensure that the criteria work as smoothly and efficiently as intended. Providing a means for the field to offer comments and feedback will continue to be of significant value for a substantial period of time beyond the Oct. 1 effective date of the policies.

Automated solution to identify claims satisfying the two-midnight benchmark: CMS should consider ways to automate the identification of claims where the time the beneficiary spent as an outpatient before the inpatient admission order is written makes the expectation of the two-midnight benchmark reasonable and supportable and therefore appropriate for inpatient payment (as is the case in Example 5 below). Possible ways to accomplish this would include:

- Utilizing the uniform billing occurrence codes – Create a new code that indicates the patient was receiving outpatient services leading to their inpatient admission, and the date span of those services
- Create a condition code similar to code 44.

Whatever option is selected should be easy for providers to use and for reviewers to find when a claim is selected for review.

GENERAL PRINCIPLES & SPECIFIC SCENARIOS

The AHA has prepared the general principles and specific scenarios discussed below to address those areas in which both providers and Medicare contractors need further guidance in order to appropriately implement these policies. Each general principle is extracted directly from CMS's final rule and then applied to specific scenarios that may occur related to that particular general principle. We believe it is fundamental that CMS address each of these guiding principles and specific scenarios in its guidance.

1. Application of the two-midnight presumption

A. In general

Principle: An inpatient stay is generally presumed to be reasonable and necessary when the patient receives medically necessary items and services furnished over a period that spans at least two midnights. A Medicare review contractor should not review such claims to evaluate whether the inpatient admission was reasonable and necessary, unless there is substantial evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the two-midnight presumption.

Example 1: A physician orders an inpatient admission for a 72-year-old Medicare beneficiary for a scheduled coronary artery bypass graft surgery (CABG.) The beneficiary arrives at the hospital at 11 a.m. on Day 1 to be prepared for surgery. After surgery, the beneficiary remains at the hospital for two nights to be monitored for complications and is discharged at 11 a.m. on Day 3.

Application of two-midnight presumption: Because the beneficiary's inpatient stay spanned two midnights, the general presumption that the inpatient admission is reasonable and necessary applies. A Medicare review contractor should not select this claim for review.

Example 2: A physician orders an inpatient admission for a 65-year-old Medicare beneficiary for a scheduled arthroscopic knee surgery. The beneficiary is active and has no other conditions or diseases and experiences no complications during or after the surgery, but remains at the hospital for two midnights. Nearly all knee surgeries performed at that particular hospital in that year were performed on an inpatient basis and involve inpatient stays lasting two midnights. It appears that there is an established pattern of performing knee surgeries on an inpatient basis regardless of the age of the beneficiary, the severity of his or her condition, the intensity of the service performed, or the presence of comorbid conditions.

Application of two-midnight presumption: Although the presumption that the inpatient admission is reasonable and necessary applies, the Medicare review contractor may find that there is a pattern of two-day inpatient admissions for knee surgeries that suggests an abusive practice and overcomes the general presumption. A Medicare review contractor may select this claim for review.

Principle: An inpatient stay spanning at least two midnights after admission shall not be reviewed for the purpose of routinely denying payment under Part A on the basis that the services should have been provided on an outpatient basis. In the rare situation where such claims are reviewed, review should be only for the purpose of monitoring and responding to patterns of incorrect DRG assignments, inappropriate or systemic delays, and lack of medical necessity for the stay at the hospital.

Example 3: A physician orders an inpatient admission for a 78-year-old Medicare beneficiary who has pain and difficulty walking after a fall on Day 1. The beneficiary remains at the hospital for two nights following the admission, during which she receives pain medication, nursing assistance with her daily activities, and physical therapy services. The beneficiary is discharged from the hospital on Day 3.

Application of two-midnight presumption: Although the presumption that the inpatient admission is reasonable and necessary applies, the Medicare review contractor may find that the services provided to the beneficiary could have been provided in a nursing facility rather than at the hospital. A Medicare review contractor may select this claim for review.

Principle: The relevant time period for determining whether the two-midnight presumption applies begins at the time the inpatient admission order is issued.

Example 4: A Medicare beneficiary presents with dizziness and shortness of breath at a hospital emergency department at 6 p.m. on Day 1. After observing the patient and performing several diagnostic tests, the physician orders the patient to be admitted to the hospital at 11 p.m. The patient remains as an inpatient at the hospital for two nights, and is discharged at 8 a.m. on Day 3.

Application of two-midnight presumption: Because the beneficiary's inpatient stay spanned two midnights, the general presumption that the inpatient admission is reasonable and necessary applies. A Medicare review contractor should not select this claim for review.

Example 5: A 90-year-old Medicare beneficiary with a history of heart disease presents with dizziness and shortness of breath at a hospital emergency department at 6 a.m. on Day 1. After observing the patient and performing several diagnostic tests, the physician orders the patient to be admitted to the hospital at 11 a.m. for a percutaneous coronary intervention (PCI) and stent placement. The patient remains as an inpatient for one night, and is discharged at 8 p.m. on Day 2.

Application of two-midnight presumption: Even though the beneficiary's inpatient stay lasted the same number of hours as in Example 4, the beneficiary's admission lasted less than two midnights and therefore the general presumption that the admission was reasonable and necessary does not apply. A Medicare review contractor may review this claim.

Example 6: A 78-year-old Medicare beneficiary presents at the emergency department of the hospital with significant hip pain after a fall at 10 a.m. on Day 1. After performing several x-rays and other diagnostic tests, the physician concludes at 6 p.m. on Day 1 that the patient has a minor fracture of the hip that requires surgery the next day. The physician orders the patient be admitted as an inpatient at 6 p.m. on Day 1. However, because the hospital is at capacity, the beneficiary is boarded in the emergency department until an inpatient bed becomes available. The beneficiary is moved to an inpatient bed at 1 a.m. on Day 2. The beneficiary undergoes surgery at 6 a.m. on Day 2 and remains at the hospital overnight after the surgery. The beneficiary is discharged at 4 p.m. on Day 3.

Application of two-midnight presumption: The duration of the beneficiary's inpatient stay is measured from the time of the inpatient order (i.e., at 6 p.m. on Day 1), even though the beneficiary was not physically moved to an "inpatient" bed until after midnight, at 1 a.m. on Day 2. Because the beneficiary's inpatient stay spanned two midnights, from 6 p.m. on Day 1 until 4 p.m. on Day 3, the general presumption that the inpatient admission was reasonable and necessary applies. The Medicare review contractor should not select this claim for review.

Principle: A Medicare review contractor should focus its medical review efforts on inpatient hospital admissions spanning zero or only one midnight after admission.

Example 7: If a Medicare review contractor selects a batch of claims for review that contains both the claim described in Example 4, a beneficiary inpatient stay

spanning two midnights after a physician order for admission, and the claim described in Example 5, a beneficiary inpatient stay lasting less than two midnights after a physician order for admission, the Medicare review contractor should review the Example 5 claim because the inpatient stay spanned only one midnight and the two-midnight presumption does not apply.

B. In cases involving transfers between hospitals

Principle: In cases involving the transfer of a Medicare beneficiary admitted as an inpatient at one hospital to a second hospital after only one midnight, the two-midnight presumption does not apply to the transferring hospital but does apply to the receiving hospital.

Example 8: A 92-year-old Medicare beneficiary with a history of arrhythmia, high cholesterol and hypertension is admitted to a community hospital for an elective pacemaker surgery at 11 a.m. on Day 1. During the surgery, the Medicare beneficiary experiences complications, such that a more complex procedure is required. The beneficiary is transferred from the community hospital and admitted to the nearest tertiary care hospital at 3 a.m. on Day 2 and receives the more complex procedure. The beneficiary is discharged from the cardiac care specialty hospital at 6 p.m. on Day 3.

Application of the two-midnight presumption: Because the beneficiary's admission lasted less than two midnights at the transferring hospital, the general presumption that the admission was reasonable and necessary does not apply to the transferring hospital. A Medicare review contractor may review the transferring hospital's inpatient claim. In contrast, because the total duration of the beneficiary's admission spanned two midnights, the general presumption that the admission was reasonable and necessary does apply to the receiving hospital. A Medicare review contractor should not review the receiving hospital's inpatient claim.

2. Evaluation of the order for admission

Principle: The order for an inpatient admission is a required component of the certification of medical necessity of the inpatient stay. No specific procedure or form is required for the certification, but the certification (including the inpatient admission order) must be documented as part of the medical record. The hospital may adopt any method that permits verification.

Principle: In rare circumstances in which an inpatient admission order may be missing from the medical record or defective (i.e., illegible or incomplete), yet the intent, decision and recommendation of the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient can clearly be derived from the medical record, the information in the medical record constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. A Medicare review contractor may find that the requirement is satisfied only in these narrow circumstances.

Example 9: An 89-year-old Medicare beneficiary's medical record contains the results of several diagnostic tests that confirm that the beneficiary has pneumonia and is experiencing difficulty breathing. The patient has a history of prolonged bouts of pneumonia. The emergency department physician who evaluated the patient made progress notes stating that the physician expects the beneficiary to need to be monitored continuously for at least 48 hours to ensure that her pneumonia does not get worse. The Medicare review contractor should find that the requirement of an inpatient order has been satisfied in this case.

Principle: A verbal inpatient admission order must be properly countersigned by the practitioner who gave the order.

Principle: The order for admission must be furnished at or before the time of the inpatient admission.

Principle: An order for inpatient admission must be supported by documentation in the medical record; no presumptive weight shall be assigned to the physician's order for purposes of determining whether an inpatient admission is reasonable and necessary.

Principle: An inpatient admission order issued by any admitting practitioner who is qualified and licensed to admit patients under state law and has admitting privileges at the hospital and is knowledgeable about the patient's hospital course, medical plan of care, and current condition satisfies the requirement for an inpatient admission order. These requirements are intended to ensure consistency with current state law and existing hospital practice; none of these requirements should be interpreted to alter or change current state law and existing hospital practice.

Principle: A Medicare review contractor's review should be limited to whether a signed inpatient order issued by a qualified and licensed practitioner is present in the medical records. A Medicare review contractor should not interpret state law or hospital by-laws, policies or practices regarding admitting privileges.

Example 10: In evaluating whether the inpatient order requirement is met, a Medicare review contractor should ask: (1) Is there an order for admission? (2) Is it sufficiently clear that the order is for inpatient care? and (3) If the answer to both of these questions is "yes," then the Medicare review contractor must review the medical record to determine whether there is documentation to support finding that the two-midnight benchmark is satisfied, as described below.

3. Application of the two-midnight benchmark

A. In general

Principle: In determining whether payment should have been made under Part A, a Medicare review contractor should evaluate whether the admitting physician has a reasonable expectation that the beneficiary will need care spanning two midnights based on all of the time that the beneficiary spent at the hospital receiving medically necessary services.

Example 11: A Medicare beneficiary presents at a hospital's emergency department with chest pain and shortness of breath at 8 p.m. on Day 1. A physician orders observation services and several diagnostic tests. Based on the results of these tests, at 4 a.m. on Day 2 a physician determines surgery is medically necessary. At that point, based on the patient's condition, comorbidities, and the intensity of the surgery, the physician expects that the beneficiary will need to receive care in the hospital for another 24 hours after the surgery. The surgery is performed on Day 2 and the beneficiary remains in the hospital for one night after the surgery. The beneficiary is discharged from the hospital at 8 a.m. on Day 3.

Application of the two-midnight presumption: Even though the beneficiary received services at the hospital for a period spanning two midnights, the beneficiary's inpatient stay lasted only one night, from the time of the admission order at 4 a.m. on Day 2, to the time of discharge at 8 a.m. on Day 3. The time that the beneficiary spent in the emergency department receiving observation services and undergoing diagnostic tests does not count as inpatient time for purposes of the two-midnight presumption because those services were provided before the physician ordered admission. Therefore, the general presumption that an inpatient stay lasting two midnights is reasonable and necessary does not apply. A Medicare review contractor may review this claim.

Application of the two-midnight benchmark: In determining whether payment should have been made under Medicare Part A, the Medicare review contractor should evaluate whether the physician had a reasonable expectation, supported by evidence in the medical record, that the total period that the beneficiary spent at the hospital receiving services (i.e., starting at 8 p.m. on Day 1), would exceed two midnights. Even though the physician expected the beneficiary to need care for only 24 hours following the surgery, the physician's expectation that the two-midnight benchmark would be met is reasonable and supported by the medical record because the beneficiary had already spent one night at the emergency department receiving medically necessary observation and diagnostic services that were documented in the medical record. Payment is appropriate under Part A.

Principle: The two-midnight benchmark is satisfied if at the time of the admission, the admitting practitioner had a reasonable and supportable expectation that the beneficiary would need care spanning two midnights, even if the beneficiary's actual length of stay is unexpectedly shorter than two midnights, such as when the beneficiary dies, is transferred to another hospital, leaves the hospital against medical advice, or improves more rapidly than expected.

Example 12: A 90-year-old Medicare beneficiary presents at a hospital emergency department with a severe respiratory infection. Diagnostic tests reveal that the beneficiary has pneumonia, and the physician orders that the beneficiary be admitted to the hospital at 6 p.m. on Day 1. The beneficiary stays one night in the hospital and departs in the morning on Day 2 against medical advice.

Application of two-midnight presumption: Because the beneficiary's admission lasted less than two midnights, the general presumption that the admission was reasonable and necessary does not apply. A Medicare review contractor may review this claim.

Application of two-midnight benchmark: In reviewing this claim, the Medicare review contractor should evaluate whether the physician had a reasonable, documented expectation that the beneficiary would need care at the hospital for a period spanning two midnights at the time that the physician ordered the admission. The Medicare review contractor must not consider the actual length of the inpatient stay. Here, in light of the beneficiary's advanced age and diagnosis, which were documented in the medical record, the physician's expectation that the beneficiary would need treatment for a period spanning two midnights was reasonable and the two-midnight benchmark was met. Payment is appropriate under Part A.

Example 13: An 82-year-old Medicare beneficiary presents at the hospital emergency department with acute abdominal pain at 8 p.m. on Day 1. Diagnostic tests indicate severe appendicitis with a significant risk of rupture, and the physician orders that the beneficiary be admitted as an inpatient for an emergency appendectomy at 10 p.m. The beneficiary is frail and has a history of gastrointestinal conditions such that the physician expects the beneficiary to receive care as an inpatient for at least two nights following the surgery, and even longer if the appendix ruptures. However, the appendectomy is completed without complications and the beneficiary recovers from the surgery more quickly than expected. The beneficiary is discharged from the hospital at 8 p.m. on Day 2.

Application of two-midnight presumption: Because the beneficiary's admission lasted less than two midnights, the general presumption that the admission was reasonable and necessary does not apply. A Medicare review contractor may review this claim.

Application of two-midnight benchmark: In reviewing this claim, the Medicare review contractor should evaluate whether the physician had a reasonable, documented expectation that the beneficiary would need care at the hospital for a period spanning two midnights at the time that the physician ordered the admission. The Medicare review contractor must not consider the actual length of the inpatient stay or the fact that the beneficiary did not experience a ruptured appendix or any other complications during or after the appendectomy because that information was not available to physician at the time the inpatient order was written. Here, in light of the beneficiary's frailty, history of gastro-intestinal complications, the severity of the beneficiary's appendicitis, and the risk of rupture, all of which were documented in the medical record, the physician's expectation that the beneficiary would need treatment for a period spanning two midnights was reasonable and the two-midnight benchmark was met. Payment is appropriate under Part A.

B. In cases involving transfers between hospitals

Principle: In cases involving the transfer of a Medicare beneficiary from one hospital to a second hospital, the two-midnight benchmark also should apply in the same manner to the hospital that receives the transferred patient as to the hospital that transfers the patient.

Example 14: In Example 8 above, the two-midnight presumption did not apply to the transferring hospital, but did apply to the receiving hospital.

Application of two-midnight benchmark: In reviewing the transferring hospital's claim, the Medicare review contractor should evaluate whether the physician had a reasonable, documented expectation that the beneficiary would need care at the hospital for a period spanning two midnights at the time that the physician ordered the admission. The Medicare review contractor must not consider the actual length of the inpatient stay. In light of the Medicare beneficiary's advanced age and documented medical history and the risks that the beneficiary could experience an adverse event, the admitting physician at the community hospital had a reasonable expectation that the beneficiary would need care at the hospital for a period spanning two midnights at the time that the physician ordered admission. The two-midnight benchmark is met and payment is appropriate under Part A to the transferring hospital.

In reviewing the receiving hospital's claim, the Medicare review contractor should evaluate whether the admitting physician had a reasonable, documented expectation that the total period that the beneficiary spent at both hospitals receiving necessary services (i.e., starting at 11 a.m. on Day 1 at the community hospital), would exceed two midnights. Even though the physician expected the beneficiary to need care for a period spanning only one midnight following the surgery, the physician's expectation that the two-midnight benchmark would be met is reasonable and supported by the medical record because the beneficiary

had already spent one night at the community hospital receiving medically necessary surgery services that were documented in the medical record. Payment is appropriate under Part A.

Example 15: A Medicare beneficiary presents to a hospital emergency department with chest pain and shortness of breath at 10 p.m. on Day 1. After performing diagnostic tests and stabilizing the patient, the beneficiary is transferred to another hospital and admitted for a PCI and insertion of a cardiac stent at the second hospital at 5 a.m. on Day 2. The beneficiary remains at the second hospital for one night following the surgery and is discharged from the second hospital at 4 p.m. on Day 3.

Application of the two-midnight presumption: The two-midnight presumption does not apply to the transferring hospital because the beneficiary was stabilized in the emergency department and was never admitted as an inpatient. Because the beneficiary's admission at the receiving hospital lasted less than two midnights (i.e., from 5 a.m. on Day 2 until 4 p.m. on Day 3), the general presumption that the admission was reasonable and necessary does not apply to the second hospital. A Medicare review contractor may review this claim.

Application of the two-midnight benchmark: In reviewing the claim, the Medicare review contractor should evaluate whether the physician had a reasonable expectation, supported by evidence in the medical record, that the total period that the beneficiary spent at the first hospital and the second hospital receiving services (i.e., starting at 10 p.m. on Day 1), would exceed two midnights. Even though the physician expected the beneficiary to need care for only 24 hours following the surgery, the physician's expectation that the two-midnight benchmark would be met is reasonable and supported by the medical record because the beneficiary had already spent one night at the emergency department at the first hospital receiving medically necessary observation and diagnostic services that were documented in the medical record. Payment is appropriate under Part A.

C. In cases involving procedures on CMS's inpatient-only list

Principle: An inpatient admission for a procedure included on CMS's inpatient-only list is reasonable and necessary regardless of the length of time the beneficiary is expected to remain at the hospital. Many of the procedures on CMS's inpatient-only list routinely involve inpatient admissions that last less than two midnights. The two-midnight benchmark does not apply to such services.

Example 16: A 65-year-old Medicare beneficiary presents at a hospital emergency department after a car accident with fractured ribs at 9 a.m. on Day 1. After performing x-rays, the physician determines that surgery is necessary to repair the fractures and orders that the beneficiary be admitted as an inpatient for

the surgery. The beneficiary experiences no complications during or after the surgery and is discharged from the hospital at 4 p.m. on Day 2.

Application of the two-midnight presumption: Because the beneficiary's admission lasted less than two midnights, the general presumption that the admission was reasonable and necessary does not apply. A Medicare review contractor may review this claim.

Application of the two-midnight benchmark: The surgical procedure performed to treat the beneficiary's rib fractures (Healthcare Common Procedure Coding System Code 21810) is specified as an inpatient-only procedure under 42 C.F.R. § 419.22(n) and is listed as inpatient only in CMS Outpatient Prospective Payment System Addendum B. Therefore, the inpatient admission is reasonable and necessary regardless of how long the physician expected the beneficiary to need care as an inpatient. The two-midnight benchmark does not apply in the first place. In reviewing this claim, the Medicare review contractor should evaluate whether there was a physician order for admission and whether the procedure performed was medically necessary and correctly coded on the hospital's inpatient claim. Payment is appropriate under Part A.

D. In cases involving state laws or other requirements regarding inpatient admissions

Principle: An inpatient admission for a stay that meets requirements to comply with state law is reasonable and necessary regardless of the length of time the beneficiary is expected to remain at the hospital. The two-midnight benchmark does not apply to such services.

Example 17: A 72-year-old Medicare beneficiary with a history of obesity, diabetes, hypertension and high cholesterol presents to the hospital emergency department with chest pain at 6 p.m. on Day 1. After the results of several diagnostic tests are inconclusive, the physician orders observation services for the patient at 8 p.m. on Day 1. The hospital is subject to a state law that prohibits a hospital from holding a patient for observation services for longer than eight hours. At 4 a.m. on Day 2, after the patient has been under observation for eight hours and has undergone additional diagnostic tests, the results of which are also inconclusive, the physician still is unable to determine the cause of the patient's chest pain. Based on the beneficiary's medical history and the significant risk that the patient could experience an adverse event if discharged, the physician expects that the beneficiary will need to receive diagnostic tests and observation services for an additional eight to 12 hours and admits the beneficiary as an inpatient. The patient is discharged at 6 p.m. on Day 2.

Application of two-midnight presumption: Because the beneficiary's admission lasted less than two midnights, the general presumption that the admission was reasonable and necessary does not apply. A Medicare review contractor may review this claim.

Application of two-midnight benchmark: In this case, the two-midnight benchmark is not met because even though the physician may consider the time spent receiving medically necessary diagnostic tests and observation services (i.e., starting at 6 p.m. on Day 1), the physician expected the beneficiary to need care for a period spanning less than two midnights (i.e., from 6 p.m. on Day 1 until 12 noon or 4 p.m. on Day 2). However, there are some circumstances in which an inpatient admission lasting less than two midnights is reasonable and necessary even though the two-midnight benchmark has not been met. Here, state law requires the admitting practitioner to make a decision either to admit or discharge the patient at 4 a.m. Based on the beneficiary's medical history, and the increased risk of adverse events if she were discharged before the cause of her chest pain was identified, the physician appropriately concluded that inpatient admission was reasonable and necessary. Payment is appropriate under Part A.

E. In cases in which the two-midnight benchmark is not met

Principle: There are some unusual cases in which, based on the specific complex medical factors of a particular beneficiary, an inpatient admission is reasonable and necessary even though the two-midnight benchmark is not met (and the procedure performed is not listed on the CMS's inpatient-only list).

Example 18: An 84-year-old Medicare beneficiary is scheduled for knee surgery to repair a damaged meniscus. The beneficiary's injury is not severe and the planned surgery is a simple procedure. The beneficiary has a history of falls; she has been seen at the emergency department twice in the last year for a sprained ankle and a broken wrist in connection with those falls and is currently undergoing outpatient physical therapy to improve her balance. The beneficiary lives alone in a two-story house and expresses apprehension about her ability to get around her house by herself. The physician expects that the beneficiary will need care for only 24 hours following her surgery, but orders the beneficiary to be admitted as an inpatient because of her medical history of falls, her lack of confidence, and her living situation, all of which indicate that there is an increased risk that the beneficiary could experience an adverse event (i.e., another fall) if discharged from the hospital. The beneficiary arrives at the hospital at 11 a.m. on Day 1 to receive pre-operative services for her surgery at 3 p.m. The beneficiary remains overnight at the hospital, and the next day is seen by a physical therapist and works with several nurses until the beneficiary is comfortable using a walker to get around. The beneficiary is discharged at 4 p.m. on Day 2.

Application of two-midnight presumption: Because the beneficiary's admission lasted less than two midnights, the general presumption that the admission was reasonable and necessary does not apply. A Medicare review contractor may review this claim.

Application of two-midnight benchmark: In this case, the two-midnight benchmark is not met because the physician expected the beneficiary to need care for only 24 hours following her knee surgery (i.e., spanning only one midnight). However, the two-midnight benchmark represents only guidance to admitting practitioners and Medicare review contractors regarding when an inpatient admission is generally appropriate; the physician's admission decision is a complex medical judgment that necessarily depends on the specific facts and circumstances of each particular case, and there are some cases where an inpatient admission is appropriate even though the two-midnight benchmark is not met. Indeed, there may be cases in which any one of the listed considerations (e.g., the intensity of the services provided) is sufficient to establish that the decision to admit a patient as an inpatient for a period spanning only one midnight was reasonable and necessary. Here, the inpatient admission was reasonable and necessary based on the beneficiary's history of falls and fall-related injuries, her lack of confidence, her living situation, and the increased risk of adverse events if she were discharged before she was comfortable using her walker. Payment is appropriate under Part A.

4. Documentation to be considered in applying the two-midnight benchmark

Principle: A Medicare review contractor must evaluate the inpatient admission based on the documentation in the medical record at the time of the admission and may not consider information that becomes available only after the admission.

Example 19: As noted in Example 13 above, in reviewing a claim for purposes of evaluating whether the two-midnight benchmark is met, the Medicare review contractor should evaluate whether the physician had a reasonable, documented expectation that the beneficiary would need care at the hospital for a period spanning two midnights at the time that the physician ordered the admission. The Medicare review contractor must not consider the actual length of the inpatient stay or the fact that the beneficiary did not experience a ruptured appendix or any other complications during or after the appendectomy because that information was not available to physician at the time the inpatient order was written. In light of the beneficiary's frailty, history of gastro-intestinal complications, the severity of the beneficiary's appendicitis, and the risk of rupture, all of which were documented in the medical record, the physician's expectation that the beneficiary would need treatment for a period spanning two midnights was reasonable and the two-midnight benchmark was met. Payment is appropriate under Part A.

Principle: A physician may consider evidence based guidelines or commercial utilization tools as part of the complex medical judgment that guides his or her decision to keep a beneficiary in the hospital and formulation of the expected length of stay.

Example 20: As noted in Example 13 above, in reviewing a claim for purposes of evaluating whether the two-midnight benchmark is met, the Medicare review

contractor should evaluate whether the physician had a reasonable, documented expectation that the beneficiary would need care at the hospital for a period spanning two midnights at the time that the physician ordered the admission. The Medicare review contractor must not treat the fact that a physician does not consider such tools or that the use of such tools is not documented in the medical record as evidence that the physician's expectation was not reasonable and necessary. In light of the beneficiary's frailty, history of gastro-intestinal complications, the severity of the beneficiary's appendicitis, and the risk of rupture, all of which were documented in the medical record, the physician's expectation that the beneficiary would need treatment for a period spanning two midnights was reasonable and the two-midnight benchmark was met. Payment is appropriate under Part A.