Hospital Patient Status, “Two-Midnight” is the Rule

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The Centers for Medicare and Medicaid Services (“CMS”) Two-Midnight Rule was crafted to put a curfew on what Medicare auditors deemed the subjective medical judgment of admitting physicians in determining the correct admission status of patients. To be or not to be “inpatient,” that is the big question! The question is indeed significant since Medicare pays significantly more under Part A for inpatient services than it does under Part B for outpatient services. Thus, improper admission means improper payment to hospitals. As the backlog of Medicare appeals mounted, CMS issued new regulations to redefine an “inpatient” for purposes of Medicare Part A payment.

This article explains the Two-Midnight Rule (the “Rule”) and analyzes some of its implications for health care providers and patients.

The Rule

Before CMS published the Rule, the benchmark was 24 hours. If the admitting physician expected that it would take 24 hours or more to treat a patient, he or she would admit the patient as an inpatient. Anything short of 24 hours was deemed outpatient. As CMS unleashed its auditors, it soon became clear that hospital inpatient status was the largest risk area for overpayments, and therefore CMS’ largest opportunity for savings. While hospitals defended their admission practices through the time-consuming appeals process, CMS sought to root out the subjectivity embedded with the then current determination of medical necessity and the Rule was born. The Rule was subsequently revised to respond to abundant criticism.

Two for One. The Rule includes two distinct medical review policies, a two-midnight benchmark and a two-midnight presumption. The two-midnight benchmark establishes that inpatient admission is generally appropriate when a practitioner expects the patient to require a stay that crosses at least two midnights. Thus, under the two-midnight presumption, inpatient claims with lengths of stay greater than two midnights after formal admission following a physician order are presumed appropriate.

Consequently, CMS has directed its auditors to apply the presumption and, absent evidence of systematic gaming or abuse, they are not to review Part A claims with stays of at least two midnights. Conversely, inpatient stays of less than two midnights are presumed improper and will systematically be denied, unless the services provided belong to the “inpatient-only list” or an exception applies (e.g., death, transfer, departure against medical advice, unforeseen clinical improvement, etc.).

Criteria. The practitioner must clearly specify the intent to admit for Part A inpatient services at or before the time of admission in the admission order and provide supporting evidence. Formal admission pursuant to the admission order triggers inpatient status. The order can be written in advance of the formal admission for pre-scheduled surgery. Complex medical factors such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event should weigh in on the practitioner’s decision to admit inpatient. These factors must be clearly documented in the medical record and progress notes so as to support the need for care covering at least two midnights.

Documentation at the time of admission must provide the justification needed to support medical necessity of the inpatient admission regardless of the actual duration of the hospital stay and whether it ultimately crosses two midnights.

Qualified Provider. The admission order must be furnished by a qualified practitioner, meaning a physician or licensed practitioner with admitting privileges at the hospital in accordance with state law and who is “knowledgeable about the patient’s hospital course, medical plan of care, and current condition.” For purposes of the Rule, such a provider is (i) the admitting physician of record, (ii) a hospitalist, (iii) the beneficiary’s primary care physician, (iv) the surgeon, (v) the emergency care provider, or (vi) the provider actively treating the patient. The practitioner may not delegate the decision to another individual who is not authorized by state law to admit patients or has not been granted admitting privileges.

Certification (except inpatient psychiatric services). The original Rule held that the provider must, for each admission, certify that the services are reasonable and necessary and provided in accordance with the Rule. Although CMS did not mandate a specific form or format, the certification requirements included all the following: (i) authentication of the practitioner order; (ii) the reason(s) for inpatient services; (iii) the estimated or actual time the beneficiary requires in the hospital; (iv) plans for post-hospital care, as applicable; (v) timing; and (vi) signature. In light of the public comments, CMS backed down from the burdensome systematic certification mandate and held that in most cases, the admission order, medical record, and progress notes would suffice to support the medical necessity of an inpatient admission. Certification is now only required for outlier and long-stay cases, i.e., 20 days or longer. The provider must, no later than 20 days into the hospital stay, certify the reasons for (i) the continued hospitalization or (ii) special or unusual services for cost outlier cases, (iii) the estimated time the patient will need to remain in the hospital, and, if applicable (iv) the plans for post-hospital care.

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Applicability. The Rule applies to acute care hospitals, critical access hospitals ("CAHs"), long-term care hospitals ("LTCHs"), and inpatient psychiatric hospitals under Medicare Part A. Notably, the Rule does not apply to Inpatient Rehabilitation Facilities ("IRFs"). It is also distinct from Medicaid agencies, which have discretion to follow their own or the same guidelines.

Inpatient Claims Denials – Now What? After receiving notice for the denial of Part A claims, the hospital has the following options: it may (i) file for an administrative appeal (large backlog dating back to the RACs); (ii) submit the claim under Outpatient Part B services using condition code 44, which permits the hospital to change patient status from inpatient to outpatient under narrow circumstances; or (iii) submit an Outpatient Part B claim for services provided prior to the denial of inpatient status and an Inpatient Part B claim for services provided after admission.

Implications for Health Care Providers
Adapting to the Rule. To adapt to the Rule, hospitals must develop new protocols to scrutinize patient admissions. This entails monitoring short inpatient stays, scrutinizing surgical procedures with average length of stay under two midnights, and correcting inappropriate admissions prior to discharge. For providers, this translates into caution and documentation.

Common Pitfalls. The most common reasons for payment denials include: (i) admission orders that fail to clearly state the intent to admit as inpatient; (ii) surgical procedures with average length of stay of less than two midnights not on the inpatient-only list; (iii) dichotomy between the physician attestation and the medical record documentation; and (iv) lack of supporting documentation for the need to keep the patient for two midnights.

Verbal Orders. The Rule does not prohibit verbal orders. However, all verbal orders must be promptly and properly countersigned by the practitioner who gave the verbal order before discharge. CMS considers a verbal order as a “temporary administrative convenience” for physicians and hospital staff but not a substitute for a properly documented and authenticated order for inpatient admission. CMS intends to take the time to review the issue of verbal orders and provide additional guidance as it did with the Conditions of Participation.

Cut & Paste. With the advent of electronic medical records, the temptation is high to create templates to streamline documentation of patient care and avoid the pitfalls highlighted above. Providers should resist the urge. Technology enables Medicare auditors to audit electronic records and track patterns of cut and paste documentation. Even if the intent is perfectly legitimate, the practice of cut and paste is a red flag.

Admitting Privileges. Medical staff privileges were once only a condition of participation. Under the Rule, the provider writing the admission order must have admitting privileges as a condition of payment. Providers and credentialing committees must pay close attention to avoid any lapse in privileges in order to prevent overpayments.

The Rule has and continues to be widely criticized by hospitals and providers. Health systems have reported declining admissions while observation stays spiked in the second quarter of 2014. These statistics suggest that the Rule is shifting patient care from inpatient to outpatient services and not necessarily eliminating unnecessary care. For now, everyone is reacting and attempting to adjust and balance the demands of a plethora of new rules, including the Affordable Care Act, which provides stiff penalties for preventable readmissions. They are trading inpatient stays for observations stays in order to avoid preventable readmissions. Only time will tell if hospitals and providers can adapt. CMS’ recent actions demonstrate the agency’s sensitivity to the industry’s vigorous and persistent stream of complaints targeted at the Rule. In April 2015, CMS announced that it will continue the “Inpatient Probe and Educate Process” until September 30, 2015, and prohibit inpatient hospital patient status reviews for dates of admission occurring between October 1, 2013 and September 30, 2015. By effectively delaying enforcement, CMS aims to improve providers’ understanding of the Rule and perhaps, as hinted in the recently unveiled 2016 proposed prospective payment rule for acute and long-term-care hospitals, buy time to regroup and rethink.

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