MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-36

Distribution: Hospitals, Medicaid Health Plans

Issued: December 1, 2014

Subject: Rebilling Medically Inappropriate or Unnecessary Inpatient Hospital Admissions, Hospital Utilization Review Committee Audits, and the Two-Midnight Rule for Inpatient Admissions

Effective: January 1, 2015

Programs Affected: Medicaid

The purpose of this bulletin is to provide clarification regarding the Michigan Department of Community Health's (MDCH) policy for rebilling medically inappropriate or unnecessary inpatient hospital admissions, hospital Utilization Review Committee Audits, and the Two-Midnight Rule for inpatient hospital admissions.

Rebilling Medically Inappropriate or Unnecessary Inpatient Admissions

MDCH policy currently states that when an inpatient hospital admission is deemed medically inappropriate or unnecessary and payment is recovered through an audit, these inpatient claims must be voided and cannot be rebilled to MDCH. Effective for claims with dates of discharge on or after October 1, 2014, for claims where the inpatient hospital admission is deemed inappropriate or unnecessary through a pre-payment predictive modeling review or a post-payment audit, hospitals are allowed to submit a hospital outpatient Type of Bill (TOB) 013X for all outpatient services and any inpatient ancillary services performed during the inpatient stay. For MDCH audit tracking purposes, providers should include the inpatient original claim Transaction Control Number (TCN) in the "note" section of the 013X hospital outpatient claim. MDCH will not accept the hospital inpatient TOB 012X.

Hospital Utilization Review Committee Audits

In cases where a hospital's Utilization Review Committee determines that an inpatient hospital admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit a hospital outpatient claim (TOB 013X) for medically necessary outpatient services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in beneficiary status from inpatient to outpatient is made prior to discharge, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicaid for the inpatient admission;

3. The provider responsible for the care of the beneficiary and the Utilization Review Committee concur with the decision; and

4. The concurrence of the provider responsible for the care of the patient and the Utilization Review Committee is documented in the beneficiary's medical record.

Two-Midnight Rule for Inpatient Admissions

In August 2013, the Centers for Medicare & Medicaid Services (CMS) released the 2014 Inpatient Prospective Payment System (IPPS) Final Rule, with an implementation date of October 1, 2013. One change specified in this Final Rule is the Two-Midnight Rule, which clarifies guidelines for physician orders of inpatient hospital admission for payment. The Two-Midnight Rule is broken into two separate but related policies: the Two-Midnight benchmark and the Two-Midnight presumption. The Two-Midnight benchmark instructs providers and Medicare review contractors that an inpatient hospital admission is generally appropriate when the provider has a reasonable and supportable expectation that the patient will require care at the hospital for a period spanning at least two midnights. The Two-Midnight presumption directs review contractors not to review inpatient claims if the stay spanned two midnights from the time of admission.

MDCH follows Medicare's observation care services coverage, claim submission, and reimbursement policies unless otherwise noted. As such, effective October 1, 2013, MDCH aligned with Medicare's policy for inpatient hospital admission determination by following the guidelines proscribed by CMS in the Two-Midnight Rule for beneficiaries where Medicaid is the primary payer. This includes alignment with any current or future CMS implementation timelines, delays or changes associated with the Two-Midnight Rule, unless otherwise specified. When Medicaid is not the primary payer, providers must follow the rules of the primary insurance.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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