Two-midnight Rule and Observation Room Implementation and Billing

Two-midnight Rule Implementation and Billing

HMSA Akamai Advantage plans will change the way it processes inpatient claims not meeting the two-midnight rule for services effective January 1, 2017.

Please refer to Medicare Advantage plans billing (inpatient services) below for billing instructions. Medical records are required to support the medical necessity of inpatient admissions that do not meet the two-midnight rule criteria. Claims submitted without medical records will be denied for not meeting medical necessity.

Two-midnight rule for admissions and coverage
On August 12, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a final rule, CMS-1599-F, known as the two-midnight rule.

Admission and Medical Review Criteria for Hospital Inpatient Services
Under this final rule, in addition to services designated as inpatient-only, surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when:

- The physician expects the beneficiary to require a stay that crosses at least two midnights.
- The physician admits the beneficiary to the hospital based on that expectation.

Medicare Advantage plans billing (inpatient services)
Two-midnight benchmark clock starts:

- When hospital care begins.
  - Observation care.
  - Emergency department, operating room, other treatment area services.
- At the start of care after registration and initial triaging activities (such as vital signs).

Excessive wait times are excluded.

While the total time in the hospital may be considered when the physician makes an admission decision (i.e., expectation of hospital care for two or more midnights), the inpatient admission doesn't begin until the inpatient order and formal admission occur.

Hospitals may use Occurrence Span Code 72 to report the number of midnights the beneficiary spent in the hospital from the start of care until formal inpatient admission.

- NUBC redefined Occurrence Span Code 72 (December 1, 2013) to allow "contiguous outpatient hospital services that preceded the inpatient admission" to be reported on inpatient claims. (See the NUBC implementation calendar.)

For more information about the CMS ruling, refer to CMS Fact Sheet: Two-Midnight Rule.

Payment of Hospital Services under Part B following Reasonable and Necessary Part A Inpatient Denials

In the final rule, CMS provides payment when a Medicare Part A claim for hospital inpatient services is denied. If the beneficiary is enrolled in Medicare Part B, the hospital may be paid for Part B services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient when the Part A claim is denied because:

- The inpatient admission was not reasonable and necessary.
- If a hospital determines through utilization review after a beneficiary is discharged that his or her inpatient admission was unreasonable and unnecessary.

Billing Guidelines when inpatient admission was denied as not reasonable and necessary

1. Hospitals may bill services furnished after the time of the inpatient admission (the order) on a Part B inpatient claim, except observation services, hospital outpatient visits and outpatient diabetes self-management training services as these services require an outpatient status.
   - Rebill for all of the services that would have been payable if the claim was originally ordered and submitted as an outpatient claim for payment under Type of Bill 12x except for the following: observation services (Revenue Code 762), outpatient visits (Revenue Code 045x and 051x) and DSMT services (Revenue Code 0942)

2. The policy for payment of services furnished prior to the inpatient admission in the 3-day (1-day for non-IPPS hospitals) payment window in the CMS regulations remains unchanged: the hospital may submit a Part B outpatient claim for payment of these services under Part B (including those requiring an outpatient status) as outpatient services. Part B coverage and payment rules must be met.
   - HMSA shall recognize and process 131 TOB claims for outpatient services that were bundled into the inpatient claim for the 3 day payment window (for IPPS hospitals) and the 1 day payment window (for non-IPPS hospitals) prior to the admission, including those services that require an outpatient status.

Services provided prior to the point of inpatient admission are outpatient services and may not be included on the 121 Part B inpatient claim; services provided after the point of admission are inpatient services and may not be included on the 131 Part B outpatient claim. Two complementary claims are therefore necessary if some services are provided before admission and others are provided after admission. In placing services on the appropriate claim, hospitals should use the same billing and coding rules used for assigning dates of service to services that cross midnight, using the start of the service to determine correct claim placement unless other specific instructions are provided, and ensuring that services are not double billed. If outpatient only services, such as outpatient observation, were continued after the point of admission, the post admission services cannot be paid because they were provided as inpatient services; the time may not be included on the 131 Part B outpatient claim because it was provided after the point of admission.

Observation Room Implementation and Billing

Observation services are covered only when ordered by a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In most cases, the decision to discharge a patient from the hospital at the end of observation care or to admit the patient is usually made in less than 24 hours. In rare and exceptional cases, reasonable and necessary outpatient observation services span more than 48 hours. See Section 20.6, Chapter 6, of the Medicare Benefit Policy Manual.

Medicare Coding
Hospitals are required to report observation charges under the following revenue codes:

Revenue Code	Subcategory
0760	General classification category
0762	Observation room

Other ancillary services performed while the patient receives observation services are reported using appropriate revenue codes and HCPCS codes. See Section 290.2. 1, Chapter 4, of the Medicare Claims Processing Manual.

To report direct referral for observation, use HCPCS code G0379. Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day the observation services start. Hospitals should only report HCPCS code G0379 when a patient is referred directly to observation care after a physician sees them. See Section 290.5.2, Chapter 4, of the Medicare Claims Processing Manual.

To report observation services, use HCPCS code G0378 (hospital observation service per hour). Beginning January 1, 2016, comprehensive payment may be made for all services on the claim, including the entire extended care encounter through comprehensive APC 8011 (comprehensive observation services), when certain criteria are met. Payment may be made when observation services are billed in conjunction with:

- A clinic visit.
- Type A emergency department visit (Level 1 through 5).
- Type B emergency department visit (Level 1 through 5).
- Critical care services.
- A direct referral as an integral part of a patient's extended encounter of care.

See Section 290.5.3, Chapter 4, of the Medicare Claims Processing Manual.

Reporting hours of observation
Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician order. Hospitals should round to the nearest hour. See Section 290.2.2 Chapter 4, of the Medicare Claims Processing Manual.