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Practice Group:

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CMS Issues New Guidance on 2-Midnights Standard and Delays Audits

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Centers for Medicare and Medicaid Services (CMS) finalized a new rule, effective October 1, 2013, under which hospital inpatient admissions are considered reasonable and medically necessary if the physician expects a patient's stay to cross two midnights.[1] Conversely, under the new 2-midnight standard, an inpatient admission is generally deemed inappropriate if the admitted physician expects the patient will need care for only a limited amount of time that does not cross 2 midnights. Additionally, CMS established "two distinct, though related" policies under which hospital inpatient admissions are reviewed: a 2-midnight presumption and a 2-midnight benchmark. [2]

Two-Midnight Presumption

Under the 2-midnight presumption, hospital inpatient admissions are entitled to a presumption that the admission was reasonable and necessary if a beneficiary receiving medically necessary services requires more than one Medicare utilization day (an encounter crossing 2 "midnights") as an inpatient.[3] Thus, medical reviewers, such as Medicare Administrative Contractors (MACs) and Recovery Auditors, should presume that inpatient hospital claims with lengths of stay greater than two midnights after the time of the admission order are appropriate. Stays crossing two midnights "will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the 2-midnight presumption."[4]

The Two-Midnight Benchmark

Under the 2-midnight benchmark, inpatient admissions are considered reasonable and necessary if it was reasonable for the admitting physician to expect, at the time of admission, that the patient's stay in the hospital would cross two midnights.[5] CMS has instructed contractors to evaluate whether the medical documentation supports that the physician reasonably expected, at the time of inpatient admission, that the patient's *total stay* in the hospital would cross two midnights, including time spent receiving services in the emergency department or in observation based only on information available to the admitting physician at the time of admission.[6]

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[1] CMS, Medicare Program Hospital IPPS FY 2014 Final Rule, 78 Fed. Reg. 50495 (August 19, 2013); 42 C.F.R. § 412.3(e)(1).

[2] 78 Fed. Reg. at 50949.

[3] *Id.*

[4] *Id*.

[5] 78 Fed. Reg. at 50949-50.

[6] 78 Fed. Reg. at 50946, 50949-52.

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New Guidance

On November 1, 2013, CMS updated its Frequently Asked Questions and issued new guidance on this standard.[7] Notably, CMS extended the time period during which Recovery Auditors are not permitted to review inpatient admissions crossing zero to one midnight. This period now extends through March 31, 2014.[8] CMS explained that until the grace period ending on April 1, 2014, MACs will conduct a prepayment review of Medicare Part A claims that span zero to one midnight to determine hospitals' compliance with the new rule and provide feedback to CMS for education and guidance purposes. CMS is limiting these prepayment record reviews to 10 claim samples for most hospitals to 25 claim samples for large hospitals. Non-compliant claims will be denied and MACs are directed to call providers with "moderate to significant or major concerns" regarding inpatient admission billing patterns to discuss the denial, answer questions, and provide education and pertinent reference material.

CMS also made the following clarifications:

- *Greater than 2 midnight stays only subject to review for gaming and abuse.* CMS reiterated that it will instruct MACs and Recovery Auditors not to review claims that span more than two midnights after admission, absent evidence of gaming or abuse. Review contractors will, however, continue to review inpatient stays that cross 2 midnights for that purpose -- to monitor for patterns of gaming, such as delaying care or providing inappropriate care. CMS clarified in separate guidance that MACs have been instructed to identify such improper Medicare payment activity though its probe reviews and data gathered by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM), and Program for Evaluating Payment Patterns Electronic Report (PEPPER).[9] CMS plans to shift reviewers' attention to the anticipated smaller volume of short inpatient stays and eventually ramp down review of short stays once hospitals consistently apply the 2-midnight benchmark correctly.
- *Retrospective review not appropriate.* CMS further reiterated that, consistent with CMS' long-standing policy, medical reviewers should not conduct retrospective review of the medical records, but rather evaluate the reasonableness of the physician's expectation that a patient's stay will cross 2 midnights based on the information available to the physician at the time of admission.
- *Start time for calculating the total time of hospital care under the 2-midnight benchmark is start time of care*. CMS clarified that, for inpatient stays that do not cross 2 midnights, review contractors should consider the time that the patient began receiving outpatient services, including services received in the emergency department or under observation and time spent undergoing a procedure, such as in an operating room. It was noted that the time receiving these services cannot be considered inpatient time since there would not be a

[7] CMS, *Frequently Asked Questions, 2 Midnight Inpatient Admission Guidance & Patient Status Review for Admission on or after October 1, 2013*.

[8] *Id.* Initially, CMS stated that Recovery Auditors were prohibited from reviewing such admissions for 90 days after the October 1, 2013 effective date.

[9] CMS, *Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013*.

formal inpatient admission order under these circumstances, but would be taken into account under the 2-midnight benchmark. Time spent in the emergency department waiting room or receiving triage services do not count as the start time under this benchmark. It further noted that hospital care that is for custodial or convenience purposes, such as a hospital stay that crosses 2 midnights due to a delay in a procedure not being immediately available, are excluded under Part A payment as not required for diagnosis or treatment, and thus will not be taken into account under the 2-midnight benchmark.

- *Separate attestations not required*. According to CMS, a separate attestation from the physician regarding the expected length of an inpatient hospital stay is not required or expected. Rather, the medical record should be "rooted in good medical practice," with reasonableness of the physician's expectation for the length of a patient's stay inferred from the physician's standard documentation, including notes, plan of care and treatment orders which outline the patient's age, signs and symptoms, comorbidities, risk for adverse outcome and other factors that influence a physician's decision to admit a patient. CMS noted that utilization committee screening decisions are not binding on CMS or the review contractors, and that the review contractors will evaluate the reasonableness of the physician's inpatient admission decision based on the medical record.
- *Hospital care less than 2 midnights warrants inpatient status only in rare and unusual circumstances.* Inpatient care for less than 2 midnights will not be considered appropriate for inpatient admission "absent rare and unusual circumstances to be further detailed in sub-regulatory instruction."[10] CMS stated that, in addition to a beneficiary's death, transfer, or departure against medical advice, many of these circumstances are already identified in the Inpatient Only list. CMS further noted that placing a patient in a telemetry or ICU unit, without more, does not qualify as a rare or unusual circumstance. CMS expects to include additional examples of circumstances considered rare and unusual in sub-regulatory guidance as those examples are identified. In such cases, physicians are encouraged to explicitly document in the medical record the reasons why an inpatient admission is warranted despite an expectation that a hospital stay will last less than 2 midnights. The discretion will remain with CMS and the review contractors as to whether the documentation supports the medical necessity of the admission. CMS also encouraged providers to email CMS with additional suggested examples of rare and unusual circumstances warranting exception to the general 2-midnight rule.
- *Denials related to inpatient care not crossing 2 midnights are not automatic.* CMS emphasized that stays lasting less than 2 midnights will not be automatically denied; however, it expects most hospital stays lasting less than 2 midnights will be provided on an outpatient basis.

[10] 78 Fed. Reg. at 50946.

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Conclusion

Denials related to appropriate level of care have been a significant focus of the Recovery Audit Contractor program, and hospital appeals related to such denials have been increasing at a rapid pace in recent years. Hospitals should educate providers on the intricacies of this new rule on the front end in an attempt to avoid future denials and the subsequent costs of the appeal process.

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