

2-MIDNIGHT RULE UPDATE: HOSPITALS MUST CONTINUE IMPLEMENTATION OF THE 2-MIDNIGHT RULE¹

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On August 2, 2013, the Centers for Medicare & Medicaid Services (“CMS”) released its 2014 Inpatient Prospective Payment System Final Rule (the “2014 IPPS Final Rule”), which became effective on October 1, 2013.² The 2014 IPPS Final Rule revised CMS’s reimbursement criteria for Part A inpatient hospital claims, creating new guidelines to establish the medical necessity of inpatient hospital admissions (i.e., instituting the “2-midnight rule”)³ and clarifying CMS’s documentation requirements related to physician inpatient admission orders⁴ and certifications – both now conditions of Medicare Part A payment.⁵ Following the effective date of the 2014 IPPS Final Rule, CMS established a *pre-payment* medical review program, known as the “probe and educate” medical review program, designed to identify and correct claims improperly billed and to provide education to hospitals implementing the requirements of the 2014 IPPS Final Rule.

Probe and Educate Medical Review

The probe and educate medical review program was announced on November 4, 2013 and was initially planned to cover Medicare Part A inpatient hospital claims with dates of admission between October 1, 2013 and March 31, 2014. On January 31, 2014 the probe and educate program was extended for an additional six months to cover claims with admission dates from October 1, 2013 through September 30, 2014. **Despite**

misleading industry guidance to the contrary, by extending its probe and educate medical review program, CMS did not delay the effective date of the 2014 IPPS Final Rule. In fact, for dates of admission between October 1, 2013 and September 30, 2014, Medicare Administrative Contractors (“MACs”) are specifically tasked to conduct pre-payment medical reviews of a sample of each hospital’s Medicare Part A inpatient claims (i.e., between 10 and 25 claims, depending on hospital size), for hospital stays crossing 0-1 midnight,⁶ for the purpose of determining a hospital’s compliance with the provisions of the 2014 IPPS Final Rule.⁷ If a hospital is out of compliance, additional reviews will take place.⁸ Medical review will focus on hospitals’ compliance with the following three requirements contained in the 2014 IPPS Final Rule: (1) order, (2) certification, and (3) the 2-midnight benchmark⁹ (i.e., whether the patient was appropriately admitted as an inpatient, or “patient status review(s)").¹⁰

During the probe and educate medical review time period (i.e., for Part A inpatient hospital claims covering admissions between October 1, 2013 and September 30, 2014), Medicare review contractors (including Recovery Auditors and SMRCs)¹¹ generally are prohibited from conducting post-payment patient status reviews.¹² However, Medicare review contractors may continue other types of post-payment inpatient hospital medical reviews for claims with admission dates within this time period (e.g., coding reviews, reviews for the medical necessity of a procedure). Additionally, Medicare review contractors may continue to conduct patient status reviews for dates of

admission prior to October 1, 2013.¹³

The steps the MACs will take following an initial probe and educate medical review will depend on the audit findings. In each of the following situations (in addition to the permitted activities summarized below), CMS also has permitted MACs to “conduct a limited number of additional reviews if provider billing trends or variances are indicative of abuse, gaming or systematic delays in the submission of claims for the purpose of avoiding the MAC prepayment probe audits during the probe and educate period.”¹⁴

- If “No or Minor Concerns”¹⁵ are identified during the probe and educate medical review process, then probe and educate medical reviews will cease. The non-compliant claims will be denied, and a summary letter will be sent to the hospital explaining the reason for denial. The summary letter will indicate that the hospital will remain subject to standard data analysis and corresponding review.¹⁶
- If “Moderate to Significant Concerns”¹⁷ are identified during the probe and educate medical review process, then the non-compliant claims will be denied, and a detailed Review Results letter will be sent to the hospital explaining each denial. In addition, a summary letter will be sent to the hospital, offering the provider a one-on-one phone call to discuss the audit findings and informing the hospital that a repeat probe and educate review of an additional 10 or 25 claims with dates of admission from October 1, 2013 through September 30, 2014 will take place.¹⁸
- If “Major Concerns”¹⁹ are identified during the probe and educate

medical review, then the non-compliant claims will be denied and detailed Review Results letters explaining each denial will be issued. Additionally, a summary letter will be sent to the hospital, offering the hospital a one-on-one phone call to discuss the audit findings and notifying the hospital that a repeat probe and educate review of an additional 10 or 25 claims with dates of admission from October 1, 2013 through September 30, 2014 will take place. If improper claims submission findings persist, then a repeat probe and educate review with an increased claim volume of 100-250 claims will take place.²⁰

Probe and educate medical reviews are presently underway. On February 24, 2014, CMS issued initial results based on the MACs' early reviews. Generally speaking, the cited examples of common denials made so far in the probe and educate medical review process include denials based on clear failures to implement the requirements of the 2014 IPPS Final Rule. Cited examples of common denials include the following:

- Missing or flawed orders for inpatient admission;
- Admissions for procedures where the expectation of a 2-midnight stay for hospital care was not supported (e.g., a patient discharged 10 hours following a pre-procedure inpatient admission);
- Admissions for medical conditions where the expectation of a 2-midnight stay for hospital care was not supported (e.g., documentation reflects an expectation to discharge after "monitoring overnight" – clearly reflecting an expectation for a hospital stay crossing 1 midnight); and
- Records containing physician attestation statements of an expectation of a hospital stay crossing 2 midnights without any supporting

documentation of this expectation in the records.²¹

Time will tell whether ongoing denials made in the probe and educate medical review process will involve less straightforward issues. For example, consider whether the audit findings would change if example (2) above involved an admission for a procedure not on the inpatient-only list performed without complication but the corresponding hospital stay spanned nearly 2 midnights. Sub-regulatory guidance that attempts to explain CMS' position on "delays in the provision of care" leaves significant room for interpretation: "CMS expects Medicare review contractors will exclude extensive delays in the provision of medically necessary services from the 2 midnight benchmark. Medicare review contractors will only count the time in which the beneficiary received medically necessary hospital services."²²

Sub-Regulatory Guidance

Following publication of the 2014 IPPS Final Rule, CMS published several sub-regulatory guidance documents in an effort to clarify its expectations. The sub-regulatory guidance has not altered the basic requirements set forth in the 2014 IPPS Final Rule related to inpatient admissions (i.e., requirements for orders, certifications, and (with certain narrow exceptions) inpatient admission decisions based on the admitting physicians' expectation of patients' need for hospital care crossing 2 midnights or to undergo an inpatient-only procedure). However, certain details with respect to the core requirements have changed over the course of the various publications. The sub-regulatory guidance documents include the following:

- Hospital Inpatient Admission Order and Certification dated September 5, 2013;

- Hospital Inpatient Admission Order and Certification dated January 30, 2014;
- Frequently Asked Questions: 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013 (last updated 03/12/2014);
- Selecting Hospital Claims for Patient Status Reviews: Admissions on or after October 1, 2013 (last updated 02/24/2014);
- Reviewing Hospital Claims for Patient Status: Admissions on or after October 1, 2013 (last updated 03/12/2014); and
- Medicare Inpatient Hospital Probe and Educate Status Update, February 24, 2014.²³

The evolving sub-regulatory guidance has created confusion among hospitals attempting to comply with the 2014 IPPS Final Rule requirements. For example, in certain circumstances (e.g., authorized practitioners to complete inpatient admission orders, content of inpatient admission orders), the sub-regulatory guidance has been inconsistent. Additionally, the evolving sub-regulatory guidance appears to have created confusion for (or at the very least, inconsistencies among) the MACs enforcing the 2014 IPPS Final Rule conducting probe and educate medical reviews. Therefore, contemporaneously with its updated guidance issued on February 24, 2014, CMS directed the MACs to re-review all claim denials made prior to January 30, 2014 under the probe and educate medical review program to ensure that the denials (and any subsequent education) were consistent with the most-recent sub-regulatory guidance. CMS authorized the MACs to reverse any previous denials outside of the Medicare appeals process; additionally, CMS waived the 120-day timeframe for filing redetermination requests for denials made as part of probe and educate medical review prior to January

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30, 2014, provided that such appeal is submitted before September 30, 2014.²⁴

The most-recent sub-regulatory guidance covering the topic “Hospital Inpatient Admission Order and Certification” dated January 30, 2014 clarifies the following:

- **Orders:**²⁵ To be qualified to issue an inpatient admission order, an ordering practitioner must be “(a) licensed by the state to admit inpatients to hospitals; (b) granted privileges by the hospital to admit inpatients to that specific facility; and (c) knowledgeable about the patient’s hospital course, medical plan of care and current condition at the time of admission.”²⁶

With respect to its guidance surrounding inpatient admission orders, the January 30, 2014 sub-regulatory guidance is mainly consistent with the sub-regulatory guidance published on September 5, 2013, with at least one noteworthy exception. With respect to residents and non-physician practitioners who are (a) authorized by the state in which the hospital is located to admit patients as inpatients and are (b) allowed by hospital bylaws to admit patients as inpatients (and who arguably would meet the part (c) knowledge requirement regarding the patient’s hospital course, medical plan of care and condition at the time of admission), the January 30, 2014 sub-regulatory guidance does not permit these individuals to admit a patient to the hospital as an inpatient in their own right. Rather, these individuals may only admit a patient as an inpatient “as a proxy for the ordering practitioner.”²⁷ The sub-regulatory guidance specifies that “[t]he ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner

approves and accepts responsibility for the admission decision by counter-signing the order prior to discharge.”²⁸

- **Certifications:**²⁹ CMS has stated that with respect to the requirement for certification of the inpatient admission as a requirement of payment, CMS is “not finalizing new documentation requirements.”³⁰ Although certification statements must be documented via a separate signed statement within the medical record, a specific form is not required to satisfy the certification requirements.³¹ Certification statements may be present on any documentation within the patient file as long as the method chosen permits verification.³²

The September 5, 2013 sub-regulatory guidance contains a sub-heading entitled “Default Methodology for Initial Certification,” and indicates that in the absence of a specific certification form, CMS and its contractors will look for the requisite elements within the medical file (e.g., the inpatient order, diagnosis, plan, discharge planning instructions, etc.).³³ Notably, this portion of the sub-regulatory guidance is removed from the January 30, 2014 document.³⁴ As it is clear that medical review intends to focus at least in part on hospitals’ compliance with the certification requirements, it makes practical sense from a compliance perspective for hospitals to require a certification form to be signed and dated prior to patients’ discharge to avoid unnecessary denials based on certification.

Sub-regulatory guidance (as updated on February 24, 2014) provides additional clarification regarding medical review policies, including guidance regarding what time will be counted towards the 2-midnight benchmark.³⁵ For example, with respect to patient

transfers, the Frequently Asked Questions document specifies that with respect to patients transferred from another hospital, the receiving hospital may take into account pre-transfer time the patient received care at the initial hospital. However, the receiving hospital should take caution when billing “close call” hospitalizations as inpatient claims, as CMS specifies that “[a]ny excessive wait times or the time spent in the hospital for non-medically necessary services shall be excluded from the physician’s admission decision.... Claim submissions for transfer cases will be monitored and any billing aberrancy identified by CMS or the Medicare review contractors may be subject to targeted review.”³⁶

S. 2082: Two-Midnight Rule Coordination and Improvement Act of 2014

On March 5, 2014, U.S. Senators Robert Menendez (D-NJ) and Deb Fischer (R-NE)³⁷ introduced the Two-Midnight Rule Coordination and Improvement Act of 2014 (S. 2082) to the U.S. Senate. In introducing S. 2082, Senator Menendez cited the need to resolve “fundamental issues” with respect to the 2-midnight rule, and Senator Fischer cited the need for a “reasonable bipartisan measure to help prevent another instance of the federal government coming in between patients and their doctors. Importantly, our bill also provides CMS with needed time to develop an alternative system that helps, and doesn’t hinder, the ability of these hospitals to provide care to the patients they treat.”³⁸

If enacted, this legislation would require the following:

- CMS, in consultation with interested stakeholders, to develop criteria for coverage of short inpatient hospital stays, accounting for the medical

necessity and appropriateness of an inpatient stay crossing less than 2 midnights;³⁹

- CMS to develop a payment methodology for short inpatient hospital stays;⁴⁰
- CMS to develop a crosswalk of ICD-10 codes and CPT codes as well as a crosswalk of DRG and CPT codes to permit hospitals to compare inpatient hospital services and outpatient services;⁴¹
- A delay in enforcement of the 2-midnight rule (with the exception of probe and educate reviews, which are permitted under the legislation);⁴²

The Senate bill has been referred to the U.S. Senate Committee on Finance.⁴³

On March 6, 2014, Richard Pollock, Executive Vice President of the American Hospital Association (“AHA”), on behalf of the AHA’s membership, drafted a letter reflecting the AHA’s support for the Two-Midnight Rule Coordination and Improvement Act of 2014. The correspondence cited hospitals’ need for additional time prior to implementation of the 2-midnight rule, in order to update internal policies and electronic medical records in order to come into compliance, as well as hospitals’ need for additional and clearer guidance from CMS.⁴⁴

Conclusion

It is essential that physicians are educated regarding the documentation requirements for which they are responsible under the 2014 IPPS Final Rule. CMS guidelines are evolving. Healthcare counsel representing hospitals must devote resources to closely monitor the CMS “Inpatient Hospital Review” website as CMS works to finalize its guidance related to the 2014 IPPS Final Rule.



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Endnotes

¹ This article updates an article that previously appeared in the December 2013 issue of *The Health Lawyer*. See Jessica L. Gustafson, Esq. and Abby Pendleton, Esq., “Billing for and Appealing Denials of Inpatient Hospital Services: Where have we been? Where are we now? What does the future hold?” Vol. 26, No. 2, December 2013, available at http://www.americanbar.org/tools/digitalasset/abstract.html/content/dam/aba/publishing/health_lawyer/health_mo_premium_hl_healthlawyer_v26_2602.pdf.

² See 78 Fed. Reg. 50496 *et seq.* (August 19, 2014).

³ See 42 C.F.R. § 412.3 (e) (1):

Except as specified in paragraph (e)(2) of this section, when a patient enters a hospital for a surgical procedure not specified by Medicare as inpatient only under § 419.22(n) of this chapter, a diagnostic test, or any other treatment, and the physician expects to keep the patient in the hospital for only a limited period of time that does not cross 2 midnights, the services are generally **inappropriate** for inpatient admission and inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed.

Surgical procedures, diagnostic tests, and other treatment are generally **appropriate** for inpatient admission and inpatient hospital

payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights...(Emphasis added.)

⁴ 42 C.F.R. § 412.3.

⁵ 42 C.F.R. § 424.11.

⁶ CMS has directed the MACs to apply the 2-midnight “presumption” in conducting patient status reviews: “CMS will direct MACs NOT to focus their medical review efforts on stays spanning at least 2 midnights after admission absent evidence of systematic gaming, abuse, or delays in the provision of care...” See *Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013* (Last Updated: 02/24/2014), available at <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/SelectingHospitalClaimsForAdmissionsForPosting02242014.pdf>.

⁷ See *Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013* (Last Updated: 02/24/2014), available at <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/SelectingHospitalClaimsForAdmissionsForPosting02242014.pdf>.

⁸ *Id.*

⁹ The 2014 IPPS Final Rule summarizes the application of the benchmark as follows:

Medical reviewers will consider the fact that the beneficiary was in the hospital for greater than 2 midnights following the onset of care when making the determination of whether the inpatient stay was reasonable and necessary. For those admissions in which the basis for the physician expectation of care surpassing 2 midnights is reasonable and well-documented, reviewers may apply the 2-midnight benchmark to incorporate all time receiving care in the hospital.

78 Fed. Reg. at 50952.

¹⁰ *Id.*

¹¹ Medicare “review contractors” include all of the following:

- Comprehensive Error Rate Testing (“CERT”) auditors, tasked to measure improper payments in the Medicare fee-for-service (“FFS”) program (see www.cms.gov/CERT);

- Medicare Administrative Contractor (“MAC”) medical reviewers;

- Recovery auditors (formerly known as Recovery Audit Contractors (“RACs”)), tasked to identify and correct improper payments in the Medicare program (see www.cms.gov/RAC);

- Program Safeguard Contractors (“PSCs”) and Zone Program Integrity Contractors (“ZPICs”), tasked to prevent, detect and deter incidences of fraud and abuse in the Medicare program (See Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 4, § 4.2.2.2), which soon will be rolled into the forthcoming Unified Program Integrity Contractors (“UPICs”); and

- Supplemental Medical Review Contractors

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