



Medicare Utilization Review Version

KEY CONCEPTS OUTLINE

Module 6: Inpatient Admission Guidelines

I. Inpatient Admissions Appropriate for Payment under Part A

Two requirements for Part A payment of an inpatient admission:

- Certification (discussed in a previous module)
 - At a PPS hospital, if
 - Cost outlier; or
 - Length of stay of 20 days or greater
 - OR
 - At a CAH, “Good faith” certification
- Appropriate for Part A payment:
 - An inpatient only procedure; or
 - Physician’s expectation the patient will require medically necessary hospital care for two midnights or longer; or
 - Physician’s case-by-case determination to admit the patient based on their clinical judgment, supported in the medical record

- A. CMS published an algorithm entitled “BFCC QIO 2 Midnight Claim Review Guideline” that provides helpful guidance on application of the 2 Midnight Rule to determine whether cases are appropriate for payment under Part A. Handout 8 is the “BFCC QIO 2 Midnight Claim Review Guideline”.

Link: [Inpatient Hospital Reviews under Medicare-Related Sites - Hospital](#)

II. Inpatient-Only Procedures

- A. CMS has determined certain procedures are not appropriate to be provided in a hospital outpatient department and designates them “inpatient only” procedures. <Medicare Claims Processing Manual, Chapter 4 § 180.7>

- B. Inpatient-only procedures have an OPPS status indicator of C on Addendum B, published quarterly. The list of inpatient-only procedures is also published in Addendum E to the OPPS Final Rule every year. <Medicare Claims Processing Manual, Chapter 4 § 180.7>

Link: OPPS – Addendum A&B under Medicare-Related Sites – Hospital
 Link: OPPS – Regulations and Notices under Medicare-Related Sites – Hospital

- C. Inpatient admission and Part A payment is appropriate if a medically necessary inpatient-only procedure is performed and documented in the medical record. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.A.>

1. Inpatient admission is appropriate based on the presence of an inpatient-only procedure, regardless of the patient’s expected length of stay. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.E.1>

- D. Exemption from Certain Medical Review Activities

1. Procedures removed from the inpatient-only list on or after January 1, 2020, are exempt from certain medical review activities for a period of 2 years from their removal from the list. <86 Fed. Reg. 63740; 42 C.F.R. 412.3 (d)(2)(i)>

Note: In CY2022, CMS amended section 412.3(d)(2)(i), providing for a two-year exemption period for procedures removed on or after January 1, 2020, as discussed in the CY2022 OPPS Final Rule. However, CMS did not remove or amend section 412.3(d)(2)(ii) which continues to provide that procedures removed on or after January 1, 2021, are exempt until the secretary determines the procedure is more commonly performed in the outpatient setting. This appears to be an error based on the discussion in the CY2022 Final Rule.

2. During the period of exemption, claims for procedures removed from the inpatient only list are not exempt from review, but are exempt from:
 - a. Site of service claim denials under Medicare Part A;
 - b. QIO referral to RACs for noncompliance with the 2-Midnight Rule; and
 - c. RAC reviews for site of service. <86 Fed. Reg. 63740>

E. Inpatient-Only Procedures Performed on an Outpatient Basis

1. Subject to certain exceptions discussed below, if an inpatient-only procedure is performed on an outpatient basis, no payment will be made for the inpatient-only procedure, or any other services furnished on the same date as the inpatient-only procedure. <IOCE Specifications, Section 6.2, Edits 18 and 49>

F. Exceptions to the Inpatient-Only Payment Rule

1. Emergency Inpatient-Only Procedure and the Patient Dies or is Transferred

- a. If an inpatient-only procedure is furnished on an emergency basis while the patient is still an outpatient and the patient dies or is transferred to another hospital prior to being admitted, payment is made for the inpatient-only procedure and all other services provided that day under a single APC. <IOCE Specifications, Section 6.6.3>
- b. Billing
 - i. The HCPCS code for the inpatient-only procedure should be reported with the -CA modifier. <IOCE Specifications, Section 6.6.3>
 - ii. The patient discharge status code (UB-04, FL 17) must reflect the patient expired or was transferred. <IOCE Specifications, Section 6.6.3>
 - a) The claim will be returned to the provider under IOCE edit 70 if modifier -CA is reported without a patient discharge status code of 20, expired, or a designated transfer code¹. <IOCE Specifications, Section 6.6.3, and Section 7.2, Edit 70>
- c. Payment
 - i. Payment for an emergency inpatient-only procedure reported with modifier -CA is made under Comprehensive APC 5881 “Ancillary Outpatient Services When Patient Dies” (\$12,241.93). <68 Fed. Reg. 63467; 80 Fed. Reg. 70339; Addendum A>
 - ii. Limitations <IOCE Specifications, Section 6.6.3>

¹ **2/82**: Discharged/transferred to a Short Term General Hospital for Inpatient Care/with a Planned Acute Care Hospital Inpatient Readmission; **5/85**: to a Designated Cancer Center or Children’s Hospital/with a Planned Acute Care Hospital Inpatient Readmission; **62/90**: to an Inpatient Rehabilitation Facility (IRF), including Rehabilitation Distinct Part Units of a Hospital/with a Planned Acute Care Hospital Inpatient Readmission; **63/91**: to a Medicare Certified Long Term Care Hospital (LTCH)/with a Planned Acute Care Hospital Inpatient Readmission; **65/93**: to a Psychiatric Hospital or Psychiatric Distinct Part of a Hospital/with a Planned Acute Care Hospital Inpatient Readmission; or **66/94**: to a Critical Access Hospital (CAH)/with a Planned Acute Care Hospital Inpatient Readmission.

- a) Payment will only be made for one -CA procedure.
- b) All other line items billed on the same day as a -CA procedure are packaged, including line items that trigger other Comprehensive APCs (i.e., assigned to status indicator J1 or J2). <IOCE Specifications, Section 6.6.3; Medicare Claims Processing Manual, Chapter 4 § 180.7>

2. Patient is Admitted as an Inpatient within Three Days of the Procedure

- a. If an inpatient-only procedure is furnished on an outpatient basis, and the patient is admitted as an inpatient within three days, the inpatient-only procedure is included on the inpatient claim according to the usual requirements under the three-day payment window. <Medicare Claims Processing Manual, Chapter 4 § 180.7, Medicare Claims Processing Manual Transmittal 3238>

The three-day payment window requires services on the day of admission and diagnostic services and clinically related non-diagnostic services in the three days before admission be included on the inpatient claim.
The three-day window will be discussed in detail in a later module.

- b. Emergency Inpatient-Only Procedure and the Patient Survives

- i. When an inpatient-only procedure is furnished on an emergency basis while the patient is still an outpatient, and the patient survives the procedure, the patient should be admitted and an inpatient claim submitted including the inpatient-only procedure. <67 Fed. Reg. 66798; Program Memorandum A-02-129; Medicare Claims Processing Manual Transmittal 3238>

Tip: Patients, who are transferred following an inpatient-only procedure provided on an emergency basis, may be admitted prior to transfer and an inpatient claim submitted including the inpatient-only procedure OR billed with modifier -CA for C-APC payment if no inpatient order was written prior to discharge.

3. Separate Procedure Exception

- a. Inpatient-only procedures on the separate procedure list are bypassed when performed incidental to a surgical procedure with Status Indicator T or J1. <IOCE Specifications, Section 6.6.3>

- i. If an inpatient-only procedure on the separate-procedure list is billed with a status indicator T or J1 procedure, the inpatient-only code is rejected and the claim is processed according to the usual OPPS rules. <IOCE Specifications, Section 6.6.3 and Section 7.2, Edit 45>
- ii. The “separate-procedure list” is available in the IOCE Quarterly Data Files, Report-Tables folder, DATA_HCPCS, column AU “SEPARATE_PROCEDURE” available on the OCE homepage. The current list is included in the materials behind the outline.

Link: OCE Specifications under Medicare-Related Sites – Hospital

Case Study 1

Facts: A Medicare patient presents to the emergency department at 1 a.m. during an acute myocardial infarction. A percutaneous transluminal revascularization of a subtotal occlusion of the coronary artery and placement of a non-drug eluting stent is performed (CPT code 92941, OPPS status indicator C effective January 1, 2018).

Following the procedure, based on facility protocols, the cardiologist anticipates discharging the patient late on the following day (i.e., after a one-night stay at the hospital). The cardiologist did not write an inpatient order because she did not expect a two midnight stay for the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care?

Modified Facts: During the procedure, the patient experienced a cardiac arrest and expired. Due to the emergency nature of the patient’s condition and urgency of the procedure, the cardiologist never entered an inpatient order to admit the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care? Are there any special coding requirements?

III. Two Midnight Benchmark

- A. The physician should order inpatient care if the physician has a reasonable expectation that the patient will require two midnights of medically necessary hospital care. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A, A.I.B; 78 *Fed. Reg.* 50946>

CMS has indicated they do not expect a patient receiving medically necessary hospital care to pass a second midnight without an order for inpatient care.

- B. The physician should consider the following timeframes in determining whether the patient will require two midnights of hospital care:

1. The physician should consider anticipated medically necessary inpatient care expected to be provided after the order for inpatient admission and initiation of care. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A, A.I.B>
 - a. Do not include time anticipated at another facility after transfer. <See *Reviewing Short Stay Hospital Claims for Patient Status: Admissions on or After January 1, 2016*, B.4>
2. The physician should consider time the patient spent receiving medically necessary inpatient or outpatient care at a transferring hospital prior to arrival. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
 - a. Reviewing contractors may request the admitting hospital provide records from the transferring hospital to verify medical necessity and when hospital care began. <*Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
3. The physician should consider time the patient spent receiving medically necessary outpatient services (e.g., in the ED, observation, outpatient surgery) prior to the order for admission. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>

Do not consider:

- Triaging activities, such as vital signs, before initiation of medically necessary care responsive to the patient's clinical presentation; or
- Time spent in the waiting room prior to initiation of care.

- a. If the patient has received two midnights of medically necessary outpatient care without an inpatient order, the physician may write the inpatient order on the third day even if the patient is being discharged that day. <See KEPRO Short Stay Reviews FAQ, pg. 15; see BFCC QIO 2 Midnight Claim Review Guideline algorithm>

- b. Hospitals may report Occurrence Span Code (OSC) 72 to indicate a contiguous outpatient day prior to an inpatient admission for one midnight to demonstrate compliance with the two-midnight benchmark. <One Time Notification Transmittal 1334>
- C. Livanta, the Short Stay Review auditor, has published several “*Claim Review Advisors*” that walk through the “BFCC QIO 2 Midnight Claim Review Guideline” (Handout 8) and how the two-midnight benchmark applies to clinical scenarios such as chest pain, atrial fibrillation, and congestive heart failure. The “*Claim Review Advisors*” are available on Livanta’s website.

Link: QIO Livanta Provider Resources under Medicare-Related Sites - Hospital

D. Unforeseen Circumstances

1. If the physician had a reasonable expectation the patient would stay two midnights for medically necessary hospital care, but the patient unexpectedly stays less than two midnights due to unforeseen circumstances, the stay may nevertheless qualify for inpatient payment under Part A. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.C; see 42 *C.F.R.* 412.3(d)(1)(ii)>

Examples of unforeseen circumstances substantiating less than a two midnight stay:

- Unforeseen death or transfer
- Departure against medical advice
- Election of hospice in lieu of continued hospital treatment
- Unexpected clinical improvement

Caution: To avoid later denials, the UR committee should review cases of unexpected clinical improvement carefully to determine the expectation of two midnights of medically necessary care was reasonable at the time the order was written.

Case Study 2

Facts: A patient is scheduled on Monday morning for a total knee arthroplasty (CPT code 27447). The surgeon documents in her plan the expectation that the patient will be discharged at the end of the day on Wednesday or Thursday morning, depending on pain control and the patient's response to the start of therapy. What status should the surgeon order?

Modified Facts: On Tuesday the patient is doing better than expected and the physician discharges the patient home Tuesday evening with plans for outpatient PT beginning on Wednesday. Is this case still appropriate for inpatient Part A payment?

E. Care that is Not Medically Necessary Hospital Care

1. The physician should not consider time the patient spent or will spend receiving care that is not medically necessary hospital care (e.g., skilled nursing, nursing, or custodial care). <See BFCC QIO 2 Midnight Claim Review Guideline algorithm; see *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B; 78 *Fed. Reg.* 50947-48>
2. Delays in Care
 - a. The physician should exclude extensive delays in the provision of medical necessary care when determining the expected length of stay (e.g., delays in the availability of diagnostic tests or consultations). <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
3. Convenience Care
 - a. Care provided for the convenience of the patient is not considered medically necessary. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
 - b. Factors resulting in inconvenience to the patient, such as time and money to care for the patient at home or to travel to and from medical care, may be considered if they affect the patient's health or are accompanied by medical conditions. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
4. Social Admissions
 - a. Social admissions, when there is no available, safe placement in the community, are not covered regardless of the expected length of stay. <78 *Fed. Reg.* 50947-48>

Case Study 3

Facts: A Medicare patient presents to the outpatient surgery department on Wednesday for an outpatient laparoscopic cholecystectomy. The patient experiences unusual pain and bleeding following the procedure and is placed in observation at 2pm on Wednesday by their surgeon.

On Thursday morning, nurses contact the surgeon because the patient is experiencing shortness of breath and chest pain. The surgeon refers the patient to the hospitalist for evaluation. The hospitalist sees the patient that morning, while the patient is still in observation, and begins to evaluate the patient's cardiac status.

At 7pm on Thursday, the hospitalist determines the patient will need to stay at the hospital an additional night for continued evaluation of their cardiac status, as well as post-operative complications and writes an inpatient admission order. The patient improves by Friday and is discharged home on Friday afternoon.

Is this case appropriate for inpatient payment under Part A (i.e., does the case meet the 2-Midnight benchmark)? What is the patient's inpatient length of stay?

Modified Facts: On Thursday afternoon at 1 pm following diagnostic testing, the hospitalist is able to determine the patient is not having a cardiac event and diagnoses the patient with anxiety not necessitating further observation. The surgeon also sees the patient on Thursday afternoon at 3 pm and determines the post-operative complications have resolved and the patient is ready for discharge.

The patient is quite anxious and states that her daughter is flying in from another state on Friday and she does not want to be discharged until the next morning when her daughter arrives. The surgeon writes an order to discharge the patient the next morning and the patient is discharged at 10am on Friday. Should the surgeon have written an inpatient admission order on Thursday because the patient was staying a second night at the hospital?

IV. Admission on a Case-by-Case Basis

- A. Inpatient admission may be appropriate when the admitting physician expects less than a two midnight stay, but determines admission is appropriate on a case-by-case basis, based on their clinical judgment, supported by the medical documentation. <See 42 C.F.R. 412.3(d)(3), 80 Fed. Reg. 70545>

1. Effective January 1, 2016, this exception expanded the former sub-regulatory rare and unusual exception policy under the Two-Midnight Rule, which formerly only included newly initiated mechanical ventilation. <80 Fed. Reg. 70541, 70545; Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.E.2>
- B. CMS has stated that rarely would a stay of less than 24 hours qualify for a case-by-case exception to the two-midnight benchmark. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.E.3>
- C. CMS provided an example of a case-by-case admission in *MLN Matters Special Edition SE19002, Case #2*, in which the patient has numerous co-morbidities, including cardiac comorbidities that cause a complication requiring treatment during the one day stay. <See *MLN Matters SE19002, Case #2*>

Note: A prior version of SE19002 had an example of an appropriate case-by-case admission, with similar risks and comorbidities to Case #2 in the current version. However, in the rescinded version of SE19002, no complications occurred and the patient was discharged without cardiac incident. It is unclear if this implies that risk alone is insufficient for an appropriate case-by-case admission.

- D. Admission under the case-by-case exception is subject to the clinical judgment of the medical reviewer. <80 Fed. Reg. 70541>
 1. Livanta, the Short Stay Review auditor, has published several “*Claim Review Advisors*” that walk through the “BFCC QIO 2 Midnight Claim Review Guideline” (Handout 8) and review how they will apply case-by-case judgment to clinical scenarios such as chest pain, atrial fibrillation, and congestive heart failure. The “*Claim Review Advisors*” are available on Livanta’s website.

Caution: To avoid later denials, the UR committee should review admissions based on case-by-case determinations of the admitting physician to ensure documentation supports the need for inpatient care at the time the order was written.

V. Documentation and Use of Screening Tools

- A. The physician’s assessment and plan should reflect the need for admission and the expected length of stay, based on complex medical factors such as:
 1. Medical history and comorbidities,
 2. The severity of signs and symptoms,

3. Current medical needs, and
 4. The risk/probability of an adverse event occurring during the time period being considered for hospitalization. <See 42 C.F.R. 412.3(d)(1)(i), see *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
- B. Auditors will review physician documentation based on the information known to the physician at the time of admission. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
1. Although the entire record may be used to support the physician's expectation for the need and length of admission, entries after the point of admission are only used by auditors in the context of determining what the physician knew and expected at the point of admission. <See *Reviewing Short Stay Hospital Claims for Patient Status: Admissions on or After January 1, 2016*, B.2>
- C. The physician need not specifically state the expected length of stay (e.g., two midnights) if this information can be inferred from the physician's other documentation such as the plan of care, treatment orders, and notes. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>

Caution: If the physician does not specify the expected length of stay, an auditor may review the case under the higher standard of a case-by-case admission rather than under the reasonable expectation standard.

- D. Inpatient Utilization Screening Tools
1. Physicians may, but are not required, to consider commercial utilization screening tools (e.g., InterQual® or MCG criteria) as part of the complex medical judgment that guides his or her decision to keep the beneficiary in the hospital and the formulation of the expected length of stay. <Medicare Program Integrity Manual, Chapter 6 § 6.5.1>
 2. Livanta, who was granted the national short stay audit contract, noted during prior short stay audits that the final decisions of their clinical reviewers will be based on their clinical knowledge and expertise and will not be based solely on Interqual® or MCG criteria. Livanta announced Interqual® or MCG criteria will only be used as a point of reference for further consultation. <See *Livanta Provider Questions and Answers for Two-Midnight Rule*>

CASE STUDIES

Case Study 1

Facts: A Medicare patient presents to the emergency department at 1 a.m. during an acute myocardial infarction. A percutaneous transluminal revascularization of a subtotal occlusion of the coronary artery and placement of a non-drug eluting stent is performed (CPT code 92941, OPPS status indicator C effective January 1, 2018).

Following the procedure, based on facility protocols, the cardiologist anticipates discharging the patient late on the following day (i.e., after a one-night stay at the hospital). The cardiologist did not write an inpatient order because she did not expect a two midnight stay for the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care?

Analysis: The hospital will not be paid for the procedure or the emergency department care because the procedure is designated an inpatient-only procedure and the patient was not admitted prior to their discharge from the hospital.

Refer to OPPS Addendum B; IOCE Specifications, Section 6.6.3.

Modified Facts: During the procedure, the patient experienced a cardiac arrest and expired. Due to the emergency nature of the patient's condition and urgency of the procedure, the cardiologist never entered an inpatient order to admit the patient.

Under what APC, if any, will the hospital be paid for the surgical procedure and emergency department care? Are there any special coding requirements?

Analysis: The hospital will be paid C-APC 5881 for Ancillary Outpatient Services When Patient Dies (\$12,241.93) for all services during the encounter, including the procedure and emergency department care. The hospital must report modifier -CA on the procedure code 92941 and patient status code 20.

Refer to OPPS Addendum B; IOCE Specifications, Section 6.6.3,
Medicare Claims Processing Manual, Chapter 4 §180.7.

Case Study 2

Facts: A patient is scheduled on Monday morning for a total knee arthroplasty (CPT code 27447). The surgeon documents in her plan the expectation that the patient will be discharged at the end of the day on Wednesday or Thursday morning, depending on pain control and the patient's response to the start of therapy. What status should the surgeon order?

Analysis: The procedure has a status indicator J1 (i.e., it is not designated as inpatient-only) so the surgeon should consider the expected length of stay of the patient. The patient is expected to have a 2 or 3 midnight stay based on the physician's plan and should be admitted as an inpatient for the procedure based on this expectation.

Refer to *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.

Modified Facts: On Tuesday the patient is doing better than expected and the physician discharges the patient home Tuesday evening with plans for outpatient PT beginning on Wednesday. Is this case still appropriate for inpatient Part A payment?

Analysis: Yes, assuming the physician's original documented plan was reasonable, the fact the patient was unexpectedly discharged after one midnight due to clinical improvement does not prevent the case from qualifying for Part A payment.

Refer to *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.C

Case Study 3

Facts: A Medicare patient presents to the outpatient surgery department on Wednesday for an outpatient laparoscopic cholecystectomy. The patient experiences unusual pain and bleeding following the procedure and is placed in observation at 2pm on Wednesday by their surgeon.

On Thursday morning, nurses contact the surgeon because the patient is experiencing shortness of breath and chest pain. The surgeon refers the patient to the hospitalist for evaluation. The hospitalist sees the patient that morning, while the patient is still in observation, and begins to evaluate the patient's cardiac status.

At 7pm on Thursday, the hospitalist determines the patient will need to stay at the hospital an additional night for continued evaluation of their cardiac status, as well as post-operative complications and writes an inpatient admission order. The patient improves by Friday and is discharged home on Friday afternoon.

Is this case appropriate for inpatient payment under Part A (i.e., does the case meet the 2-Midnight benchmark)? What is the patient's inpatient length of stay?

Analysis: Yes, at the time the hospitalist wrote the inpatient order on Thursday, the patient had already spent one night in the hospital receiving outpatient services and based on their expectation that the patient would need one additional night of hospital services, the inpatient admission meets the 2-Midnight benchmark and is appropriate. The inpatient length of stay is one night.

Refer to 42 C.F.R. 412.3(d)(1); 78 Fed. Reg. 50946.

Modified Facts: On Thursday afternoon at 1 pm following diagnostic testing, the hospitalist is able to determine the patient is not having a cardiac event and diagnoses the patient with anxiety not necessitating further observation. The surgeon also sees the patient on Thursday afternoon at 3 pm and determines the post-operative complications have resolved and the patient is ready for discharge.

The patient is quite anxious and states that her daughter is flying in from another state on Friday and she does not want to be discharged until the next morning when her daughter arrives. The surgeon writes an order to discharge the patient the next morning and the patient is discharged at 10am on Friday. Should the surgeon have written an inpatient admission order on Thursday because the patient was staying a second night at the hospital?

Analysis: No, the patient no longer needed hospital care and could have been discharged home on Thursday after one medically necessary night at the hospital. The remaining care is custodial in nature and cannot be counted towards the 2-Midnight benchmark.

Medicare Program Integrity Manual, Chapter 6 § 6.5.2.

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 412 - Prospective Payment Systems for Inpatient Hospital Services

Subpart A - General Provisions

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 50 FR 12741, Mar. 29, 1985, unless otherwise noted.

§ 412.3 Admissions.

- (a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. In addition, inpatient rehabilitation facilities also must adhere to the admission requirements specified in § 412.622.
- (b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.
- (c) The physician order must be furnished at or before the time of the inpatient admission.
- (d)
 - (1) Except as specified in paragraphs (d)(2) and (3) of this section, an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.
 - (i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.
 - (ii) If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and payment for an inpatient hospital stay may be made under Medicare Part A.
 - (2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under § 419.22(n) of this chapter is generally appropriate for payment under Medicare Part A regardless of the expected duration of care. Procedures no longer specified as inpatient only under § 419.22(n) of this chapter are appropriate for payment under Medicare Part A in accordance with paragraph (d)(1) or (3) of this section. Claims for services and procedures removed from the inpatient only list under § 419.22 of this chapter on or after January 1, 2020 are exempt from certain medical review activities.

- (i) For those services and procedures removed on or after January 1, 2020, the exemption in this paragraph (d)(2) will last for 2 years from the date of such removal.
 - (ii) For those services and procedures removed on or after January 1, 2021, the exemption in this paragraph (d)(2) will last until the Secretary determines that the service or procedure is more commonly performed in the outpatient setting.
- (3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

[78 FR 50965, Aug. 19, 2013, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70602, Nov. 13, 2015; 83 FR 41700, Aug. 17, 2018; 85 FR 86300, Dec. 29, 2020; 86 FR 63992, Nov. 16, 2021]

Version 05/30/2023
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Medicare Program Integrity Manual, Chapter 6

6.5.2 - Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions

(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)

This section applies to Unified Program Integrity Contractors (UPIC), Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Audit Contractors and the Comprehensive Error patient Rate Testing (CERT) contractor.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors shall conduct reviews of medical records for inpatient acute IPPS hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) claims, as appropriate and as so permitted by CMS, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay, and that the stay was appropriate for Medicare Part A payment.

A. Determining the Appropriateness of Part A Payment

The term “patient status review” refers to reviews conducted by Medicare contractors to determine a hospital’s compliance with Medicare requirements to bill for Medicare Part A payment. Medicare contractors shall conduct such reviews in accordance with two distinct, but related, medical review policies: a 2-midnight presumption, which helps guide contractor selection of claims for medical review, and a 2-midnight benchmark, which helps guide contractor reviews of short stay hospital claims for Part A payment. “Patient status reviews” may result in determinations that claims are not properly payable under Medicare Part A; “patient status reviews” do not involve changing a beneficiary’s status from inpatient to outpatient.

 Per the 2-midnight presumption, Medicare contractors shall presume hospital stays spanning 2 or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Medicare contractors shall not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.

 Per the 2-midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights, and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than 2 midnights. If a stay is not reasonably expected to span 2 or more midnights, Medicare contractors shall assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

- If the procedure is on the Secretary’s list of “inpatient only” procedures (identified through annual regulation);
- If the procedure is a CMS-identified, national exception to the 2-midnight benchmark; or
- If the admission otherwise qualifies for a case-by-case exception to the 2-midnight benchmark because the medical record documentation supports the admitting physician/practitioner’s judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2- midnight expectation. Medicare contractors shall note CMS’ expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The 2-midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

I. Reviewing Hospital Claims for Patient Status: The 2-Midnight Benchmark

A. Determine if the stay involved an “Inpatient Only” procedure

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor shall determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the Secretary as an “inpatient only” procedure is performed. “Inpatient only” procedures are so designated per 42 C.F.R. § 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

Medicare contractors shall review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are

 present, then the Medicare review contractor shall deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay.

If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the 2-midnight benchmark.

B. Calculating Time Relative to the 2-Midnight Benchmark

Per the 2-midnight benchmark, Medicare contractors shall assess short stay (i.e., less than 2 midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor

 identifies information in the medical record supporting a reasonable expectation on the

part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least two midnights.

Medicare review contractor reviews shall assess the information available at the time of the original physician/practitioners' decision. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner's standard medical documentation, such as his or her plan of care, treatment orders, and progress notes. Medicare contractors shall consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary's medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.

For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning 2 or more midnights at the time of admission, the Medicare contractors shall take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission. This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area. If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the 2-midnight benchmark at the recipient hospital, the Medicare contractors shall take into account the time and treatment provided to the beneficiary at the initial hospital. That is, the start clock for transfers begins when the care begins in the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor shall request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.

Medicare contractors shall continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors shall exclude extensive delays in the provision of medically necessary care from the 2-midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors shall consider them in determining whether Part A payment is appropriate for an inpatient admission.

NOTE: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not

qualify as inpatient time. (See Pub. 100-02, Ch. 1, Section 10.2 for additional information regarding the formal order for inpatient admission.)



C. Unforeseen Circumstances Interrupting Reasonable Expectation

The 2-midnight benchmark is based on the expectation at the time of admission that medically necessary hospital care will span 2 or more midnights. Medicare contractors shall, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span 2 or more midnights, Medicare contractors shall look to see if there was an intervening event that nonetheless supports the reasonableness of the physician/practitioner's original judgment. An event that interrupts an otherwise reasonable expectation that a beneficiary's stay will span 2 or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.

D. Stays Expected to Span Less than 2 Midnights

When a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than 2 midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor shall assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.



E. Exceptions to the 2-Midnight Rule

1. Medicare's Inpatient-Only List

As discussed above, inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for Part A payment regardless of expected or actual length of stay.

2. Nationally-Identified Rare & Unusual Exceptions to the 2-Midnight Rule

If a general exception to the 2-midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor shall consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met.

CMS has identified the following national or general exception to the 2-midnight rule:

Mechanical Ventilation Initiated During Present Visit

CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than 2 midnights, and to embody the same characteristics as those procedures included in Medicare's inpatient-only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.



3. Physician-Identified Case-by-Case Exceptions to the 2-Midnight Rule

For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors shall consider, when assessing the physician's decision, complex medical factors including, but not limited to:

- The beneficiary history and comorbidities;
- The severity of signs and symptoms;
- Current medical needs; and
- The risk of an adverse event.

Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark, and as such, may be prioritized for medical review.

A. Determining Whether Covered Care Was Given at Any Time During a Stay in a PPS Hospital

Medicare contractors shall utilize the medical record to determine whether procedures and diagnoses were coded correctly. If the medical record supports that they were, pay the claim as billed. If the medical record supports that they were not, then utilize ICD-9-CM or ICD-10-CM coding guidelines to adjust the claim and pay at the appropriate DRG. See section 6.5.4 of this chapter for further details on DRG validation review. When you determine that the beneficiary did not, at the time of admission, have an expected length of stay of 2 or more midnights, or otherwise meet CMS standards for payment of an inpatient admission, but that the beneficiary's condition changed during the stay and Part A payment became appropriate, you shall review the case in accordance with the following procedures:

- The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission;

- The deemed date of admission applies when determining cost outlier status (i.e., days or services prior to the deemed date of admission are excluded for outlier purposes); and
- The diagnosis determined to be chiefly responsible for the beneficiary's need for covered services on the deemed date of admission is the principal diagnosis.
- Adjust the claim according to the diagnosis determined to be responsible for the need for medically necessary care to have been provided on an inpatient basis.

When you determine that the beneficiary did not meet the requirements for Part A payment at any time during the admission, deny the claim in full.

6.5.3 - DRG Validation Review

(Rev. 608, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

The contractor shall perform DRG validation on PPS, as appropriate, reviewing the medical record for medical necessity and DRG validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

NOTE: For PPS waived/excluded areas, review shall be performed appropriate to your area.

A. Coding

The contractor shall use individuals trained and experienced in ICD coding to perform the DRG validation functions. The validation is to verify the accuracy of the hospital's ICD coding of all diagnoses and procedures that affect the DRG.

The contractor shall base DRG validation upon accepted principles of coding practice, consistent with guidelines established for ICD coding, the Uniform Hospital Discharge Data Set data element definitions, and coding clarifications issued by CMS. The contractor shall not change these guidelines or institute new coding requirements that do not conform to established coding rules.

The contractor shall verify a hospital's coding in accordance with the coding principles reflected in the ICD Coding Manual. Contractors shall use the ICD version in place at the time the services were rendered, and the official National Center for Health Statistics and CMS addenda, which update the ICD Manual annually. The annual addenda are effective on October 1 of each year and apply to discharges occurring on or after October 1. The contractor shall use only ICD Manual volumes based on official ICD Addendum and updates when performing DRG validation.

For the guidance prior to January 1, 2016, please see <http://qioprogram.org/sites/default/files/20151109-ReviewingHospitalClaimsforAdmissionMemo%20Final.pdf>.

For the guidance on or after January 1, 2016, please see <http://qioprogram.org/announcements>

cms.gov <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/inpatienthospitalreviews.html>



Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016

(Last Updated: 12/31/2015)

Medical Review of Inpatient Hospital Claims

On October 1, 2015, the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIOs) began conducting initial patient status reviews of acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims. The claims are being reviewed in accordance with the FY 2014 Hospital IPPS Final Rule CMS-1599-F, which provided two distinct, although related, medical review policies: a 2 midnight presumption and a 2 midnight **benchmark**. Under the 2-midnight presumption, inpatient hospital claims with lengths of stay greater than 2 midnights after the formal admission following the order are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. CMS finalized proposed refinements to the 2-midnight policy in the FY 2016 OPSS Final Rule, CMS-1633-F, effective January 1, 2016.

Beginning in January 2016, Recovery Auditors may conduct patient status reviews for those providers that have been referred by the QIO as exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to:

- consistently failing to adhere to the Two Midnight rule, or
- failing to improve their performance after QIO educational intervention.

Patient Status Reviews

Throughout this document, the term “patient status reviews” will be used to refer to medical record reviews conducted by the QIOs to determine the appropriateness of Part A payment for short stay inpatient hospital claims (i.e., assessing whether Part A (inpatient) or Part B (outpatient) payment is most appropriate).

On October 1, 2015, QIOs began applying CMS-1599-F when conducting patient status reviews for adjudicated claims that were submitted by acute care inpatient hospital facilities and Long Term Care Hospitals (LTCHs) for dates of admission within the previous 6 months. QIOs will NOT apply these instructions to admissions at Inpatient Rehabilitation Facilities (IRFs) and Critical Access Hospitals (CAHs). IRF patient status reviews are specifically excluded from the 2-midnight inpatient admission and medical review guidelines per CMS-1599-F.

When conducting a patient status review, QIOs will review the medical record to assess the hospital’s compliance with:

- a) the admission order requirements, and
- b) the 2-midnight benchmark

I. Reviewing Hospital Claims for Inpatient Status: Inpatient Admission Order Requirements

When conducting patient status reviews, QIOs will assess whether the inpatient admission order requirements were met. While the inpatient admission order continues to be required for all admissions, effective January 1, 2015, the physician certification is only required for outlier cases and long stay cases of 20 days or more under the Inpatient Prospective Payment System.

A. Claims Eligible for Review

A.1. BFCC-QIOs will conduct patient status reviews on a sample of inpatient hospital Part A claims for appropriateness of inpatient admission under the 2 midnight rule for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities impacted by CMS-1599-F.

A.2. Twice a calendar year, the BFCC-QIOs will conduct patient status reviews using a provider sample from claims paid within the previous 6 months.

B. Medical Records

B.1. BFCC-QIOs will request a minimum of 10 records in a 30-45-day time period from hospitals. The maximum number of record requests per 30 days will be 30 records.

B.2. A hospital's failure to provide the requested medical record for the identified claim(s) to the BFCC-QIO within 30-45 days of the request may result in the BFCC-QIO reopening the initial determination on the claim and a subsequent denial of payment on the claim(s) selected for review.

C. Provider Education

BFCC-QIOs shall rate and stratify providers for education and corrective action based upon the results of the completed initial patient status claim review.

1. C.1. Provider Results Letters
 - a. The BFCC-QIO shall develop a detailed results letter for all providers after the completion of the initial patient status claim review.
 - b. CMS minimally expects detailed results letters to include individualized, claim-by-claim denial rationales and encourages the BFCC-QIO to include the written clinical details that are to be discussed during any 1:1 telephonic education.
 - c. The letter shall include a specific phone number and/or point of contact, clearly indicated on the face of the letter for providers to request or schedule a provider education teleconference.
 - d. CMS will approve a letter template for the BFCC-QIOs to use to share the provider's results.
2. 1 on 1 Provider Education
 - a. The 1 on 1 (1:1) provider education is to be done within 90 days after BFCC-QIO's completion of the initial patient status claim review.

- b. The BFCC-QIO conducting 1:1 telephonic education for providers will use or facilitate the educational session with a clinician who is knowledgeable of the denied claim(s). **NOTE:** This knowledge may be the result of serving as the primary or secondary clinical reviewer for the identified claim(s).
 - c. The 1:1 provider education session is designed to be provider-specific and interactive giving the provider the opportunity to review the BFCC-QIO claim(s) decisions, ask questions and receive meaningful feedback conducive to behavioral change to increase provider compliance. The provider determines the appropriate personnel to receive the education.
 - d. The BFCC-QIO is to notify providers at the start of every teleconference that the discussion may be monitored by CMS as a third party for quality assurance purposes.
3. QIO Referral to the Review Auditors
- a. At the direction of CMS, the BFCC-QIO will refer providers with inpatient status claims identified as having ‘Major Concerns’ to the Recovery Audit Contractor (RACs) to implement provider specific audits.

II. Reviewing Hospital Claims for Inpatient Status: The 2-Midnight Benchmark

The 2-midnight benchmark represents guidance to Medicare review contractors to identify when an inpatient admission is generally appropriate for Medicare Part A payment under CMS-1599-F, as revised by CMS-1633-F.

A. General Rule for Expected 0-1 Midnight Stays

A.1. General Rule for Services on Medicare’s Inpatient Only List: Medicare’s “Inpatient-Only” list, as authorized by 42 C.F.R. § 419.22(n), defines services that support an inpatient admission and Part A payment as appropriate, regardless of the expected length of stay. The QIOs will approve these cases so long as other requirements are met.

Providers are reminded that the list of procedural codes defined as “inpatient-only” are accessible at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html>. Providers trying to determine if a procedure is classified as inpatient-only for the year in which the procedure is being performed shall access the final rule for the year in question, click on the “OPPS Addenda” under the related links, and review the file containing addendum E.

A.2 When the Expected Length of Stay was Less Than 2 Midnights:

Pursuant to the 2 Midnight Rule [or CMS-1599-F], except for cases involving services on the “Inpatient-Only” list, Part A payment is generally not appropriate for admissions where the expected length of stay is less than two midnights. Under the revised exceptions policy pursuant to CMS-1633-F, for admissions not meeting the two midnight benchmark, Part A payment is appropriate on a case-by-case basis where the medical record supports the admitting physician’s determination that the patient requires inpatient care, despite the lack of a 2 midnight expectation. The QIOs will consider complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event to determine whether the medical record supports the need for inpatient hospital care. These cases will be approved by the QIOs when the other requirements are met.

B. General Rule for Expected 2 or More Midnight Stays

When a patient enters a hospital for a surgical procedure, a diagnostic test, or any other treatment and the physician expects the beneficiary will require medically necessary hospital services for 2 or more midnights (including inpatient and pre-admission outpatient time), and orders admission based upon that expectation, the services are generally appropriate for inpatient payment under Medicare Part A. QIOs will approve these cases so long as other requirements are met.

B.1. Unforeseen Circumstances: If an **unforeseen** circumstance results in a shorter beneficiary stay than the physician's reasonable expectation of at least 2 midnights, hospital inpatient payment may still be made under Medicare Part A despite the actual length of stay being less than 2 midnights. Such circumstances must be documented in the medical record in order to be considered upon medical review. Examples include unforeseen: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice care in lieu of continued treatment in the hospital.

B.2 Documentation Requirements: The 2-midnight benchmark is based upon the physician's expectation of the required duration of medically necessary hospital services at the time the inpatient order is written and the formal admission begins. QIOs will, when conducting patient status reviews, consider complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2-midnight benchmark. Both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered. In other words, if the reviewer determines, based on documentation in the medical record, that it was reasonable for the admitting physician to expect the beneficiary to require medically necessary hospital care lasting 2 midnights, the inpatient admission is generally appropriate for payment under Medicare Part A; this is regardless of whether the anticipated length of stay did not transpire due to unforeseen circumstances (See section B1.)

QIOs will continue to follow longstanding guidance to review the reasonableness of the inpatient admission for purposes of Part A payment based on the information known to the physician at the time of admission. The expectation for sufficient documentation is well rooted in good medical practice "supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities," according to § 1156 of the Social Security Act. Physicians need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. QIOs will expect such factors to be documented in the physician assessment and plan of care. The entire medical record may be reviewed to support or refute the reasonableness of the physician's expectation, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission.

B.3. The 2 Midnight Benchmark and Outpatient Time:

1. General

For purposes of determining whether the 2-midnight benchmark was met the QIOs will review the claim to determine if either the benchmark is met or the medical record supports the determination that the

patient required inpatient care. Upon review, QIOs will consider time the beneficiary spent receiving outpatient services within the hospital prior to inpatient admission, in addition to the post-admission duration of care. This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area.

2. 2-Midnight Benchmark Reviews

Whether the beneficiary receives services in the ED as an outpatient prior to inpatient admission (for example, receives observation services in the ED) or is formally admitted as an inpatient upon arrival at the hospital (for example, inpatient admission order written prior to an elective inpatient procedure), the starting point for the 2 midnight timeframe for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital.

For the purpose of determining whether the 2-midnight benchmark was met, QIOs will exclude triaging activities (such as vital signs) and wait times prior to the initiation of medically necessary services responsive to the beneficiary's clinical presentation. If the triaging activities immediately precede the initiation of medically necessary and responsive services, it is the initiation of diagnostic or therapeutic services responsive to the beneficiary's condition that QIOs will consider to "start the clock" for purposes of the 2 midnight benchmark. QIOs will not count the time a beneficiary spent in the ED waiting room while awaiting the start of treatment.

In other words, a beneficiary sitting in the ED waiting room at midnight while awaiting the start of treatment would not be considered to have passed the first midnight, but a beneficiary receiving services in the ED at midnight would meet the first midnight of the benchmark.

B.4. The 2 Midnight Benchmark and Transfers: For the purpose of determining whether the 2-midnight benchmark was met, the QIO shall take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, the "clock" for transfers begins when the care begins in the initial hospital. Any excessive wait times or time spent in the hospital for non-medically necessary services shall be excluded.

The QIOs may request records from the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving care to ensure compliance and deter gaming or abuse. The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility.

B.5. Delays in the Provision of Care: 1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of reasonable and necessary medical treatment. As such, CMS expects Medicare review contractors will continue to follow CMS' longstanding instruction that Medicare payment is prohibited for care rendered for social purposes or reasons of convenience. Therefore, QIOs will exclude extensive delays in the provision of medically necessary care from the 2 midnight benchmark calculation. QIOs will only count the time in which the beneficiary received medically necessary hospital treatment. Factors that may result in an inconvenience to a beneficiary, family, physician or hospital do not, by themselves, justify Part A payment. When such factors affect the beneficiary's health, QIOs will consider them in determining whether inpatient hospitalization was reasonable and necessary for purposes of Part A payment. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify Part A payment for a continued hospital stay.

B.6. The Two Midnight Benchmark and Cancelled Surgical Procedures: QIOs will review the initial determination on paid Part A inpatient claims in which a surgical procedure was cancelled based on the general 2-Midnight benchmark instruction. In other words, if the physician reasonably expects the beneficiary to require a hospital stay for 2 or more midnights at the time of the inpatient order and formal admission, and this expectation is documented in the medical record, the inpatient admission is generally appropriate for Medicare Part A payment.

C. Monitoring Hospital Billing Behaviors for Gaming

CMS may monitor inpatient hospital claims spanning 2 or more midnights after admission for evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. CMS may identify such trends through probe reviews and through its data sources, such as those provided by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and Program for Evaluating Payment Patterns Electronic Report (PEPPER).

Version 05/30/2013
Check for Updates

Inpatient-Only Separate Procedure Exception List (Data_HCPCS, Column AU "SEPARATE PROCEDURE")

HCPCS	LO_VERSION	HI_VERSION	DESCRIPTION	STATUS_INDICATOR
21750	86	90	Repair of sternum separation	C
21825	86	90	Treat sternum fracture	C
22010	86	90	I&d p-spine c/t/cerv-thor	C
22015	86	90	I&d abscess p-spine l/s/l	C
22110	86	90	Remove part of neck vertebra	C
22112	86	90	Remove part thorax vertebra	C
22114	86	90	Remove part lumbar vertebra	C
22116	86	90	Remove extra spine segment	C
22206	86	90	Incis spine 3 column thorac	C
22207	86	90	Incis spine 3 column lumbar	C
22208	86	90	Incis spine 3 column adl seg	C
22210	86	90	Incis 1 vertebral seg cerv	C
27005	86	90	Incision of hip tendon	C
27090	86	90	Removal of hip prosthesis	C
27140	86	90	Transplant femur ridge	C
27161	86	90	Incision of neck of femur	C
31725	63	90	Clearance of airways	C
32220	63	90	Release of lung	C
32225	63	90	Partial release of lung	C
32310	63	90	Removal of chest lining	C
33140	63	90	Heart revascularize (tmr)	C
33496	63	90	Repair prosth valve clot	C
33800	89	90	Aortic suspension	C
38100	63	90	Removal of spleen total	C
38101	63	90	Removal of spleen partial	C
38562	86	90	Removal pelvic lymph nodes	C
38564	63	90	Removal abdomen lymph nodes	C
38765	63	90	Remove groin lymph nodes	C
38770	63	90	Remove pelvis lymph nodes	C
38780	63	90	Remove abdomen lymph nodes	C
43848	63	90	Revision gastroplasty	C
44005	63	90	Freeing of bowel adhesion	C
44130	63	90	Bowel to bowel fusion	C
44300	86	90	Open bowel to skin	C
44314	86	90	Revision of ileostomy	C
44316	63	90	Devise bowel pouch	C
44322	63	90	Colostomy with biopsies	C
44345	86	90	Revision of colostomy	C
44346	86	90	Revision of colostomy	C
44680	63	90	Surgical revision intestine	C
44820	63	90	Excision of mesentery lesion	C
44850	63	90	Repair of mesentery	C
47460	63	90	Incise bile duct sphincter	C
47480	63	90	Incision of gallbladder	C
47900	63	90	Suture bile duct injury	C
49000	63	90	Exploration of abdomen	C

Inpatient-Only Separate Procedure Exception List (Data_HCPCS, Column AU "SEPARATE PROCEDURE")

49010	86	90	Exploration behind abdomen	C
49255	86	90	Removal of omentum	C
50100	90	90	Trnsxj/repos abrrnt rnl vsls	C
50340	63	90	Removal of kidney	C
50600	63	90	Exploration of ureter	C
50650	63	90	Removal of ureter	C
50900	63	90	Repair of ureter	C
51525	63	90	Removal of bladder lesion	C
51570	63	90	Removal of bladder	C
57270	63	90	Repair of bowel pouch	C
58400	63	90	Suspension of uterus	C
58605	63	90	Division of fallopian tube	C
58700	63	90	Removal of fallopian tube	C
58720	63	90	Removal of ovary/tube(s)	C
60521	63	90	Removal of thymus gland	C
60522	63	90	Removal of thymus gland	C
60540	63	90	Explore adrenal gland	C
60545	63	90	Explore adrenal gland	C
61210	63	90	Pierce skull implant device	C
61535	63	90	Remove brain electrodes	C

Version 05/30/2023
Check for Updates

Total Knee Arthroplasty (TKA) Removal from the Medicare Inpatient-Only (IPO) List and Application of the 2-Midnight Rule

MLN Matters Number: SE19002 **Reissued**

Related Change Request (CR) Number: N/A

Article Release Date: January 24, 2019

Effective Date: January 1, 2018

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: This article was reissued on January 24, 2019, to clarify information.

PROVIDER TYPE AFFECTED

This MLN Matters Special Edition Article is intended for hospital providers that submit hospital inpatient or outpatient claims for Total Knee Arthroplasty (TKA) procedures. The Two-Midnight Rule impacts acute-care hospitals, inpatient psychiatric facilities, long-term care hospitals (LTCHs), and Critical Access Hospitals (CAHs). CMS recognizes that such facilities may vary in their billing for TKAs.

CMS recognizes that a MLN article on the 2-Midnight Rule has already been published and can be found at the following link: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf>

This article is distinguished by its focus on TKA procedures and application of the 2-Midnight Rule now that this procedure has been removed from Medicare's inpatient-only (IPO) list.

*NOTE: Throughout this document the term "Provider" when used means "Hospital".

What You Need To Know

The Centers for Medicare & Medicaid Services (CMS) removed the Current Procedural Terminology (CPT) code describing TKA procedures from Medicare's Inpatient-Only List (IPO) effective January 2018. This allows TKA procedures to be performed on an *inpatient* or *outpatient* basis. In other words, it allows Medicare payment to be made to the hospital for TKA procedures regardless of whether a beneficiary is admitted to the hospital as an inpatient or as an outpatient, assuming all other criteria are met. This does not have any impact on CMS' 2-midnight policy.

CMS policy does not dictate a patient's hospital admission status and has no default determination on whether a TKA procedures should be done on an inpatient or outpatient basis.

Rather, CMS continues its long-standing recognition that the decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary, and should consider the individual beneficiary's unique clinical circumstances.

The Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) are contracted by CMS to review a sample of Medicare fee-for-service (FFS) short-stay inpatient claims (claims with hospital stays lasting less than 2 midnights after formal inpatient admission) for compliance with the 2-Midnight Rule.

BACKGROUND

The 2-Midnight Rule

Effective October 1, 2013, CMS finalized the 2-Midnight rule which directed how claims are to be reviewed by Medicare review contractors to determine the appropriateness of Medicare Part A payment. The regulation established two distinct but related medical review policies, the two midnight **presumption** and the two-midnight **benchmark**.

2-Midnight Presumption (helps guide contractor selection of claims for medical review): Hospital claims with lengths of stay greater than 2 midnights after the formal admission are presumed to be reasonable and necessary for Medicare Part A payment. Although these claims may be submitted among a sample of cases received, the BFCC-QIOs generally will not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the Two-Midnight presumption.

2-Midnight Benchmark (helps guide contractor reviews of short stay hospital claims for Part A payment): Hospital claims are generally payable under Medicare Part A if the admitting practitioner reasonably expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights and this expectation is supported by the medical record documentation. The time a beneficiary has spent receiving hospital care prior to inpatient admission will be considered when assessing whether this benchmark is met.

CMS revised the 2-Midnight Rule, effective January 2016 in the CY 2016 Hospital Outpatient Prospective Payment System (OPPS) [CMS-1633-F](#) to add the **Case-by-Case Exception**. The case-by-case exception states that for hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital inpatient care despite lack of a 2-midnight expectation based on complex medical factors including but not limited to:

- Patient's history, co-morbidities, and current medical needs
- Severity of signs and/or symptoms

- Risk of Adverse Events

Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs)

BFCC-QIOs are tasked by CMS to review a sample of Medicare fee-for-service short-stay inpatient claims for compliance with the 2-Midnight Rule. CMS began using BFCC-QIOs, rather than Medicare Administrative Contractors (MAC) or Recovery Audit Contractors (RACs), to conduct the initial medical reviews of providers who submit claims for short stay inpatient admissions on October 1, 2015.

The focus of these reviews is also for BFCC-QIOs to educate admitting physicians/practitioners and providers about the Part A payment policy for inpatient admissions.

CMS instructs BFCC-QIOs to conduct routine analysis of hospital billing and target for review hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy.

TKAs, like any other condition or procedure not on the IPO list, are subject to medical review by CMS contractors. The review is based on documentation in the medical record that supports either the 2-Midnight Benchmark or the Case-by-Case Exception. It is important to note that CMS does NOT target condition or disease-specific claims, such as TKA procedures, for BFCC-QIO review.

BFCC-QIO reviewers look for documentation in the medical record that supports:

- the admitting physician/practitioner's reasonable expectation that the beneficiary will require medically necessary hospital services spanning 2 midnights or longer and admits the patient to the hospital based on that expectation

OR:

- the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite lack of a 2-midnight expectation based on complex medical factors including but not limited to
 - Patient's history, co-morbidities and current medical needs;
 - Severity of signs and/or symptoms
 - Risk of adverse events.

The BFCC-QIO reviews the entire medical record for supporting documentation.

What does Removing TKA from the IPO list mean?

1. This **allows** TKA procedures to be paid by Medicare FFS when performed in **either** the hospital inpatient or hospital outpatient setting, assuming all other criteria are met.
2. This **allows** TKA short-stay inpatient claims (if chosen in a sample of claims) to be reviewed by the BFCC-QIOs for compliance with the 2-Midnight Benchmark or Case-by-Case exception (note that the two-year prohibition of RAC review for patient status continues to apply regardless of whether the case is performed on an inpatient or outpatient basis.)

NOTE: The cost-sharing amount the beneficiary is responsible for will differ based on whether the surgery is performed on an inpatient or outpatient basis (and will vary based on other factors such as geographic location).

What does Removing TKA from the IPO list NOT mean?

1. It does not mean that all TKAs must be performed on a hospital outpatient/observation basis nor does it mean that there is a presumption about where TKAs are performed.
2. It does not mean that TKA Short Stay inpatient claims are targeted for review by CMS.

NOTE: CMS has not made any pre-determinations on the number of patients receiving TKA procedures that should be treated as an inpatient or outpatient.

This MLN Matters article further clarifies and provides context for statements in the preamble for the CY 2018 OPSS final rule. In the CY 2018 OPSS final rule, CMS also prohibited Recovery Audit Contractor (RAC) patient status reviews for TKA procedures performed in the hospital inpatient setting for a period of two (2) years (CY 2018-2019).

Examples of TKA Cases and Rationale for Payment Determinations:

NOTE: The time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, but such time does not qualify as inpatient time. (See the Medicare Benefit Policy Manual, Chapter 1, Section 10, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf> for additional information regarding the formal order for inpatient admission.)

Case #1: Documentation Supports 2-Midnight Benchmark:

Dates of Service: On 1/6/18, patient was receiving hospital observation services; on 1/07/18, the physician order was written for inpatient admission; on 1/8/18, the patient was discharged home. (2 Midnights total; 1 Midnight after inpatient admission)

Case Summary: This 65-year-old female presented to the facility on January 6, 2018 for elective TKA surgery. She was placed in observation after receiving routine post-operative care.

She had a medical history of arthritis, diabetes mellitus, arrhythmia, sleep apnea, and chronic pain. The Physical Therapy (PT) progress notes from the morning on Post-op Day (POD) 1, indicated that the patient complained of feeling shaky and dizzy and was unable to complete her PT. The patient returned to her room, ate breakfast and her regular insulin dose was administered. Further nurse assessment noted that she remained light-headed. After a check of her blood sugar, the patient was found to be hypoglycemic and a snack was administered with improvement in her symptoms. However during afternoon PT session on POD 1, documentation in the medical record indicated that the patient again became shaky and complained of feeling hot. The patient was again returned to their room, sugars were assessed and the physician alerted—resulting in adjustments to her diabetic medications. The patient was admitted as an inpatient on 1/7/18 for continued monitoring and glucose stabilization. PT progress notes on the morning of POD 2 indicate the patient tolerated the session well, progressed as expected without other complaints. The patient was discharged 1/8/18.

Rationale for Approval: Medical management provided surgical repair, anesthesia administration, pre- and post-operative monitoring, pain and glucose management. No intraoperative complications were noted. On January 8, 2018, she was discharged home. Despite the lack of a 2 midnight stay after formal inpatient admission, the medical record documented symptoms during PT and two episodes of hypoglycemia, requiring adjustment of her insulin and close blood sugar monitoring post-op. This documentation provided a reasonable expectation, at the time the inpatient order was written, of medically appropriate hospital care spanning 2-Midnights.

Case #2: Medical Record Documentation Supports Case-by-Case Exception

Dates of Service: 02/12/2018 - 02/13/2018 (one midnight)

Case Summary: This 73-year-old male presented for elective total left knee replacement surgery on February 12, 2018, and was admitted to inpatient status the same day after developing post-operative bradycardia. He had a history of coronary artery disease, atrial fibrillation, complete heart block with pacemaker placement, diabetes, osteoarthritis, and hypertension. Medical management consisted of urgent evaluation by electrophysiology and correction of pacemaker malfunction, intravenous hydration, cardiac monitoring, laboratory testing, analgesics, antiemetics, anticoagulant, and IV antibiotic and home medications. On February 13, 2018 he was discharged to home.

Rationale for Approval: This was an elective admission for a TKA. The procedure was performed without complications, and the patient was quickly mobilized. His pain was controlled with oral pain medication soon after the procedure, however the patient demonstrated clinical decompensation of a chronic medical problem requiring urgent evaluation and treatment. The medical record documents that while this patient was previously physically active, due to the patient's extensive cardiac history with decompensation and need for urgent evaluation and treatment, it is reasonable to approve this case based upon patient history and comorbidities and current medical needs, severity of signs and symptoms, and presence of risk factors for an adverse event.

Case #3: Medical Record Documentation Did Not Support the 2-Midnight benchmark or the case by case exception:

Dates of Service: 03/6/18 - 03/07/18 (one midnight)

Case Summary: This 77 year-old female presented on March 6, 2018 for an elective TKA surgery and was admitted to inpatient status that same day. The patient had a history of gastroesophageal reflux disease. No other medical comorbidities were documented in the medical record. Medical management provided consisted of the surgical procedure of left TKA, pre- and post-operative monitoring, imaging, laboratory studies. Medications administered during this hospitalization included intravenous fluids, prophylactic antibiotics and post-op pain medication. The patient was discharged to her home on March 7, 2018. No potential intraoperative or potential post-operative complications were noted in the medical record.

Rationale: 77 year old presented for elective left TKA. Medical review is based on associated risk factors, comorbidities, and/or complications. The procedure was performed without any intraoperative complications. Patient comorbidities were minor and no adverse concerns were documented. The patient was monitored post operatively with good pain control, stable vital signs and was discharged the next day. The documentation did not support that hospital services were expected to span 2-midnights or more, nor did it support a case-by-case exception. There were no intra or post-operative complications documented in the medical record that supported inpatient status.

FREQUENTLY ASKED QUESTIONS

Question 1: Will CMS target TKA procedures for patient status review now that they are not on Medicare FFS IPO list?

Response 1: **No.** Claim selection is not condition or disease-specific. Sampling is done at the hospital level not at the claim level. Accordingly, TKA procedures are not targeted for review by CMS. CMS instructs BFCC-QIOs to conduct routine analysis of a sample of hospital claims with high or increasing numbers of inpatient stays less than 2-Midnights. When TKA or any type of claim is reviewed for Part A eligibility, BFCC-QIOs identify and educate the hospital on opportunities for improvement.

Question 2: Does removal of TKA from Medicare's FFS IPO list mean that this procedure should only be performed on a hospital outpatient basis?

Response 2: **No.** Removing a procedure from Medicare's FFS IPO list does not require the procedure to be performed on an outpatient basis. Rather, it allows the procedure to be performed in a hospital inpatient or hospital outpatient status.

Question 3: Who determines patient status as a hospital inpatient or outpatient?

Response 3: CMS continues its long-standing recognition that the decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary, considering the individual beneficiary's unique clinical circumstances. CMS policy does not dictate patient status.

Question 4: What do BFCC-QIOs look for when evaluating a TKA or other short-stay inpatient claim, for compliance with the 2-Midnight Rule?

Response 4: BFCC-QIOs look for:

- documentation in the medical record that supports a reasonable expectation of medically necessary hospital services for 2 midnights or longer including all outpatient/observation and inpatient care time

OR

- documentation in the medical record that supports the admitting physician's determination that the patient required inpatient care despite the lack of a 2-midnight expectation based upon complex medical factors including but not limited to:
 - Patient's history, co-morbidities and current medical needs
 - Risk of adverse events
 - Severity of signs and symptoms

Question 5: Are there plans to remove other orthopedic inpatient surgical procedures from Medicare's FFS IPO list?

Response 5: Any future plans to remove orthopedic procedures from Medicare's FFS IPO will be communicated through the rulemaking process. This allows for stakeholder comments to be submitted and reviewed prior to release of CMS final rules.

ADDITIONAL INFORMATION

MLN Matters Article, MM10417, January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) Update with the removal of TKA from the IPO is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10417.pdf>.

MLN Matters Article, MM10080, Clarifying Medical Review of Hospital Claims for Part A Payment, is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf> for additional information of the 2-midnight rule.

CMS-1633 is available at <https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf>. A fact sheet on the Two-Midnight Rule Fact Sheet is available at <https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
January 24, 2019	CMS reissued the article to clarify information.
January 11, 2019	CMS rescinded the article.
January 8, 2019	Initial article released.

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