

2014 IPPS FINAL RULE - CMS CLARIFIES INPATIENT ADMISSION CRITERIA TO REDUCE PAYMENT UNCERTAINTY

EXECUTIVE SUMMARY

On August 2, 2013, the Centers for Medicare and Medicaid Services ("CMS") displayed the acute care hospital and long-term care hospital inpatient prospective payment system final rule for fiscal year 2014 ("Final Rule"). In one provision in the Final Rule, CMS aims to provide physicians and hospitals with a clear benchmark for determining the appropriateness of an inpatient hospital admission by finalizing the "2-midnight rule."

Under the Final Rule, CMS codified the definition of an inpatient admission at 42 C.F.R. § 412.3. An inpatient admission is appropriate and payable under Medicare Part A when:

- The patient is formally admitted to the hospital pursuant to an order for inpatient admission by a physician or other qualified practitioner¹ eligible to admit;
- The order is present in the medical record and is supported by the physician admission and progress notes; and
- The physician certifies the services are required to be provided on an inpatient basis, and the certification must include:
 - The order for inpatient admission;
 - A documented reason for the inpatient hospitalization for either inpatient medical treatment or diagnostic study, or special or unusual services for cost outlier cases; and
 - A statement that the inpatient hospital services were provided in accordance with new section 42 C.F.R. §412.3 (i.e., the order).

Importantly, CMS clarified in the Final Rule that there are actually two distinct 2-midnight policies:

- A 2-midnight benchmark, which gives guidance to admitting practitioners and reviewers when determining whether it is appropriate to admit on an inpatient basis; and
- A 2-midnight presumption, which states that claims for inpatient services with lengths of stay greater than 2 midnights after an admission order will generally be presumed to be appropriate for payment under Medicare Part A.

The 2-midnight benchmark states that if the physician admits a Medicare beneficiary as an inpatient, *with the expectation* that the beneficiary will require care that "crosses 2 midnights," Medicare Part A payment is "generally appropriate." In the Final Rule, CMS makes clear that the admitting physician should consider all time spent at the hospital, including time spent receiving initial outpatient services, when estimating the beneficiary's total expected length of stay.

Similarly, the 2-midnight presumption states that a Medicare external review contractor auditing a medical record will *presume* that an inpatient hospital admission is reasonable and necessary (and therefore payable under Part A) if a beneficiary requires more than one "Medicare utilization day" (i.e., an encounter crossing 2 midnights) and receives medically necessary services, such as a surgical procedure or diagnostic test after the inpatient admission. Conversely, services spanning fewer than 2 midnights and not involving "inpatient-only" services would not receive the benefit of the 2-midnight presumption. However, contractors may consider time that the beneficiary was in the hospital receiving outpatient services prior to inpatient admission when determining whether the inpatient stay was reasonable and necessary.

The Final Rule specifies the following additional caveats:

- The 2-midnight admission guidance and other medical review criteria for determining the general appropriateness of inpatient admission and Part A payment apply to all hospitals, critical access hospitals and long-term care hospitals, but not to inpatient rehabilitation

facilities.

- The time a patient spends in the hospital before the formal inpatient admission order is outpatient time, not inpatient time. However, per above, hospitals and contractors can consider this pre-inpatient admission time in determining whether there is a reasonable expectation of the patient staying over 2 midnights, as part of an admission decision.
- Since procedures designated as inpatient-only are deemed statutorily appropriate for inpatient payment, inpatient-only procedures are excluded from the 2-midnight benchmark.

The Final Rule responds to hospital requests for additional guidance concerning when inpatient admission is appropriate and payable by Medicare. It is effective October 1, 2013.

BACKGROUND

In recent years, physicians have been hesitant to order an inpatient admission "too soon" in the patient's episode of care for fear of costly inpatient admission denials. Until recently, if a Medicare claims review contractor denied a Part A inpatient claim (resulting in recoupment), a hospital would end up significantly underpaid for its provision of reasonable and medically necessary services because only a very limited set of mostly ancillary services provided during the denied inpatient admission were payable under *Part B* (known as "Part B Inpatient" or "Part B Only" services). In contrast, if the patient had been designated as an outpatient from the start, those same reasonable and necessary services would have been payable under the outpatient Part B benefit. Once the patient is discharged, a hospital cannot retroactively change the admission status from "inpatient" to "outpatient." Due to this concern, hospitals, increasingly, had been treating patients as extended observation outpatients in order to keep inpatient payment denials to a minimum.

In the CY 2013 OP/ASC proposed rule and final rule with comment period, CMS expressed its concern over the prolonged outpatient treatment period trend. Beneficiaries receiving lengthy observation services (e.g., 24-48 hours) as hospital outpatients when an inpatient admission may well have been medically justifiable, may incur greater financial liability in the form of Medicare Part B copayments, charges for self-administered drugs and, in some cases, charges for post-hospital skilled nursing facility care.

Concerns for protection of beneficiaries, as well as hospital requests for improved guidance on when inpatient admission is payable, prompted CMS to engage in further rulemaking. Policies in the Final Rule 1) addressing the requirements for inpatient admissions; and 2) providing for fair payment of necessary services rendered under an inpatient admission, which is ultimately denied, are interrelated and work together to reduce the frequency of extended observation care inappropriately furnished².

PRACTICAL TAKEAWAYS

- The Final Rule provides helpful guidance to physicians tasked with the job of deciding to admit or not to admit. If the Final Rule works as intended, hospitals should show a decrease in inpatient admission denials and beneficiaries should spend less time in extended observation and should incur fewer Part B-related costs.
- Hospitals should be aware that CMS will be on the lookout for hospitals gaming the system. In commentary, CMS warned:

If a hospital is found to be abusing this 2-midnight presumption for nonmedically necessary inpatient hospital admissions and payment (in other words, the hospital is systematically prolonging the provision of care to surpass the 2-midnight timeframe), CMS review contractors would disregard the 2-midnight presumption when conducting review of that hospital.

- CMS believes that hospital stays expected to last less than 2 midnights are "generally inappropriate" for inpatient hospital admission and Part A payment absent "rare and unusual circumstance[s]." CMS intends to provide further subregulatory guidance on this aspect of the Final Rule. Related to this point, CMS emphasized that the 2-midnight benchmark instruction would not override a physician's complex clinical judgment.
- Hospitals and physicians should be aware that while outpatient time may be considered in application of the 2-midnight benchmark, it may not be retroactively included as inpatient care for skilled nursing care eligibility or other benefit purposes.
- Finally, physicians must be careful to provide clear documentation in the medical record supporting the physician's order and expectation that the beneficiary requires care spanning at least 2 midnights. Review contractors will take this documentation into account and may decide favorably on the appropriateness of an inpatient admission, *even if*, for whatever reason (e.g., death, transfer,

unexpected rapid improvement), the patient was discharged early.

If you have any questions or would like additional information about this topic, please contact:

- Adele Merenstein at 317-752-4427 or amerenst@hallrender.com;
- Regan E. Tankersley at 317-977-1445 or rtankersley@hallrender.com;
- Lori A. Wink at 414-721-0456 or lwink@hallrender.com;
- Joseph R. Krause at 414-721-0906 or jkrause@hallrender.com; or
- Your regular Hall Render attorney.

¹ For purposes of this article, "physician" includes a qualified practitioner eligible to admit in accordance with Medicare conditions of participation, state law and the hospital's medical staff bylaws and policies and procedures.

² For more information on a proposed fix for inpatient denials, click [here](#) to view a Hall Render article summarizing a Medicare proposed rule addressing Part B Inpatient Billing in Hospitals from March 18, 2013. Stay tuned for a future Hall Render Health Law News article addressing the Final Rule providing for additional Part B payment to hospitals denied inpatient Part A payment.