2-Midnight Rule:
Implications for Auditor Behavior and Appeal Strategies

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2014 IPPS Final Rule

- CMS published its 2014 Inpatient Prospective Payment System ("IPPS") Final Rule (the "Final Rule") on August 2, 2013.
  - Final Rule was codified in the Federal Register on August 19, 2013, available at 78 Fed. Reg. 50496.
  - **Effective Date: October 1, 2013.**

2014 IPPS Final Rule

- Increased documentation requirements:
  - Physician orders and certifications
  - Establishing medical necessity: 2-midnight rule
    - Medical review policies
      - 2-midnight presumption
      - 2-midnight benchmark

Orders and Certifications

Orders

- Condition of Payment
- 42 C.F.R. § 412.3
- Must be made at or before the time of inpatient admission
- Must specify admission for inpatient services
  - Should include the word “inpatient”
- May be made verbally or in writing

Orders and Certifications

Orders

- Must be made by a physician or other practitioner who is:
  - (a) licensed by the State to admit inpatients to hospitals;
  - (b) granted privileges by the hospital to admit inpatients to that specific facility;
  - (c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission

Orders and Certifications

Orders

- Who has the requisite "knowledge" to admit?
  - The admitting physician of record, or a physician on call for him or her;
  - Primary or covering hospitalists caring for the patient in the hospital;
  - The beneficiary's primary care practitioner or a physician on call for him or her;
  - A surgeon responsible for a major surgical procedure on the beneficiary, or a surgeon on call for him or her;
  - Emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission; and
  - Other practitioners qualified to admit inpatients and actively treating the beneficiary at the point of inpatient admission.

  - ***UR committee physician may sign the required certification, but does not have direct responsibility for the care of the patient and therefore <u>is not considered to be sufficiently knowledgeable to order the IP admission.</u>***

Orders and Certifications

Orders

- Verbal orders
  - The practitioner ***may not*** delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges by the hospital's medical staff.
  - Practitioners lacking the authority to admit patients under either State law or hospital bylaws (e.g., residents, PAs, RNs) may document the hospital admission orders under certain conditions:
    - An admission order (including verbal order) may be documented by an individual who does not possess qualifications to admit patients ***following a discussion with and at the direction of the ordering practitioner;***
    - The documentation of the order (transcription) must be in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules and regulations.
    - The order must identify the qualified "ordering practitioner"
    - The order must be authenticated (signed, dated and timed) by the ordering practitioner or by another practitioner with the required admitting qualifications prior to the patient's discharge or earlier if required by State law or hospital policy.
      - In these cases, the ordering practitioner need not separately record the order to admit.

Orders and Certifications

Orders

- The ordering practitioner may be, but is not required to be, the physician who signs the certification.

Orders and Certifications

Certifications

- Condition of payment
- 42 C.F.R. § 424.13
- The Final Rule creates a requirement that physicians complete certifications of the medical necessity of IP admissions for all IP admissions
  - Requirement for certification is not limited to longer hospital stays and outlier cases

Orders and Certifications

Certifications

- Required elements:
  - Order to IP status
  - The reasons for either the hospitalization (i.e., the diagnosis) or special or unusual services for cost outlier cases
  - The estimated time the patient will need to remain in the hospital;
  - Plans for post-hospital care; and
  - CAHs: For inpatient CAH services, the physician must certify the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH

Orders and Certifications

Certifications

- The certification must be completed, signed, and documented in the medical record **prior to a patient's discharge**
  - Because the admission order is a requisite component of the certification, for the purposes of efficiency, it would make operational sense for admitting physicians to complete the order and certification contemporaneously at the time of admission.

Orders and Certifications

Certifications

- May only be signed by:
  - (1) A physician who is a MD or DO
  - (2) A dentist in the circumstances specified in 42 C.F.R. 424.13(d).
  - (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.
- Must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff
  - *UR Committee physician <u>is</u> permitted to complete the certification.*

Orders and Certifications

Certifications

- No specific forms are required for certification and recertification statements.
- The provider may adopt **any method that permits verification.**
  - Certifications may be made on forms, notes or records that the appropriate individual signs *or* on a special separate form
  - Except as provided for delayed certifications, **there must be a separate signed statement for each certification or recertification**

Orders and Certifications

Certifications

- In the absence of specific certification forms, the default methodology to determine a hospital's compliance with certification requirements is as follows:
  - (a) The authentication requirement for the practitioner order will be met by the signature or countersignature of the inpatient admission order by a physician meeting the requirements of a certifying physician;
  - (b) The requirement to certify the reasons that inpatient hospital services are or were medically necessary will be met either by the diagnosis and plan documented in the inpatient admission assessment or by the inpatient admitting diagnosis and orders;
  - (c) The estimated time requirement will be met by the inpatient admission order written in accordance with the 2-midnight benchmark, supplemented by physician notes and discharge planning instructions;
  - (d) The post-hospital care plan requirement will be met either by physician notes or by discharge planning instructions.

CMS sub-regulatory guidance dated September 5, 2013, "Hospital Inpatient Admission Order and Certification," *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-09-05-13.pdf.

Orders and Certifications

Orders and Certifications

- Although admission orders are required for payment, no presumptive weight will be given to physician orders and certifications.
  - Orders and certifications must be supported by the admission notes and progress notes.

Establishing Medical Necessity
2-Midnight Rule

- 42 C.F.R. § 412.3 (e)
  - When a patient enters a hospital for a surgical procedure not specified by Medicare as IP only, 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.
  - Surgical procedures, diagnostic tests, and other treatment are generally appropriate for IP admission and IP hospital payment under Medicare Part A when the physician *expects* to the patient to require a stay that crosses at least 2 midnights.

Establishing Medical Necessity: Medical Review
2-Midnight Presumption

- Under the 2-midnight *presumption,* IP claims with lengths of stay greater than 2 midnights after the formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absence evidence of systemic gaming, abuse or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.

Establishing Medical Necessity: Medical Review
2-Midnight Presumption

- Inpatient hospital claims satisfying the 2-midnight presumption will still be assessed by medical review contractors in the following circumstances:
  - (1) To ensure the services provided were medically necessary;
  - (2) To ensure that the hospitalization was medically necessary;
  - (3) To validate provider coding and documentation;
  - (4) When a CERT Contractor is directed to review such claims;
  - (5) If directed by CMS or other entity to review such claims.

- *Per the Final Rule at p. 50951: "We note that it was not our intent to suggest that a 2-midnight stay was presumptive evidence that the stay at the hospital was necessary; rather, only that* **if** *the stay was necessary, it was appropriately provided as an inpatient stay… [S]ome medical review is always necessary…"*

Establishing Medical Necessity: Medical Review
2-Midnight Benchmark

- If a hospital stay does not cross 2 midnights after the order is written, CMS and its contractors will not presume that the inpatient status was reasonable and necessary for payment purposes, but may instead evaluate the claim pursuant to the 2-midnight benchmark.

Establishing Medical Necessity: Medical Review
2-Midnight Benchmark

- Applying the 2-midnight *benchmark*, medical review contractors will evaluate the following:
  - (a) the physician order and certification;
  - (b) the medical documentation supporting the expectation that care would span at least 2 midnights; and
  - (c) the medical documentation supporting a decision that it was reasonable and necessary to keep the patient at the hospital to receive such care.
- The ordering physician may consider the time a beneficiary spent receiving outpatient services (including observation services, treatment in the ED and outpatient procedures) when determining whether the 2-midnight benchmark will be met.

Establishing Medical Necessity: Medical Review

2-Midnight Benchmark

- Pursuant to the Final Rule at p. 50952:
  - *Medical reviewers will still 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.***

Implications for Auditor Behavior
Probe and Educate

- http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html
- For inpatient admissions between 10/1/2013 and 3/31/2014:
  - CMS will direct the Medicare review contractors to apply the 2-midnight presumption – i.e., contractors should not select Medicare Part A IP claims for review if the IP stay spanned 2 midnights from the time of formal admission *for the purposes of determining whether IP status was appropriate.*

Implications for Auditor Behavior
Probe and Educate

- MACs may still review Part A IP claims crossing 2 midnights following the formal admission for purposes unrelated to patient status:
  - (1) To ensure the services provided were medically necessary;
  - (2) To ensure that the hospitalization was medically necessary;
  - (3) To validate provider coding and documentation;
  - (4) When a CERT Contractor is directed to review such claims;
  - (5) If directed by CMS or other entity to review such claims.

Per the Final Rule at p. 50951: "We note that it was not our intent to suggest that a 2-midnight stay was presumptive evidence that the stay at the hospital was necessary; rather, only that **if** *the stay was necessary, it was appropriately provided as an inpatient stay… [S]ome medical review is always necessary…"*

- Claims with evidence of systemic gaming, abuse or delays in the provision of care in an attempt to surpass the 2 midnight presumption could warrant medical review at any time. *See* CR 8508, Transmittal 1315, 11/15/2013

Implications for Auditor Behavior
Probe and Educate

- For inpatient admissions between 10/1/2013 and 12/31/2013:
  - CMS will *not allow* MACs, recovery auditors, and SMRCs to conduct post-payment reviews of IP admissions for the purposes of determining whether IP status was medically necessary.
    - However, MACs, recovery auditors and SMRCs may continue other types of IP hospital review during this time period

Implications for Auditor Behavior
Probe and Educate

- For inpatient admissions between 10/1/2013 and 3/31/2014:
  - CMS will conduct *pre-payment reviews* of a probe sample of hospital's IP claims spanning less than 2 midnights, to determine hospitals' compliance with the IP regulations and provide important feedback to CMS for purposes of jointly developing further education and guidance.

Implications for Auditor Behavior
Probe and Educate

MAC Actions Following Patient Status Probe Reviews

	Number of Claims in Sample That Did NOT Comply with Policy (Dates of Admission October – March 2014)		
	No or Minor Concerns	**Moderate to Significant Concerns**	**Major Concerns**
10 claim sample	0-1*	2-6*	7 or more*
25 claim sample	0-2*	3-13*	14 or more*
Action	For each provider with no or minor concerns, CMS will direct the MAC to: 1. Deny non-compliant claims 2. Send summary letter to providers indicating: • What claims were denied and the reason for the denials • That no more reviews will be conducted under the Probe & Educate process. • That the provider will be subjected to the normal data analysis and review process 3. **Await further instruction from CMS**	For each provider with moderate to significant concerns, CMS will direct the MAC to : 1. Deny non-compliant claims 2. Send detailed review results letters explaining each denial 3. Send summary letter that: • Offers the provider a **1:1 phone call** to discuss • Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims 4. **Repeat Probe & Educate of 10 or 25 claims with dates of admission January – March 2014**	For each provider with major concerns, CMS will direct the MAC to : 1. Deny non-compliant claims 2. Send detailed review results letters explaining each denial 3. Send summary letter that: • Offers the provider a **1:1 phone call** to discuss • Indicates the review contractor will REPEAT Probe & Educate process with 10 or 25 claims 4. **Repeat Probe & Educate of 10 or 25 claims with dates of admission January – March 2014** 5. **If problem continues, Repeat Probe & Educate with increased claim volume of 100 – 250 claims**

**Note: If the provider claim submissions do not fulfill the requested sample, the error rate shall be calculated based on percentage of claims with findings.*

Implications for Auditor Behavior

- Generally speaking, IP stays spanning 0-1 midnight following formal IP admission will be the focus of review for patient status.
  - Order
  - Certification
  - Benchmark
    - When does the benchmark begin?
    - Delays in the provision of care?
    - Evidence of gaming?

Implications for Auditor Behavior

- Cases where IP stays lasting less than 2 midnights are generally appropriate for Part A payment:
  - If an unforeseen circumstance results in a shorter beneficiary stay than the physician's reasonable expectation of at least 2 midnights. Examples:
    - Death
    - Transfer to another hospital
    - Departure AMA
    - Clinical improvement
      - **Importance of documentation**

Implications for Auditor Behavior

- Cases where IP stays may be appropriate with an expected stay of less than 2 midnights:
  - IP only list
    - NOT Telemetry, NOT Admissions to ICU
  - "CMS will work with the hospital industry and with MACs to determine if there are any categories of patients that should be added."

Appeal Strategies

- Are their provisions of 2014 IPPS Final Rule that can be used for appeals for DOS prior to October 1, 2013?

Appeal Strategies

- Subjectivity within 2014 IPPS Final Rule and sub-regulatory guidance:
  - E.g., What is a “reasonable” expectation of hospital care crossing 2 midnights?

QUESTIONS?

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