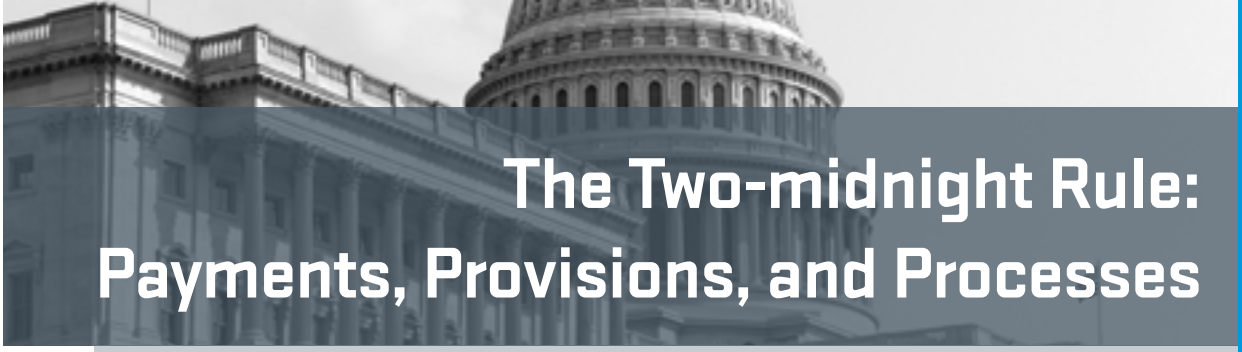

The Two-midnight Rule: Payments, Provisions, and Processes

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CMS never rescinded the Two-midnight Rule.

Overview

After a decision by a Federal District Court in September 2015, the Centers for Medicare and Medicaid Services (CMS) announced in April 2016, that it has decided to rescind an across the board inpatient payment rate cut that was imposed. This decision only affects this across the board reduction in inpatient reimbursement. The decision in no way affects the implementation of the Two-midnight Rule or the overpayment recoveries that CMS will pursue for those providers not following the rule.

Below is a breakdown of the Two-midnight Rule: payments, provisions, and processes.

Payments

Background

The Medicare Inpatient Prospective Payment System (IPPS) is based on Diagnosis Related Group (DRG) payments. DRG payments are supposed to reflect the average cost of inpatient care resulting in a payment methodology that aligns hospital and payer interests in care that is provided within an appropriately timed stay in the hospital. The inpatient payment system was designed to function along with a payment system for outpatient care, to appropriately provide different care setting options and to balance payments for patients depending on the level of care needed.

Unfortunately, CMS and other payers' experience was that patient levels of care were often inappropriately categorized resulting in inaccurate payments and patient cost sharing. CMS had concerns that beneficiary Medicare Part A and Part B benefits were being applied inconsistently and began seeking a solution.

The Rule

CMS proposed a solution to the problem of inappropriate care levels with changes to the 2014 Inpatient Prospective Payment System (IPPS) Final Rule that became effective in October 2013. The solution, known as the Two-midnight Rule, was to declare that hospital based care where the patient's stay did not span two midnights would be "generally" considered appropriate for outpatient "observation" level of care and inappropriate for Medicare Part A inpatient reimbursement. There was a provision that allowed for billing inpatient care if the treating practitioner determined that there was an expectation that the hospital stay would exceed two midnights AND if the information documented in the medical record supported that expectation. These exceptions were to be "rare and unusual" according to CMS.

Consequences

The CMS Two-midnight Rule generated significant complaints and concern from all parts of the healthcare system. After hearing the complaints (and with the help of a congressional mandate), CMS suspended financial enforcement of the Two-midnight Rule. Instead CMS used federal Medicare Administrative Contractors (the MACs) to perform "probe and educate" audits of hospitals to look for compliance with the rule. Many health plans suspended their efforts to control "short stay" hospitalizations while waiting for clarification from CMS. It is important to note that CMS never rescinded the Two-midnight Rule and hospitals were still expected to comply with the rule, even though financial penalties were not imposed.

Provisions

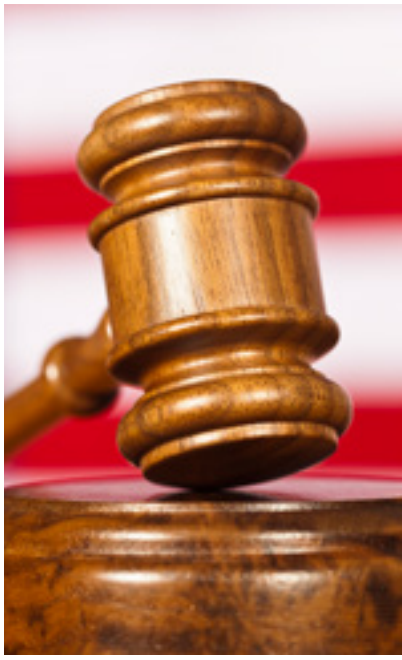
CMS included changes to the Two-midnight Rule, clarifying when inpatient admissions were appropriate for payment under Medicare Part A, in the 2016 Outpatient Prospective Payment System (OPPS) Final Rule that was released on October 30, 2015. CMS will be instituting financial enforcement of the Two-midnight Rule as it applies to inpatient payments under Medicare Part A. Most of the original 2013 Two-midnight Rule program did not change but there were some new revisions outlined in the Final Rule document to the CMS program. Key ongoing provisions of the current Two-midnight Rule and significant revisions are outlined below.

Ongoing

- As previously stated in the rule, inpatient admissions are generally payable under Medicare Part A if the admitting practitioner ordering an inpatient admission documents that they reasonably expect that the patient's condition will require a hospital stay that crosses two midnights AND the medical record documentation supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays expected to last less than two midnights. Exceptions to this are if patients are admitted for a procedure on the Medicare "inpatient only" list or that were identified as rare and unusual exceptions. Currently only newly initiated mechanical ventilation is recognized as an approved "rare and unusual exception" by CMS.
- CMS medical reviews will continue to be based on the clinical judgement of the reviewer involving synthesis of all submitted medical record information to establish whether the expectation of a two-midnight stay or case-by-case inpatient admission decision met CMS guidelines and whether the care was reasonable and necessary. Although commercially available screening tools and guidelines can be used to help guide decision making of the reviewer, such tools are not binding to hospitals or CMS. Although CMS reviewers will take into consideration the physician's decision to admit a beneficiary, the admission and care furnished must be reasonable and necessary and supported by clear documentation in the patient's medical record in order to be covered under Medicare Part A.
- CMS requires that a valid inpatient order for hospital inpatient care in order for care to receive payment under Medicare Part A components of a valid inpatient order include:
  - The order must clearly specify that inpatient care is being ordered (although no specific language is required);
  - The order must come from a qualified practitioner who is licensed by the state to admit inpatient to hospitals, granted inpatient admitting privileges by the specific facility;
  - The order must come from a practitioner knowledgeable about the patient's hospital course, plan of care and current condition at the time of admission; and
  - Inpatient orders must be signed or co-signed prior to the patient's discharge in order to be valid.

Revisions

- *In a revision of the policy,* cases where the admitting physician expects a stay that will not cross two midnights but believes that the patient requires inpatient admission, may be considered on a case-by-case basis after medical review if the physician determines based on their clinical judgment due to the condition of the patient and documents in the medical record that an inpatient admission is required. CMS states that these cases will be prioritized for medical review.
- *In a revision of the policy,* CMS made changes to medical review responsibilities. CMS is having the Quality Improvement Organizations (QIOs) provide the initial medical reviews of short-stay admissions rather than Recovery Audit Contractors (RACs). QIOs will be responsible to review whether inpatient services were reasonable and necessary and whether services provided as an inpatient could have been appropriately and effectively provided on an outpatient basis. QIOs will review cases and refer findings to the MACs for payment



adjustments. Providers with high denial rates for failing to adhere to the Two-midnight Rule or failing to improve their performance after QIO educational intervention will be referred to the RACs for further medical review.

- *In a revision of the policy,* CMS changed the lookback period for medical review to six months from date of service in order to allow hospitals the opportunity to re-bill for outpatient services when their inpatient service request is denied.

- *April 2016 update*

  - After a decision by a Federal District Court in September 2015 the CMS announced in April 2016, that it has decided to rescind an across the board inpatient payment rate cut that was imposed. The decision to drop the proposed cut came after a September 2015 ruling in Shands Jacksonville Medical Center v. Burwell. The case concerned a legal challenge by hospitals to a 0.2% across the board reduction for inpatient services that was designed to offset increased costs to Medicare projected by CMS as a result of a shift to observation stays by hospitals as a result of the CMS Two-midnight Rule. Hospitals contended that the payment reduction was based on faulty analysis and did not follow the usual CMS process allowing for review and comments.

  - CMS stated that, "We still believe the assumptions underlying the 0.2% reduction to the rates put in place beginning in fiscal year 2014 were reasonable at the time we made them in 2013. Nevertheless, taking all the foregoing factors into account, in the context of this case, we believe it would be appropriate … to prospectively remove, beginning in 2017, the 0.2% reduction."

  - This decision only affects this across the board reduction in inpatient reimbursement. The decision in no way affects the implementation of the Two-midnight Rule or the overpayment recoveries that CMS will pursue for those providers not following the rule.

  - HMS clients who are using the CMS Two-midnight Rule as the basis for their short stay/place of service audit are unaffected by this CMS decision and should not anticipate making any changes to their program as a result of this announcement.

Processes

HMS believes that overpayments resulting from inappropriate billing of short-stay hospital inpatient admissions will continue to be a significant medical cost driver for health plans. HMS recommends that all clients establish or continue a vigorous short-stay/place of service review program. HMS believes that the CMS Medicare Fee For Service (FFS) program provides a credible model and authority for clients in establishing short-stay/place of service review programs for their Medicare Advantage, Managed Medicaid (in the absence of contrary specific state Medicaid program guidance) and commercial lines of business where DRG prospective payment systems are used for inpatient hospital care reimbursement.

The HMS standard program for short stay/place of service reviews includes the following key processes consistent with the CMS model:

- Implement appropriate revisions when needed to health plan hospital authorization processes to assure that short-stay/place of service reviews meet contractual, accreditation and regulatory requirements.

- Pursue data- and analytics-driven targeting of cases for medical record review of short stay hospital admissions.

- Review valid inpatient orders (as defined above) from qualified practitioners in order to pay for inpatient hospital stays. Admissions without a valid inpatient order will be denied reimbursement for inpatient care.

- Review the medical record for physician documentation that there was an expectation of an inpatient hospital stay that would cross two midnights AND confirm the documentation in the medical record supports that expectation. Exceptions are made when patient is admitted for an "inpatient only" listed procedure or new initiation of mechanical ventilation.

- Review the medical record in cases where the admitting physician does not expect a stay of at least two midnights, but uses clinical judgement to decide that the patient requires inpatient admission to the hospital and confirm that judgement is appropriately supported in the medical record documentation.
- As specified by CMS, HMS uses reviewer's clinical review judgement for medical review rather than commercially available clinical screening tools. HMS medical review is based on information documented in the medical record and available to the admitting practitioner at or around the time that the inpatient admission decision was made. Review parameters include the severity of presenting complaints, physical exam findings, and diagnostic testing results, relevant patient co-morbidities that might increase the risk of significant adverse events, initial responses to therapy and the patient's course during the emergency room or other outpatient care.
- HMS agrees with CMS that commercially available clinical screening tools are not adequate to review the appropriateness of the complex decision to admit a patient to inpatient status and does not recommend their use. Despite this recommendation, HMS will honor client requests to use specific clinical screening tools to evaluate short-stay hospital admissions.
- HMS will work with clients to accommodate those who wish to change review "look back" periods when clients wish to allow hospitals the opportunity to re-bill for outpatient services in the event that inpatient services were found to be inappropriate.

Summary

HMS promotes and performs the appropriate review of questionable short-stay hospital admissions consistent with CMS FFS policy. Recent changes to and full implementation of the CMS Two-midnight Rule should remove uncertainty and provides a model health plans can follow to perform such reviews in a way that is consistent with CMS guidance. HMS strongly encourages all clients to engage such a program.

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HMS uses reviewer's clinical review judgement for medical review rather than commercially available clinical screening tools.

Learn more about how our cost containment solutions can help you at hms.com.