



THE TWO-MIDNIGHT RULE: Overview and Practical Strategies for Compliance

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Physicians, case managers and utilization review staff have struggled to comply with nuanced CMS guidance regarding to the medical necessity of inpatient hospital admissions for decades. Just when they thought they knew the rules, the Centers for Medicare and Medicaid (CMS) has changed them again. Final policy changes set forth in the 2014 Inpatient Prospective Payment system (IPPS) final rule were published in the Code of Federal Register on August 19, 2013 and include implementation of a set of admission guidelines, known as the two-midnight rule. These policies became effective on October 1, 2013; however, enforcement of the two-midnight rule has been delayed [again] until April 1, 2015 with the passage of bill H.R. 4302 on April 1, 2014.

So what is the Two-Midnight Rule?

The FY 2014 IPPS final rule sets forth a time-based presumption period for determining medically necessary inpatient care. Under the two-midnight rule, an admission is presumed to be eligible for Medicare Part A payment if a physician expects a beneficiary's treatment to require a two-night hospital stay and admits the patient under that assumption. Under the rule, admissions that do not span two midnights will be reimbursed under Medicare Part B outpatient rates. The rule states that hospital admissions shorter than two midnights in length are generally inappropriate for payment under Medicare Part A; regardless of the hours the patient came to the hospital or whether the patient used a bed. The two-midnight benchmarks represent guidance to Medicare review contractors to identify

when an inpatient admission is generally appropriate for Medicare Part A payment under CMS-1599-F. CMS contractors will operate under the presumption that stays of at least two midnights are medically necessary, with the clock starting when the patient starts receiving hospital services (including observation services).

CMS will direct Medicare review contractors to apply CMS-1599-F, as well as all future guidance, in conducting patient status reviews for claims submitted by acute care inpatient hospital facilities, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs) and Inpatient Psychiatric Facilities (IPFs) for dates of admission on or after 10/1/2013; Medicare review contractors will be instructed to NOT apply these instructions to admissions at Inpatient Rehabilitation Facilities (IRFs). IRF patient status reviews are specifically excluded from the two-midnight inpatient admission and medical review guidelines per CMS-1599-F.

When conducting a patient status review in accordance with 1599-F, CMS will instruct Medicare review contractors to assess the hospital's compliance with three things:

- A. the admission order requirements,
- B. the certification requirements, and
- C. the two-midnight benchmark

The CMS continues to address the issues of utilization and medical necessity through rule making and auditing functions. The two-midnight rule is intended to provide guidance to hospitals in determining when an admission is medically necessary for Medicare claims purposes; that is, the decision to admit a patient should be based on an expectation that the patient will require at least a two-midnight stay. Through implementation and enforcement of the rule, the expected results include a reduction in the number extended observation stays at hospitals and a reduced financial burden on Medicare beneficiaries.

How did the rules change?

Hospitals have undergone heavy auditing for short patient stays in recent years, despite their protests that the rules were unclear. Clarification of the two-midnight rule by CMS reveals that the expectation of a two-midnight stay is sufficient justification for admission, even though the patient may not stay for two midnights due to unforeseen circumstances such as a transfer

or self-discharge against medical advice. If a patient is admitted but ultimately does not stay for two midnights, there must be clear physician documentation supporting the inpatient admission order that includes the expectation of at least a two midnight stay. Note that a patient undergoing a procedure on the "in-patient" only list is excluded from the two-midnight rule.

The agency also set forth new documentation requirements for physicians related to the admission order and certification, which, if not followed, will result in a claim denial for the hospital. CMS clarified that a physician must certify and accept responsibility for any Medicare inpatient admission prior to a patient's discharge under the two-midnight rule. CMS further clarified that when nurses and other professionals accept and document a physician's verbal order to admit a Medicare patients, the physician must countersign or authenticate the order before the patient is discharged. The medical record should clearly indicate why a physician deemed an inpatient stay necessary, supported by medical factors including patient history, the presence of comorbidities, signs and symptoms, current patient care requirements, and the risk of an adverse event during the hospital stay. In the absence of an appropriate inpatient order and supporting documentation of medical necessity, the hospital may still bill Medicare under Part B for outpatient services.

Despite the length of time in observation or in the emergency department (ED) counting toward the two-midnight rule time presumption, the inpatient stay does not begin until the physician writes an order for inpatient admission. Therefore, time spent in observation prior to an inpatient admission will not count toward the three-day inpatient stay requirement for SNF reimbursement from Medicare.

What is the impact on reimbursement?

According to CMS, its actuaries estimate that the two-midnight rule will increase IPPS expenditures by approximately \$220 million. These additional expenditures result from a shift in approximately 400,000 encounters of greater than two midnights to the IPPS and approximately 360,000 encounters of less than two midnights shifting to the OPSS. These estimates yield a net shift of 40,000 encounters into the IPPS which represents more costly inpatient care (78 Fed. Reg. 0952).

Within an individual facility, the impact is less straightforward due to the significant operational differences and challenges. The facility's processes for managing observation patients becomes of paramount importance in the estimations. An aggressive case management or care navigation process should be in place to help ensure patients are appropriately assessed, classified and status decisions are made as soon as clinically appropriate. A solid and consistent twenty-four/seven point of entry case management program, with experienced case managers, is a key factor in determining status quickly and accurately for every patient, every time. Additionally, a strong and proactive clinical documentation improvement program is critical for ensuring adequate documentation to support patient status and reimbursement.

What are some practical strategies for responding to the rule?

There are a number of practical strategies hospitals can implement to ensure consistent application of the two-midnight rule across the organization. Education and training of physicians and other licensed medical staff members should focus on the appropriate use of observation status. Use of educational materials provided by CMS and Quality Improvement Organizations (QIOs) will help ensure consistency and accuracy.

Another strategy is to make sure each physician has the support and resources needed to make the most informed decision on admission as soon as possible. Develop reference sheets, Electronic Medical Record (EMR) triggers, pathways and protocols to assist in the determination of patient status. ED case management and patient navigators can play a major role in assisting and supporting the ED staff, particularly in status decisions that may not be obvious or clear cut. CMS will direct Medicare review contractors to exclude extensive delays in the provision of medically necessary care from the two midnight benchmark calculation. CMS will instruct Medicare review contractors to only count the time in which the beneficiary received medically necessary hospital treatment.

A third strategy is for case management to focus daily reviews on new admissions and observation patients from the previous 24 hours. This can be completed in the case management morning huddle or the multidisciplinary daily huddle. The review should focus on appropriateness of patient status as well as any opportunities to re-educate or reinforce protocols and processes.

Hospitals should have processes in place to self-identify cases that resulted in an inappropriate admission so that a rebill can occur before the one-year filing requirement expires. Remember that the RAC audits may occur up to three years after a patient encounter resulting in a payment denial. Medicare review contractors will continue to follow longstanding guidance to review the reasonableness of the inpatient admission decision 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. 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. If the physician believes the beneficiary represents a rare and unusual exception to the two-midnight benchmark, in which the expected length of stay is less than two midnights but inpatient admission may be appropriate, the physician must clearly document this rationale and supporting information in the medical record for CMS review.

Summary

The final rule addresses the problem of appropriate and medically necessary inpatient short stays on two fronts. First, CMS revised its guidance on inpatient admissions by stating that an admission will be deemed appropriate if the stay requires duration of at least two midnights, barring any evidence of gaming the system by the hospital.

Secondly, CMS removed some of the previous financial disincentive for inpatient admission (such as a potential short-stay payment denial) by allowing hospitals to rebill a retrospectively determined inappropriate admission as an outpatient visit under Part B. Hospitals can do so for up to one year from the point of service.

The IPPS final rule leaves many questions unanswered, particularly regarding how the two-midnight rule will be interpreted and applied in April 2015. The two-midnight rule is challenging hospitals to change their thinking, their training and their decision making about when to admit a patient to their facility. Even with the grace period in enforcement, the Probe and Educate Audits are continuing with some of their MACs recouping payments for denied claims pursuant to their Audits. Hospitals would be well advised to begin the education and internal audit processes as if there were no delay in enforcement. As providers continue to question the specificity and applicability of the rule, CMS Probe and Educate Audits will continue.

Glossary of Terms

CMS 1599-F is the final rule which provides guidance on Medicare fiscal year 2014 payment policies and rates; and clarified CMS policy on how Medicare contractors review inpatient hospital and critical access hospital admissions for payment purposes.

IPPS – Inpatient Prospective Payment System is the CMS reimbursement system for inpatient hospital services provided to Medicare beneficiaries.

Medicare Part – A is coverage for inpatient hospital care, treatment and services.

Medicare Part – B is coverage for outpatient care, treatment and services.

MAC – Medicare Administrative Contractors are responsible for processing Medicare claims, make payments to providers and educate providers on accurate submission of Medicare coded claims.

OPPS – Outpatient Prospective Payment System is the CMS reimbursement system for outpatient services provided to Medicare beneficiaries.

QIO – Quality Improvement Organization is contracted by CMS to monitor access and quality of services to Medicare beneficiaries.

RAC – Recovery Audit Contractors are CMS contractors that review Medicare beneficiary claims to identify overpayments and underpayments.

CMS References and Links

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>

<http://cms.gov/center/provider-type/hospital-center.html>

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/ReviewingHospitalClaimsforAdmissionforPosting03122014.pdf>

Two-Midnight Rule Tools/Resources

<http://coliseumhealthsystem.com/util/documents/two-midnight-faqs-and-fact-sheet.pdf>

<http://www.beckershospitalreview.com/finance/10-things-to-know-about-the-two-midnight-rule.html>

<http://www.advisory.com/daily-briefing/2014/03/17/moodys-two-midnight-rule-will-cost-hospitals>

<http://www.advisory.com/research/cardiovascular-roundtable/tools/2014/two-midnight-impact-assessment>



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