

# **CMS Revises Two-Midnight Rule to Allow An Exception for Part A Payment for Hospital Services Provided to Patients Requiring Inpatient Care for Less Than Two Midnights**

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Executive Summary, December 2015

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After two years of dialogue with stakeholders regarding challenges associated with the Two-Midnight Rule, the Centers for Medicare & Medicaid Services (CMS) recently finalized policy changes in the Calendar Year (CY) Outpatient Prospective Payment System (OPPS) Final Rule.<sup>1</sup> Specifically, under the revised rule, CMS will allow an exception for Medicare Part A (Part A) payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark if documentation in the medical record supports that the patient required inpatient care. The changes in the Final Rule will go into effect on January 1, 2016.

## **Background**

In the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) Final Rule, CMS established criteria for short inpatient hospital admissions to be billed appropriately under Part A, commonly referred to as the Two-Midnight Rule.<sup>2</sup> The rule is comprised of both a benchmark for reviewers to identify when an inpatient admission will likely be viewed as suitable for Part A payment, and a presumption instructing medical reviewers not to focus on certain claims that will generally be considered appropriate for payment under Part A.

The Two-Midnight Rule benchmark specifies that an inpatient admission and Part A payment are generally appropriate if, at the time of admission, the physician expects the patient stay will cross two midnights or require services that are on the inpatient-only list. This benchmark applies regardless of a patient's severity of illness or the intensity of care required. Under the Two-Midnight Rule presumption, inpatient claims for lengths of stay greater than two midnights after a formal inpatient order for admission are appropriate for Part A payment and, therefore, should not be selected for medical review.

Since implementation of the Two-Midnight Rule, providers have expressed concerns with the benchmark, because it failed to allow sufficient deference to medical judgment

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<sup>1</sup> 80 Fed. Reg. 70298, 70538-70549 (Nov. 13, 2015).

<sup>2</sup> 78 Fed. Reg. 50495, 50943-50954 (Aug. 19, 2013).

in certain circumstances where the severity of a patient's symptoms and medical needs necessitate an inpatient admission irrespective of the projected or actual duration of the stay.

### **Changes to the Two-Midnight Rule in the CY 2016 OPPS Final Rule**

In the CY 2016 OPPS Final Rule, CMS revised the Two-Midnight Rule to allow an exception for Part A payment on a case-by-case basis for services provided during an inpatient admission that is not expected to cross two midnights, if the admitting physician determines and documents in the medical record that inpatient hospital care is reasonable and necessary.<sup>3</sup> CMS explained that the case-by-case evaluation would take into account the following factors, among others:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient; and
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).<sup>4</sup>

To implement this change, CMS revised Section 412.3(d)(1) of the regulations to state that "Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination."<sup>5</sup>

CMS has made it clear that these modifications do not entirely negate the two-midnight benchmark or presumption.<sup>6</sup> Rather, the changes simply mean a broader range of

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<sup>3</sup> 80 Fed. Reg. 70298, 70541 (Nov. 13, 2015).

<sup>4</sup> *Id.* at 70541.

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* at 70542.

cases could be considered exceptions to the benchmark, if the medical record adequately supports the inpatient admission.

Previously, the only exception to the Two-Midnight Rule was a very narrow “rare and unusual” exceptions policy. While CMS agreed to work with the hospital industry and Medicare Administrative Contractors (MACs) to determine if there are circumstances or types of patients that should be considered appropriate for inpatient admission regardless of the two-midnight expectation, only newly initiated mechanical ventilation<sup>7</sup> was determined to fall under the rare and unusual exceptions policy. Therefore, it is significant that CMS’ revisions provide an exception that will allow a broader range of medically necessary inpatient stays that do not cross two midnights to be considered appropriate for inpatient admission.

CMS made no changes to the presumption that inpatient stays expected to last longer than two midnights are generally considered to be appropriate inpatient admissions, acceptable for Part A payment.<sup>8</sup> Therefore, medical review efforts will not focus on these longer stays, unless there is evidence of systematic gaming, abuse, or delays in furnishing care as a means of qualifying for the presumption.

### **How CMS' Changes to the Two-Midnight Rule Will Be Applied**

Pursuant to the CY 2016 OPPS Final Rule, Part A payment is allowable if the physician decides that an inpatient stay is necessary—irrespective of length—and this determination is supported by the medical record. Under the revised policy, Part A payment of a claim will be subject to the clinical judgment of the medical reviewer if a stay does not meet the two-midnight benchmark, the medical record does not support a reasonable expectation of two nights of hospital care, and the service is not on the inpatient-only list or a rare and unusual exception (which only currently applies to new

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<sup>7</sup> See 80 Fed. Reg. 70298, 70548 (Nov. 13, 2015) (“In January 2014, we identified newly initiated mechanical ventilation (when medically necessary and excluding anticipated intubations related to minor surgical procedures or other treatment) as the first such rare and unusual exception to the 2-midnight benchmark”).

<sup>8</sup> *Id.* at 70541.

onset mechanical ventilation). This medical review would determine whether the aggregate submissions to the medical record including “progress notes, diagnostic findings, medications, nursing notes, and other supporting documentation” meet the clinical requirements for an inpatient admission.<sup>9</sup> Medicare review contractors may take into account evidence-based guidelines or commercial utilization tools as allowed under CMS policies.

To be covered under Part A, the medical record documentation must clearly demonstrate that the physician’s decision to admit the beneficiary and the care furnished were reasonable and necessary.<sup>10</sup> Even if CMS reviewers determine that the inpatient admission is not reasonable and necessary and Part A payment is inappropriate, the patient’s status will remain “inpatient” because this status may not be changed post-discharge.<sup>11</sup> In these circumstances, the hospital will not receive Part A payments for the services, but it may be able to use Part A to Medicare Part B (Part B) rebilling rules to submit a Part B inpatient claim for the Part B services that would have been payable under Part B had the beneficiary been treated as an outpatient.<sup>12</sup>

CMS clarified that the revisions to the Two-Midnight Rule do not alter its policy that there are circumstances in which a hospital inpatient admission will rarely be considered appropriate for Part A payment.<sup>13</sup> For instance, when a beneficiary has scheduled a minor surgical procedure, it would be unusual for such a hospital stay to be considered appropriate for Part A payment, even if the patient is expected to remain overnight in the hospital due to the timing of the procedure. Consistent with the Medicare Benefits Provider Manual (MBPM), CMS maintains that treatments that only are expected to keep a patient in the hospital less than 24 hours should generally be billed as outpatient hospital services, even if the patient uses a hospital bed or the stay extends past midnight.<sup>14</sup> While the revised Two-Midnight Rule will allow Part A payment for services provided during certain stays expected to last less than 24 hours, the services would

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<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 70542.

<sup>11</sup> *Id.*, *see also*, CMS Ruling 1455-R (78 Fed. Reg. 16617).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*, citing Section 10, Chapter 1 of the MBPM.

have to be more complex than those generally associated with a minor surgical procedure, and the medical necessity of the inpatient admission would have to be clearly justifiable based on the medical record.<sup>15</sup> CMS will monitor admissions that last less than 24 hours, and has indicated that these cases will be prioritized for medical review.<sup>16</sup> The agency also will be monitoring for patterns of systematic delays that could indicate fraud or abuse.<sup>17</sup>

### **Negative 0.2% Adjustment Associated with the Two-Midnight Rule**

When CMS implemented the Two-Midnight Rule in FY 2014, it also finalized a 0.2% reduction to IPPS payments to offset expected shifts in utilization between inpatient and outpatient settings. While certain details about the assumptions CMS relied on to quantify these projected shifts remain unclear, and the process by which CMS imposed this adjustment has been contested through litigation, the offset has remained in place since FY 2014. CMS indicated that the recent modifications to the Two-Midnight Rule included in the CY 2016 OPPS Final Rule are not likely to result in new adjustments either to mitigate the effects of the prior offset or to adjust for the modified policy.<sup>18</sup> Rather, CMS believes the recent modifications could result in further costs to the Medicare program due to the expanded number of overnight hospital stays that could fall under an exception to the rule and would, therefore, be eligible for Part A payment. As a result, CMS has indicated that it might even determine that a downward adjustment to payment rates beyond the original -0.2% currently in place would be appropriate.<sup>19</sup> Any additional adjustment will be determined after further evaluation of claims data to evaluate the impact of the original adjustment. CMS also expressed concern that Medicare beneficiaries may be subject to greater cost sharing under the

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<sup>15</sup> *Id.*

<sup>16</sup> *Id.* at 70546.

<sup>17</sup> *Id.* at 70543.

<sup>18</sup> *Id.* at 70544.

<sup>19</sup> *Id.*

modified policy if it results in more short hospital stays being considered appropriate for Part A payment.<sup>20</sup>

After releasing the CY 2016 OPPS Final Rule, CMS issued a *Federal Register* notice on December 1, 2015 in response to the U.S. District Court for the District of Columbia order in *Shands Jacksonville Medical Center Inc. v. Burwell*,<sup>21</sup> challenging the 0.2% reduction in IPPS rates.<sup>22</sup> This notice provides further information about the assumptions CMS' actuaries relied on to estimate that the two-midnight policy would increase IPPS expenditures by approximately \$220 million in FY 2014, which served as a basis for the 0.2% reduction. CMS invites comments on the assumptions and methodologies underlying the 0.2% payment reduction, and whether CMS' calculations and reasons for this reduction remain justifiable when taking into account new claims data.<sup>23</sup> Comments are due by February 2, 2016, and CMS will respond to these comments in a final notice that will be published by March 18, 2016. Additionally, as indicated in the CY 2016 OPPS Final Rule, CMS will continue to review and consider claims experience for FY 2014 and subsequent years, and will evaluate whether the assumptions underlying the original reduction and the implications of recent revisions to the Two-Midnight Rule should be reconsidered in future rulemaking.

## **QIO Patient Status Reviews**

CMS announced in the CY 2016 OPPS Proposed Rule that effective October 1, 2015 (regardless of whether the proposed revisions to the Two-Midnight Rule were ultimately finalized), CMS would change the medical review strategy to have Quality Improvement Organizations (QIOs) conduct the reviews of short inpatient stays, rather than MACs.<sup>24</sup>

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<sup>20</sup> *Id.*

<sup>21</sup> No. 14-263 (D.D.C.).

<sup>22</sup> Medicare Program, Inpatient Prospective Payment Systems; 0.2 Percent Reduction, 80 Fed. Reg. 75107- 75117 (Dec. 1, 2015).

<sup>23</sup> CMS' "actuaries are currently conducting an analysis of claims experience for FY 2014 and FY 2015 in light of available data, including the MedPAR data." CMS also seeks comment on whether to await completion of this analysis before resolution of proceedings related to the 0.2% reduction. *Id.* at 75110.

<sup>24</sup> *Id.* at 70545. More information on the announcement is *available at* <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html>

QIOs will refer hospitals to Recovery Auditors for further medical review only if they are determined to exhibit a pattern of practices (e.g., high denial rates or frequent inpatient admissions for stays shorter in duration than one midnight) or do not improve even after QIO educational efforts.<sup>25</sup> The claim volume of a particular hospital and the denial rate identified by the QIO will determine the number of claims that the Recovery Auditor will be allowed to review. When CMS announced the change in medical review strategy, the agency also stated that it will not allow Recovery Auditors to conduct patient status reviews for dates of admission of October 1, 2015 through December 31, 2015.<sup>26</sup>

QIOs have already started to conduct post-payment reviews of claims and will refer findings to MACs for payment adjustments. Beginning on January 1, 2016, QIOs will conduct medical reviews based on the revised two-midnight policy adopted in the OPPTS Final Rule.<sup>27</sup> Providers may challenge denied claims through the appeals process. QIOs will educate providers regarding denials associated with the two-midnight policy and will work with hospitals to develop a quality improvement framework or to improve organizational systems and processes as needed.

## **Conclusion**

CMS' revisions to the Two-Midnight Rule will provide an exception to allow Part A payment for hospital stays lasting less than two midnights that are documented to be reasonable and necessary inpatient admissions. This exception provides some flexibility to reimburse services provided during short hospital stays in a manner that aligns with medical judgment regarding the inpatient admission, rather than universally applying a rigid time-based standard to determine whether a stay should be reimbursed as inpatient or outpatient. The dialogue around inpatient status is likely to continue as the revised Two-Midnight Rule is implemented and QIO reviews of short inpatient stays move forward. CMS has indicated that it will continue to monitor and evaluate the

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<sup>25</sup> *Id.* at 70546.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 70547.

application of the Two-Midnight Rule, the new exception, and reimbursement for short inpatient stays and may make modifications in the future based on any observations.

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