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HEALTH LAW NEWS

JULY 31, 2015

WHAT'S NEW WITH THE 2-MIDNIGHT RULE?

EXECUTIVE SUMMARY

CMS recently published its CY 2016 Hospital OPPS and ASC Proposed Rule in which it proposes to create a new exception under the 2-Midnight Rule. The 2-Midnight Rule provides that hospital inpatient admissions are generally payable under Medicare Part A if the admitting physician (or other admitting practitioner) expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation. The rule became effective for hospital admissions beginning on or after October 1, 2013.

Currently, the only exceptions to the 2-midnight benchmark (inpatient stay must cross two midnights) are services designated by Medicare as "inpatient-only" and the rare and unusual circumstances identified by CMS in sub-regulatory guidance; only one of these circumstances has been identified to date: prolonged mechanical ventilation. Under the proposed revised policy, Part A payment will be permitted on a case-by-case basis for *expected* inpatient stays of *under* two midnights if the admitting physician believes the inpatient stay is warranted and there is medical record documentation supporting the medical necessity of the short stay. This proposed policy change reiterates CMS's acknowledgement of the importance of physician clinical judgment and decision-making in the treatment of Medicare patients.

The rule also introduces a new medical review strategy tasking Quality Improvement Organizations ("QIOs") with reviews of short inpatient stays instead of the Medicare Administrative Contractors ("MACs") or Recovery Audit Contractors ("RACs"). The rule can be found here.

BACKGROUND

In the FY 2014 Hospital IPPS Final Rule, CMS provided payment guidance specifying that, generally, a hospital inpatient admission is considered reasonable and necessary if a physician orders the admission based on the expectation that the Medicare beneficiary's length of stay will exceed two midnights or if the beneficiary requires a procedure specified by Medicare as inpatient only. Related, CMS established a 2-midnight "benchmark" providing that surgical procedures, diagnostic tests and other treatments generally would be considered appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the patient to require a hospital stay that crosses at least two midnights and admits the patient to the hospital based upon that expectation.

CMS also finalized a presumption relating to instructions to medical reviewers regarding the selection of claims for medical review. Under the 2-midnight "presumption," inpatient hospital claims with lengths of stay greater than two midnights after the formal admission are presumed to be appropriate for Medicare Part A payment and will not be the focus of medical review efforts, absent evidence of systematic gaming, abuse or delays in the provision of care.[1] Together, the "benchmark" and "presumption" make up the "2-Midnight Rule," and the Rare and Unusual Exceptions Policy qualifies that rule.

CMS hoped that the 2-Midnight Rule would create more certainty for hospitals tasked with making outpatient versus inpatient admission decisions and that more inpatient admissions (as a consequence of hospitals' greater confidence that they would get paid under Part A) would protect Medicare beneficiaries from the extra costs associated with prolonged (outpatient) observation stays. As it turns out, the 2-Midnight Rule raised a myriad of provider questions and comments regarding the practical application of the rule.

PROPOSED CHANGE TO THE 2-MIDNIGHT RULE

Rare and Unusual Exceptions Policy. CMS proposes to modify its current 2-Midnight Rule-related Rare and Unusual Exceptions Policy to permit Medicare Part A payment on a case-by-case basis for inpatient admissions that do not meet the 2-midnight benchmark. If a physician determines that a patient requires inpatient hospital care despite an expected length of stay of under two midnights, Part A payment may be appropriate if medical record documentation supports the physician's decision. CMS identified three factors that, among others, would be relevant to deciding whether Part A payment is appropriate:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient; and
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the

patient to remain at the hospital for 24 hours or more).

Notwithstanding the proposed policy change, CMS continues to expect that stays under 24 hours would "rarely qualify for an exception" to the 2-midnight benchmark.

CMS stated that with respect to hospital stays that meet the 2-midnight benchmark, there is no change in policy. This includes stays where the physician's expectation of at least a two-midnight stay is supported but where the stay is cut short due to unforeseen circumstances such as an unexpected patient death, transfer, clinical improvement or discharge against medical advice.

New Medical Review Strategy. CMS also proposes that no later than October 1, 2015, it will have QIOs perform "probe and educate" audits of short inpatient stays under the 2-Midnight Rule instead of the MACs or RACs. QIOs will review a sample of post-payment claims and determine whether inpatient admission was medically appropriate. As to the RACs who were prohibited from doing patient status reviews on claims with dates of admission from October 1, 2013 through September 30, 2015, effective for dates of admission October 1, 2015 and beyond, RACs will once again be permitted to conduct patient status reviews but only for those providers with high denial rates referred to the RACs by the QIOs. The claim volume of the hospital and the denial rate identified by the QIO will determine the number of claims the RAC will be permitted to review for patient status.

CMS believes the proposed change in medical review of short inpatient hospital stays will complement certain changes CMS already has made to rein in the RACs. The below changes will become effective when new RACs are appointed, or sooner.

1. CMS will change the RAC "look-back period" for patient status reviews to six months from the date of service where a hospital submits the claim within three months of the date of service. This will give hospitals a greater chance to timely rebill for Part B services when a Part A inpatient claim is denied.
2. CMS will limit additional documentation requests imposed by RACs.
3. CMS will require RACs to complete complex reviews within 30 days or forfeit their contingency fee even if an error is identified.
4. CMS will require RACs to wait 30 days before sending a claim to the MAC for adjustment thereby giving the affected provider an opportunity to submit a discussion period request before the MAC makes any payment adjustments.

CMS will accept comments on the 2-Midnight Rule portion of the CY 2016 OPPS Proposed Rule until August 31, 2015 and will respond to comments in a final rule to be issued on or around November 1, 2015.

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

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[1] The 2-midnight presumption does not preclude contractors from performing other types of medical reviews such as coding reviews and reviews for the medical necessity of surgical procedures.