The Impact of Medicare's "Two-Midnight" Rule

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On August 19, 2013, the Centers for Medicare & Medicaid Services (CMS) published a final rule implementing a new Medicare hospital inpatient prospective payment system admissions regulation that imposes specific requirements and constitutes a condition of payment for inpatient admissions.

The final rule purports to clarify CMS' long-standing policy regarding the manner in which Medicare contractors review inpatient hospital and critical access hospital admissions for payment purposes. Instead, the final rule actually increases the prior 24-hour benchmark for inpatient admissions to two-midnights and gives rise to many questions as to how it will be applied and how it will affect hospitals and patients. This article will attempt to answer many of those questions and to offer ways for hospitals to mitigate their risks under this rule.

Much of the confusion revolves around the specific requirements for the so-called "two-midnight rule." Under this rule, surgical procedures, diagnostic tests and other treatments (other than services designated as inpatient-only) are generally appropriate for inpatient hospital admission and payment under Medicare Part A when (1) the physician expects the beneficiary to require a stay that spans at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation.

According to CMS, this policy responds to both hospital and beneficiary concerns. Hospitals, however, have requested more guidance about ensuring a beneficiary is appropriately treated and will be paid by Medicare as an inpatient. Organizations representing beneficiaries have sought more information to quell concerns about increasingly long stays as outpatients due to hospital uncertainties about payment.

Although this rule took effect October 1, 2013, CMS recently announced that it would direct Medicare Administrative Contractors (MACs) not to focus medical review on stays spanning at least two midnights (i.e., meeting the two-midnight presumption).

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For stays spanning less than two midnights, CMS will conduct prepayment patient status reviews for dates of admissions on or after October 1, 2013, but before March 31, 2014, as part of its "Probe and Educate" program. Claims that are not in compliance with the final rule will be denied. Based on the results of these initial reviews, MACs will conduct educational outreach efforts and repeat the process as necessary.

The Effects of the Two-Midnight Rule

- A physician's decision to admit a patient must be based on the physician's expectation that the patient will require a hospital stay of at least two midnights.
- The two-midnight benchmark clock begins when the beneficiary begins receiving services. Therefore, time spent at the hospital receiving services can

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count as outpatient (even prior to admission) to support the two-midnight benchmark (e.g., if the beneficiary has been considered outpatient, is in observation, or is in the emergency department for one midnight, the two-midnight benchmark is met if the physician expects the beneficiary to require an additional midnight in the hospital).

- Time spent in a waiting area may not be included in the determination of whether the two-midnight benchmark has been met. Triaging activities such as vital signs before the initiation of medically necessary services will not be considered.
- The two-midnight presumption clock does not commence until the inpatient admission order is formally documented.
- For medical review purposes, the inpatient status is presumed to be appropriate if the length of the inpatient stay is more than two midnights after the formal admission order was written.
- The medical record must include clear documentation of the physician's admission order, certification and the factors (patient history, comorbidities, severity of symptoms, risk of adverse events, etc.) that led to the two-midnight expectation.
- The certification is a condition for payment, as it must be completed, signed, dated and documented in the medical record prior to patient discharge.
- Inpatient stays of less than two midnights after the formal admission order was written are subject to review (unless the beneficiary receives procedure on the inpatient-only list) and the time spent as outpatient may be considered for purposes of determining whether the two-midnight requirement was met.
- Time spent in observation or the emergency room will not count toward the three-day inpatient stay requirement for skilled nursing facility coverage, but does count towards the two-midnight benchmark.
- Filing deadline for hospitals to rebill rejected or self-disallowed Medicare Part A claims under Medicare Part B is one year after the date of service>

Will Federal Regulators Come After Hospitals?

CMS has directed MACs (in the next five months) to select a sample of 10 to 25 claims (depending on the size of the hospital) for prepayment review and to deny each non-compliant claim (in addition to providing education about the denials). Regardless of the limited review of claims within the next five months, systematic gaming, abuse or delays in attempt to surpass the two-midnight presumption could warrant further medical review. Finally, note that after the five-month period, other Medicare regulators and auditors, including RACs and MACs, may resume reviewing all types of claims.

Mitigating Risks

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- Educate physicians and staff about the requirements of this rule to ensure compliance.
- Consider preparing a separate “Inpatient Admission Statement Form” to assist physicians in complying with these new requirements.
- Consider implementing protocol to assist physicians in managing “outpatient” status patients to effectively transition patients to either inpatient status or discharge.
- Consider self-auditing to identify and correct gaps rather than waiting for MACs or RACs to perform audits after the claim filing period has expired.

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