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THE LIVANTA CLAIMS REVIEW ADVISOR

A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

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Short Stay Review (SSR) – Second Year Review Findings

This month's issue of The Livanta Claims Review Advisor reports on findings from the second year of reviews under Livanta's national Claim Review Services contract. Results for the second year encompass reviews completed from November 1, 2022 through October 31, 2023.

The Two-Midnight Rule

The Centers for Medicare & Medicaid Services (CMS) implemented the Two-Midnight Rule in Fiscal Year (FY) 2014 to assist hospitals in determining when an inpatient admission would be appropriate for payment under Medicare Part A (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 and the medical record supports that expectation. This Rule outlines two medical review policies: (1) a two-midnight presumption; and (2) a two-midnight benchmark.

In the FY2016 Outpatient Prospective Payment System (OPPS) Final Rule, CMS amended the Two-Midnight Rule and clarified that Medicare would allow exceptions to the two-midnight benchmark to be determined on a case-by-case basis by the physician responsible for the care of the patient, subject to medical review. CMS continues to expect that stays under 24 hours would rarely qualify for an exception to the two-midnight benchmark. The Two-Midnight Rule does not apply to procedures on the Inpatient-Only List.

CMS issued the BFCC-QIO Two-Midnight Claim Review Guideline, which 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 (file may appear in a download folder)
https://www.cms.gov/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimRiewGuideline.%20508.pdf

Livanta's CMS-approved sampling strategy for SSR claims is described in the May 2023 edition of this newsletter, which can be found **here**.

Overall Findings

The findings below are from Livanta's second year of reviews under the national Claim Review Services contract. The date range for these reviews was November 1, 2022 through October 31, 2023.

After review, 90 percent of SSR claims were approved for appropriate Part A reimbursement.

Description	Number	Percent
Approved	19,375	90%
Admission Denials	2,135	10%
Total Claims Reviewed	**21,510**	**100%**

Length of Stay

Length of stay is calculated from the date of inpatient admission to the date of discharge as submitted on the claim. Claims with a 0-day length of stay (LOS) are more likely to be denied.

Length of Stay	Number of Claims Reviewed	Number of Claims Denied	Percent of Claims Denied
0-Day Stay	5,303	716	14%
1-Day Stay	16,207	1,419	9%
Total Reviewed	**21,510**	**2,135**	**10%**

Findings by CMS Region

These regional findings are based on claims sampled and reviewed in accordance with the CMS-approved sampling strategy as outlined in the May 2023 edition of this newsletter referenced above.

CMS Region	Number of Claims Reviewed	Number of Claims Denied	Regional Error Rate	Proportion of All Denials
1	1,339	148	11%	7%
2	1,592	240	15%	11%
3	2,660	280	11%	13%
4	5,077	515	10%	24%
5	3,645	278	8%	13%
6	2,356	268	11%	13%
7	1,030	81	8%	4%
8	724	56	8%	3%
9	2,490	222	9%	10%
10	597	47	8%	2%
Total	**21,510**	**2,135**	**10%**	**100%**

Region 1 - Boston
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region 2 - New York
New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands

Region 3 - Philadelphia
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia

Region 4 - Atlanta
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region 5 - Chicago
Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region 6 - Dallas
Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region 7 - Kansas City
Iowa, Kansas, Missouri, and Nebraska

Region 8 - Denver
Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region 9 - San Francisco
Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Marshall Islands, and Republic of Palau

Region 10 - Seattle
Alaska, Idaho, Oregon, and Washington

Top Reasons for Denial

- Provider documentation in support of a two-midnight expectation at the time of the admission order is insufficient. (Review Guideline Step 4)
- The plan of care does not support a reasonable expectation of two midnights of hospital care. (Review Guideline Step 4)
- The need for inpatient care without a two-midnight expectation is not supported by provider documentation regarding the patient's documented medical needs and risk for an adverse event. (Review Guideline Step 6)
- Misclassification of a procedure as being on the Inpatient-Only List for the date the procedure is performed. (Review Guideline Step 3)

SSR Denials by Service Category

Seven major diagnostic categories (MDCs) comprised 85 percent of all denials, with more than one-third arising from MDC 05, Circulatory System.

MDC	MDC Description	Claims Denied	MDCs Contribution to Total Denials
05	Circulatory System	731	34%
08	Musculoskeletal System and Connective Tissue	294	14%
06	Digestive System	242	11%
01	Nervous System	173	8%
11	Kidney & Urinary Tract	170	8%
04	Respiratory System	99	5%
10	Endocrine, Nutritional, and Metabolic	96	5%
	TOTAL	**1,805**	**85%**

Provider Samples

During this second year of reviews, monthly SSR samples included intensive provider samples selected based on empiric review results with the intention of focusing on individual provider education about the proper application of the Two-Midnight Rule.

During this reporting period, 38 provider samples were completed with the following overall results:

- The error rate for these samples ranged from 0 percent to 50 percent
- The average error rate across the 38 samples was 25 percent
- These 38 samples resulted in 25 individual provider educational teleconferences to discuss the specific claims found to be in error and the rationale for the denials

Livanta will continue to accrue claim findings at the provider level to inform future sampling.

Best Practices for Claim Approval

Documentation of the treating physician's reasoning supporting inpatient admission is critical. Livanta advises that patient-specific documentation be included in the medical record to support the reason(s) for inpatient admission.

Clear documentation of the factors that support a two-midnight expectation or the need for inpatient care absent a two-midnight expectation. Patient-specific documentation will help Livanta clearly understand the physician's reasoning without needing to infer this reasoning.

Correct classification of procedures performed being on the Inpatient-Only List for the date the procedure was performed. Livanta advises that hospitals prescreen scheduled surgical admissions for accurate classification of the procedure being on the appropriate year's Inpatient-Only List.

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.

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