

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Revised product from the Medicare Learning Network® (MLN)

- [“Inpatient Rehabilitation Facility Prospective Payment System”](#) Fact Sheet, ICN 006847, downloadable

MLN Matters® Number: MM8586

Related Change Request (CR) #: CR 8586

Related CR Release Date: January 24, 2014

Effective Date: December 1, 2013

Related CR Transmittal #: R13340TN

Implementation: February 25, 2014

Occurrence Span Code 72; Identification of Outpatient Time Associated with an Inpatient Hospital Admission and Inpatient Claim for Payment

Provider Types Affected

This MLN Matters® Article is intended for hospitals submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8586 to provide clarification to hospitals regarding the billing of inpatient hospital stays and the 2-Midnight Rule, codified under the Fiscal Year 2014 Inpatient Prospective Payment System Final Rule CMS-1599-F.

The 2-Midnight Rule allows hospitals to account for total hospital time (including outpatient time directly proceeding the inpatient admission) when determining if an inpatient admission order should be written based on the expectation that the beneficiary will stay in the hospital for 2 or more midnights receiving medically necessary care. Because currently the inpatient claim only permits CMS to accurately track inpatient time after formal inpatient order and admission (i.e., utilization days/midnights), CMS would also like to use Occurrence Span Code 72 to track the total, contiguous outpatient care prior to inpatient admission in the hospital. This will enable CMS to identify claims in

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which the beneficiary received care as an outpatient for 1 or more midnights and was subsequently admitted as an inpatient based on the expectation that the beneficiary would require 2 or more midnights of hospital care.

Background

The change in billing instruction is associated with CMS-1599-F, in which CMS clarifies and modifies its guidance regarding the proper billing of inpatient hospital stays. Under the rule, surgical procedures, diagnostic tests, and other treatments (not specifically designated as inpatient-only) are generally appropriate for inpatient hospital payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least 2 midnights and admits the beneficiary to the hospital based on that expectation.

The final rule emphasizes the need for a formal order of inpatient admission to begin inpatient status and time, but permits the physician and the medical reviewer to consider all time a beneficiary has already spent in the hospital receiving outpatient services (including observation services and treatment in the emergency department, operating room, or other treatment area) in guiding their 2-midnight expectation. This rule is available in the Federal Register on Page 50508 at <http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf> on the Internet.

The redefinition of occurrence span code 72 allows providers to voluntarily identify those claims in which the 2-midnight benchmark was met because the beneficiary was treated as an outpatient in the hospital prior to the formal inpatient order and admission. In other words, it permits providers and subsequently review contractors to identify the "*contiguous outpatient hospital services [midnights] that preceded the inpatient admission,*" as well as the total number of midnights after formal inpatient order and admission, on the face of the claim.

While MACs may still select this claim type for medical review, the use of occurrence span 72 will help support the medical record and the MAC's review decision. Since the 2 midnight benchmark allows hospitals to account for *total* hospital time in determining if the beneficiary is expected to meet the 2 midnight benchmark, CMS has provided examples scenarios below, to illustrate circumstances in which an outpatient midnight was pertinent to the inpatient admission decision. In the future, occurrence span 72 may also be used to guide the claim selection process at CMS' discretion.

Examples in which the 2-Midnight Benchmark was met based on *total* (outpatient and inpatient) hospital time. CMS would like to track the outpatient time on an automated basis, using occurrence span code 72, so we may focus medical review as needed:

Example 1: Beneficiary is an outpatient and is receiving observation services at 10PM on 12/1/2013, and is still receiving observation services at one minute past midnight on 12/2/2013 and continues as an outpatient until admission. Beneficiary is admitted as an inpatient on 12/2/2013 at 3 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on 12/3/2013 at 8AM. Total time in the hospital meets the 2 midnight benchmark.

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Example 2: Beneficiary having arrived at the hospital and begun treatment in the ED at 8PM on 12/11/2013 is still in the Emergency Department (ED) at one minute past midnight on 12/12/2013 and continues as an outpatient until admission. The beneficiary is admitted as an inpatient on 12/12/2013 at 2 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. The beneficiary is discharged on 12/13/2013 at 8AM. Total time in the hospital meets the 2-midnight benchmark.

Example 3: Beneficiary in an outpatient Surgical Encounter at 6PM on 12/21/2013 is still in the Outpatient Encounter at one minute past midnight on 12/22/2013 and continues as an outpatient until admission. Beneficiary is admitted as an inpatient on 12/22/2013 at 1 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight. Beneficiary is discharged on 12/23/2013 at 8AM. Total time in the hospital meets the 2 midnight benchmark.

Additional Information

The official instruction, CR8586, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1334OTN.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- [MLN Matters® Article #MM8433](#), "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- [MLN Matters® Article #SE1336](#), "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- [HealthMap Vaccine Finder](#) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.
- The CDC website for [Free Resources](#), including [prescription-style tear-pads](#) that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1334	Date: January 24, 2014
	Change Request 8586

SUBJECT: Occurrence Span Code 72; Identification of Outpatient Time Associated with an Inpatient Hospital Admission and Inpatient Claim for Payment

I. SUMMARY OF CHANGES: The purpose of this change request is to notify contractors that occurrence span code 72 was redefined by the National Uniform Billing Committee (NUBC), for inpatient bills, so that contractors may denote contiguous outpatient hospital services that preceded the inpatient admission. This should permit the contractor the ability to determine the total time in the hospital, as it is voluntarily recorded on an inpatient claim.

EFFECTIVE DATE: December 1, 2013

IMPLEMENTATION DATE: February 25, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Number	Requirement	Responsibility							
		A/B MAC		D M E M A C	Shared- System Maintainers				Other
		A	B		H H H	F I S S	M C S	V M S	
	formal inpatient admission and the number of outpatient midnights occurring before the inpatient admission, as identified with newly defined occurrence span code 72. NOTE: Future CMS medical review technical directions may include occurrence spans of various lengths as a parameter to include or exclude claims.								
8586.2.1	Contractors should be able to identify Inpatient claims with occurrence span 72 with occurrence span code dates for 2 calendar days of contiguous services (i.e. 12/1/2013—12/2/2013 = 1 midnight of outpatient care) and one midnight hospitalized in inpatient status.	X							
8586.2.2	Contractors should be able to identify Inpatient claims with occurrence span 72 with occurrence span code dates for 3 calendar days of contiguous services (i.e. 12/1/2013—12/3/2013 = 2 midnights of outpatient care) and zero midnights hospitalized in inpatient status.	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC			D M E M A C	C E D I	
		A	B	H H H			
8586.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included	X					

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
	in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	The 2 midnight benchmark allows hospitals to account for <i>total</i> hospital time in determining if the beneficiary is expected to meet the 2 midnight benchmark (receiving medically necessary services) for inpatient admission. Since currently the inpatient claim only permits CMS to accurately track inpatient time (i.e. utilization days/midnights), CMS would also like to use occurrence span 72 to track the total, contiguous outpatient care received that may account for additional "midnights" receiving hospital care.
	<p>Example 1:</p> <p>Bene is an outpatient and is receiving observation services at 10PM on 12/1/2013 is still receiving observation services at one minute past midnight on 12/2/2013 and continues as an outpatient until admission.</p> <p>Bene is admitted as an inpatient on 12/2/2013 at 3 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight.</p> <p>Bene is discharged on 12/3/2013 at 8AM.</p> <p>Total time in the hospital meets the 2 midnight benchmark.</p> <p>CMS would like to track the outpatient time on automated basis, so CMS may focus medical review as needed.</p>
	<p>Example 2:</p> <p>Bene having arrived at the hospital and begun treatment in the ED at 8PM on 12/11/2013 is still in the Emergency Department (ED) at one minute past midnight on 12/12/2013 and continues as an outpatient until admission.</p> <p>The beneficiary is admitted as an inpatient on 12/12/2013 at 2 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight.</p>

X-Ref Requirement Number	Recommendations or other supporting information:
	<p>The bene is discharged on 12/13/2013 at 8AM.</p> <p>Total time in the hospital meets the 2-midnight benchmark.</p> <p>CMS would like to track the outpatient time on an automated basis, so CMS may focus medical review as needed.</p>
	<p>Example 3:</p> <p>Bene is in outpatient Surgical Encounter at 6PM on 12/21/2013 is still in the Outpatient Encounter at one minute past midnight on 12/22/2013 and continues as an outpatient until admission.</p> <p>Bene is admitted as an inpatient on 12/22/2013 at 1 AM, under the expectation that the beneficiary will require medically necessary hospital services for an additional midnight.</p> <p>Bene is discharged on 12/23/2013 at 8AM.</p> <p>Total time in the hospital meets the 2 midnight benchmark.</p> <p>CMS would like to track the outpatient time on an automated basis, so CMS may focus medical review as needed.</p>

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jennifer Dupee, 410-786-6537 or Jennifer.Dupee@cms.hhs.gov, Fred Rooke, 404-562-7205 or Fred.Rooke@cms.hhs.gov, Jennifer Phillips, 410-786-1023 or Jennifer.Phillips@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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