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Compliance and Legal Analyst, Masonicare

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by Janice Anderson, Esq. and Sara Iams, Esq.

The Two-Midnight Rule: Past, present, and future

» The Two-Midnight Rule, effective October 1, 2013, provides guidelines for making Medicare inpatient admission decisions.

» An inpatient admission is "generally appropriate" if the admitting practitioner expects the patient to require a stay that crosses at least two midnights and admits the patient based upon that expectation.

» The two-midnight benchmark and the two-midnight presumption are the medical review policies used by MACs and RACs to evaluate compliance.

» Compliance officers need to use lessons learned from the Probe & Educate audit period to prepare for RAC audits as of May 1, 2015.

» Compliance officers must stay abreast of changes to Two-Midnight Rule policies, including pending case law and proposed legislation, which may further delay enforcement of this controversial rule.

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In an effort to simplify its hospital admission guidelines, the Centers for Medicare & Medicaid Services (CMS) introduced the so-called Two-Midnight Rule in the FY 2014 Inpatient Prospective Payment System (IPPS) final rule.[1] Since its introduction, aspects of the Two-Midnight Rule have been repeatedly delayed and "clarified," making it difficult for hospitals and their compliance teams to keep up with its status, to manage the Medicare Administrative Contractor (MAC) Probe & Educate program, and to prepare for Recovery Audit Contractor (RAC) or other enforcement. This article will provide an overview of the Two-Midnight Rule, a discussion of its current status, and tips to prepare for the expiration of the RAC enforcement moratorium on April 30, 2015.

History of the Two-Midnight Rule

Prior to FY 2014, CMS counseled hospitals to follow a "24-hour" benchmark to determine whether an inpatient admission was appropriate. Specifically, CMS guidance called for hospitals to designate a patient as an "inpatient if formally admitted…with the expectation that he or she will remain at least overnight," but also acknowledged that the decision to admit "is a complex medical judgment which can be made only after the physician has considered a number of factors…."[2] (Please note that this historic admission policy, although superseded by the Two-Midnight Rule, still appears in the Benefit Policy Manual as of January 1, 2015.)

Over time, this guidance proved problematic for a number of reasons. First, according to CMS, the application of the policy varied widely among hospitals, causing beneficiaries with identical clinical characteristics to be assigned a different patient status (inpatient or outpatient)—and to incur a different cost—depending on the hospital. Second, beginning in 2011, RAC auditors began to review short-stay inpatient admissions and increasingly alleged that, although in many cases the patient may have received

medically necessary services, the patient should have been cared for as an outpatient. These RAC audits highlighted the ambiguity of the Medicare admission criteria and the inadequacy of CMS Part B rebilling policies following Part A denials. In addition, in response to the short-stay denials, hospitals increasingly placed patients in outpatient observation status, often resulting in higher out-of-pocket costs for the beneficiary.

To resolve the issues created by its historic guidance and to standardize hospital admissions for Medicare beneficiaries, CMS adopted the Two-Midnight Rule, effective October 1, 2013. The Two-Midnight Rule provides that an inpatient admission is "generally appropriate" under Part A if the admitting practitioner "expects the patient to require a stay that crosses at least 2 midnights" and admits the patient to the hospital based upon that expectation. Conversely, if the admitting practitioner does not expect the patient to stay for two midnights, then inpatient care would be generally inappropriate. To make this determination, admitting practitioners are expected to consider such factors as patient history, comorbidities, severity of signs and symptoms, current medical needs, and the risk of an adverse event. All relevant factors must be documented in the medical record. For purposes of making the initial two-midnight determination, the admitting practitioner may start the clock at the time the patient receives his/her first outpatient service. All time spent receiving observation services, treatment in the Emergency Department, or other services in outpatient treatment areas may be considered in the two-midnight calculation. Time spent in the waiting room or receiving preliminary triage services (e.g., vital signs) may not be considered.

CMS informed its contractors regarding the application of the Two-Midnight Rule through two separate, but related, policies: the two-midnight presumption and the two-midnight benchmark. Under the presumption, CMS instructs MACs and RACs to presume that inpatient stays are reasonable and necessary—and therefore payable under Part A—if they cross two midnights following the formal patient admission order. Absent evidence of systemic gaming by the hospital, such stays should not be the focus of MAC and RAC medical reviews. If a practitioner admits the beneficiary, but the inpatient stay lasts only 0-1 midnight following the formal patient admission order, CMS and the review contractors will instead apply the two-midnight benchmark. The benchmark requires reviewers to evaluate whether, at the time of the admission order, it was reasonable for the admitting practitioner to expect the beneficiary to require medically necessary services for at least two midnights, taking into account all time spent receiving outpatient services. If the review contractor finds the admission expectation to be reasonable and the medical record supports that decision, Part A payment will be considered appropriate.

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Several limited exceptions to the Two-Midnight Rule exist. Specifically, CMS and the review contractors will consider Part A inpatient payment appropriate, even though the length of stay may be expected to be shorter than two midnights:

- for procedures on the "inpatient only" list, in which cases, length of stay is irrelevant;
- in "rare and unusual circumstances" in which a two-midnight stay is not expected by the admitting practitioner, but inpatient status is nonetheless deemed necessary; and
- in unforeseen circumstances that lead to a short stay, such as death, transfer, or patient departure against medical advice.

Enforcement: Moving from Probe & Educate to full-scale RAC audits

The Two-Midnight Rule was not well-received by the provider community. It was criticized as an effort to usurp the clinical judgment of admitting practitioners and, even though it was intended to clarify CMS's admission policies, it seemed only to muddy the waters. In response to this industry feedback, CMS announced the Probe & Educate program, a focused pre-payment audit program designed to:

- ensure provider understanding of the Two-Midnight Rule,
- offer provider-specific education, and
- correct improper claims as necessary.

The Probe & Educate audits began in November 2013 and encompass claims with dates of admission between October 1, 2013, and April 30, 2015. Within this time period, and using sample sizes of 10 claims (small hospitals) and 25 claims (large hospitals), MACs are auditing inpatient claims spanning 0–1 midnight after formal patient admission. MACs will deny claims found to be out of compliance with the Two-Midnight Rule and, consistent with the goal of the Probe & Educate program, provide hospitals with feedback regarding the reason(s) for any denials. In addition, based on relatively low error-rate thresholds (i.e., more than one error in a sample of 10 draws "moderate to significant" concern from CMS), hospitals may be subject to additional Probe & Educate audits with increasing claim volumes.

To date, RACs have had no role in Two-Midnight Rule enforcement. CMS prohibited RACs from conducting pre- or post-payment "patient status" claim reviews of claims with dates of admission during the Probe & Educate period. This has allowed hospitals to avoid the scrutiny of contingency-fee driven RACs and to engage with MACs on a less adversarial basis. But the RAC enforcement moratorium ended May 1, 2015, and although RACs are unlikely to take up auditing immediately—they are prohibited from looking backward in their audits—hospital compliance teams nonetheless need to be prepared for the additional scrutiny.

As CMS transitions from MAC Probe & Educate to the possibility of full-scale RAC audits, keep in mind the following tips:

- It was likely a shock to the (compliance) system to go from adversarial interactions with MACs/RACs to cooperative and education-based interactions under the Probe & Educate program. Get ready to flip the switch again. Interactions with RACs are inherently more adversarial, and compliance teams need to be ready not just to explain how they comply with the Two-Midnight Rule, but to *defend* their compliance as well.
- Hospitals have been frustrated by the level of subjectivity in the Probe & Educate reviews. Evaluating compliance with the two-midnight benchmark ultimately depends on clinical judgment, and the clinical basis for the admission can be subject to debate. The best way to combat the subjectivity is to have comprehensive documentation in the medical record. Requiring the admitting practitioner to attest explicitly to Two-Midnight Rule compliance is one option (although it is *not* mandated by CMS), but ultimately, the depth and

descriptiveness of the clinical support will short-circuit the MACs' arguments. Training physicians and other admitting practitioners on the scope of the required documentation is essential.

- Remember that meeting admission criteria, including Interqual or Milliman criteria, is no longer sufficient support for an inpatient admission. Despite the longstanding use of these criteria, CMS and the contractors will expect to see support in the medical record to justify the expectation that the patient's stay would cross two midnights.
- CMS and a number of MACs have published lists of the most common errors found during the Probe & Educate audits. Even if a hospital performs well on its initial Probe & Educate audit, compliance teams can and should still use these lists to identify shortcomings and to improve processes internally.
- One silver lining of the Probe & Educate program is the rare opportunity to develop relationships with MAC personnel in a non-adversarial context. To the extent you have developed a good working relationship with the MAC, maintain it. It will only serve the hospital and the entire compliance team well to have a close contact at the MAC for Two-Midnight Rule issues or any other issue that may arise in the future.

Looking ahead

Lest the industry get too comfortable with the Two-Midnight Rule, an ongoing court case and recently proposed federal legislation may result in further changes to the inpatient admission policy. Fortunately for hospitals, the case and the legislation are driven by the provider industry, so any changes are likely to be in the hospitals' favor.

In the case, in which competing motions for summary judgment are still pending, numerous hospitals along with the American Hospital Association are challenging the 0.2% rate cut imposed by CMS in connection with the Two-Midnight Rule.[3] The rate cut is based upon CMS's assumption that it would be required to pay hospitals an additional $220 million annually because of the Two-Midnight Rule. The hospitals, by contrast, estimate the new policy will lead to a $200 million *reduction* in annual payments. If the hospitals are victorious, the Two-Midnight Rule itself would not change, but it would call into question the assumptions made by CMS in cutting rates and may offer a basis for further challenge.

In addition, as of the date this publication went to print, Congress continues to debate the Medicare Access and CHIP Reauthorization Act of 2015, which would extend the RAC enforcement moratorium for an additional five months through September 30, 2015. Compliance officers will need to keep a close eye on this legislation to determine if and when the RAC audits will begin.

Conclusion

The only thing constant in the implementation of the Two-Midnight Rule has been change. Without question, compliance officers have played a key role thus far in managing the changes, training workforce members, and understanding the implications for hospital operations. In 2015, compliance officers will need to double-down on these efforts to prepare for RAC audits and to stay abreast of the changes that are almost certain to come.

1. 78 Fed. Reg. 50496, 50944-50952. August 19, 2013. Available at http://bit.ly/1DskdEA
2. Medicare Benefit Policy Manual, Chapter 1, § 10.
3. *Shands Jacksonville Medical Center et al. v. Sylvia Mathews Burwell et al.*, Case No. CIV-14-263-EGS Summary Judgment filed September 15, 2014 in District Court for the District of Columbia.