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Centers for Medicare & Medicaid Services

Fact Sheet: Two-Midnight Rule

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On October 30, 2015, CMS released updates to the Two-Midnight rule regarding when inpatient admissions are appropriate for payment under Medicare Part A. These changes continue CMS' long-standing emphasis on the importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries. These updates were included in the calendar year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule.

Hospital Inpatient vs. Outpatient

Because of the way the Medicare statute is structured, the Medicare payment rates for inpatient and outpatient hospital services differ.

CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the Hospital Inpatient Prospective Payment System (IPPS) in the Medicare Part A program. CMS sets payment rates prospectively for inpatient stays based on the patient's diagnoses, procedures, and severity of illness.

In contrast, the Hospital Outpatient Prospective Payment System (OPPS) is paid under the Medicare Part B program and is a hybrid of a prospective payment system and a fee schedule, with some payments representing costs packaged into a primary service and other payments representing the cost of a particular item, service, or procedure.

When a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner must decide whether to admit the beneficiary as an inpatient or treat him or her as an outpatient. These decisions have significant implications for hospital payment and beneficiary cost sharing. Not all care provided in a hospital setting is appropriate for inpatient, Part A payment.

The Two-Midnight Rule

Background

In recent years, through the Recovery Audit program, CMS identified high rates of error for hospital services rendered in a medically-unnecessary setting (*i.e.*, inpatient rather than outpatient).

CMS also observed a higher frequency of beneficiaries being treated as hospital outpatients and receiving extended "observation" services. Hospitals and other stakeholders expressed concern about this trend, especially since days spent as a hospital outpatient do not count towards the three-day inpatient hospital stay that is required before a beneficiary is eligible for Medicare coverage of skilled nursing facility services.

To address both of these issues, hospitals and other stakeholders requested additional clarity regarding when an inpatient admission is payable under Medicare Part A. In response, in 2012, CMS solicited feedback on possible criteria that could be used to determine when inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

The Two-Midnight Rule

To provide greater clarity to hospital and physician stakeholders, and to address the higher frequency of beneficiaries being treated as hospital outpatients for extended periods of time, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when determining whether inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In general, the original Two-Midnight rule stated that:

- Inpatient admissions would generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation.
- Medicare Part A payment was generally not appropriate for hospital stays expected to last less than two

midnights. Cases involving a procedure identified on the inpatient-only list or that were identified as "rare and unusual exception" to the Two-Midnight benchmark by CMS were exceptions to this general rule and were deemed to be appropriate for Medicare Part A payment.

The Two-Midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule did not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service.

Following the adoption of the Two-Midnight rule, CMS received extensive feedback from the stakeholder community, including concerns that the new policy was impacting physician and hospital practices.

Process for Developing Proposed Updates

Extensive Input

The proposed changes to the Two-Midnight rule reflected extensive stakeholder input, from hospitals, physicians, the Medicare Payment Advisory Commission (MedPAC), beneficiary advocates, Congress, and others.

CMS also received important information from the Probe and Educate process conducted by the Medicare Administrative Contractors (MACs), in which CMS contractors have worked with hospitals to clarify the parameters of Medicare payment policy with regard to inpatient and outpatient patient status.

Principles for Proposing to Update the Two Midnight Rule

As we considered changes to this rule, CMS sought to balance multiple goals, including: continuing to respect the judgment of physicians; supporting high quality care for Medicare beneficiaries; providing clear guidelines for hospitals and doctors; and providing incentives for efficient care to protect the Medicare trust funds.

CY 2016 OPPS Final Rule

In the CY 2016 OPPS final rule, CMS:

- Maintains the benchmark established by the original Two Midnight rule, but permits greater flexibility for determining when an admission that does not meet the benchmark should nonetheless be payable under Part A on a case-by-case basis.
- Discusses a shift in enforcement of the Two Midnight Rule from MACs to Quality Improvement Organizations (QIOs) (discussed in more detail below).

Changes in Review: Short Inpatient Hospital Stays

For stays expected to last less than two midnights – CMS is adopting the following policies:

- For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.
- CMS is reiterating the expectation that it would be unlikely for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight. CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.

No change for stays over the two-midnight benchmark:

- For hospital stays that are expected to be two midnights or longer, our policy is unchanged; that is, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports that expectation that the patient would stay at least two midnights. This includes stays in which the physician's expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice.

A More Collaborative Approach to Education and Enforcement

The final rule also includes a discussion of changes to CMS' approach to educating hospitals and our enforcement of the Two Midnight rule. Specifically, CMS began using Beneficiary and Family Centered Care (BFCC) QIOs, rather than MACs or Recovery Auditors, to conduct the initial medical reviews of providers who submit claims for short stay inpatient admissions on October 1, 2015. Beginning in 2016, BFCC-QIOs will begin reviewing inpatient cases under the revised Two Midnight Rule being announced today.

BFCC-QIO reviews of short inpatient hospital claims focus on educating doctors and hospitals about the Part A payment policy for inpatient admissions. BFCC-QIOs will refer providers to the Recovery Auditors based on patterns of practices, such as high rates of claims denial after medical review or failure to improve after QIO assistance has been

rendered. Accordingly, we do not expect substantial Recovery Auditor medical review activity for such claims for several months.

This change in medical review strategy compliments a number of changes CMS has already made to the Recovery Audit Program. CMS has either adopted or is in the process of working with the Recovery Auditors to implement the enhancements described below.

- To address hospitals' concerns that they do not have the opportunity to rebill for medically necessary Medicare Part B services by the time a Recovery Auditor has denied a Medicare Part A claim, CMS changed the Recovery Auditor "look-back period" for patient status reviews to 6 months (as opposed to 3 years) from the date of service in cases where a hospital submits the claim within 3 months of the date that it provides the service.
- CMS established incrementally applied Additional Documentation Request (ADR) limits for providers that are new to Recovery Auditor reviews and will establish limits on ADRs that are based on a hospital's compliance with Medicare rules and that are diversified across all claim types of a facility.
- CMS has also announced that it will establish a requirement that Recovery Auditors complete complex reviews within 30 days, and that failure to do so will result in the loss of the Recovery Auditor's contingency fee, even if an error is found.
- Finally, CMS will require Recovery Auditors to wait 30 days before sending a claim to the MAC for adjustment. This 30-day period allows the provider to submit a discussion period request before the MAC makes any payment adjustments.

For more information on the CY 2016 OPPS final rule, see this fact sheet. The final rule will appear in the November 13, 2015 Federal Register and can be downloaded from the Federal Register at: http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1