CMS’s New Two-Midnight Rule for Inpatient Admissions: Strategies for Hospital Compliance

Thursday, September 26, 2013

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Moderator: Francie Fernald, contributing editor of AIS’s Report on Medicare Compliance

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WEBINAR PROGRAM

• Introductions/Administrative Reminders
• Speakers’ Presentation
• 30-Minute Q&A Session

WEBINAR MATERIALS

CMS’s New Two-Midnight Rule for Inpatient Admissions: Strategies for Hospital Compliance....page 5

Presentation by Jessica Gustafson and Abby Pendleton

Selected Report on Medicare Compliance Articles .................................................................page 29

Supplemental Materials ...........................................................................................................page 42

Regulatory Language, 42 CFR §412.3, §412.46 and §424.13 ..................................................page 43
Preamble, Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals etc.,
CMS: Hospital Inpatient Admission Order and Certification (Sept. 5, 2013) .....................page 63
Transcript: CMS Special Open Door Forum: Inpatient Hospital Admission and Medical Review
Criteria (2-Midnight Provision) and Part B Inpatient Billing in Hospitals (Aug. 15, 2013) ......page 68
FAQs: CMS Delays RAC Review of Claims With Stays of Less Than Two Midnights
(Sept. 26, 2013) ....................................................................................................................page 97

WEBINAR OUTLINE


• Background on the New Documentation Requirements
• Physician Acknowledgment Statements
• Orders and Certifications
  » Orders
  » Certifications
  » Orders and Certifications
• Establishing Medical Necessity
  » 2-Midnight Rule
  » 2-Midnight Presumption
  » 2-Midnight Benchmark

Part 2: Questions and Answers
CMS’s New 2-Midnight Rule for Inpatient Admissions: Strategies for Hospital Compliance

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Sept. 26 AIS Webinar
CMS published its 2014 Inpatient Prospective Payment System ("IPPS") Final Rule (the "Final Rule") on August 2, 2013.

- **Effective Date:** October 1, 2013.
• Increased documentation requirements:
  – Physician acknowledgment statements
  – Physician orders and certifications
  – Establishing medical necessity:
    2-midnight rule
    • Medical review policies
      – 2-midnight presumption
      – 2-midnight benchmark
Physician Acknowledgment Statements

- 42 C.F.R. § 412.46 (a)
- Hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received a notice stating the following:

  - Notice to Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.
• Must be on file at the time a claim is submitted.
• Must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient.
  – October 1, 2013
• Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.
Orders and Certifications

Orders

• Condition of Payment
• 42 C.F.R. § 412.3
• May be made verbally or in writing
• Must include the word “inpatient”
• Must be made at or before the time of inpatient admission
Orders and Certifications

Orders (continued)

• Must be made by a “qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient’s hospital course, medical plan of care, and current condition.”
  – 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 (continued)

- 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 (continued)

• 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 inpatient admissions for all inpatient admissions.
  – Requirement for certification is not limited to longer hospital stays and outlier cases
Orders and Certifications

Certifications (continued)

• Required elements
  – Order to inpatient 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; and
  – Plans for post-hospital care.
Orders and Certifications

Certifications (continued)

• 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 (continued)

- 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
- May only be signed by:
  1. A physician who is an MD or DO
  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
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 (continued)

• 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.

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 inpatient 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.
    • Note regulatory exception to 2-midnight rule for inpatient-only procedures.
    • If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician’s expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and hospital inpatient payment may be made under Medicare Part A.
      – Other acceptable unforeseen circumstances?
    – Surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient admission and inpatient 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*, inpatient 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, absent 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 (continued)

• 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.

• Pursuant to 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 (continued)

• 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

2-Midnight Benchmark (continued)

• 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.
Establishing Medical Necessity

2-Midnight Rule

• If a hospital stay does not cross 2-midnights (including a patient’s time spent receiving outpatient services), hospitals may choose to either utilize Condition Code 44 to change the patient’s status to outpatient prior to discharge, or

• Use the Part B billing option based on self-audit by the hospital’s Utilization Review Committee to change the patient’s status – given that the claim has a higher likelihood to be reviewed by a medical review entity and the inpatient admission will not be presumed to be medically necessary.
QUESTIONS?

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RACs to Back Off Longer Stays as ‘Two-Midnight’ Standard Survives in IPPS Rule


Starting Oct. 1, recovery audit contractors (RACs) generally won’t scrutinize inpatient stays that last two midnights or more. RACs and other Medicare auditors will focus on shorter stays because CMS generally will assume admissions that cross two midnights are medically necessary unless they’re delayed on purpose, according to the 2014 final inpatient prospective payment system (IPPS) regulation announced Aug. 2. That shifts the medical-necessity emphasis to time spent in the hospital and puts a premium on documentation and utilization review, experts say.

Although the two-midnight clock doesn’t start ticking until physicians sign an inpatient order, CMS says hospitals and auditors may count outpatient hours, such as observation, when evaluating the medical necessity of the inpatient admission. And the regulation distinguishes between a two-midnight “presumption” and “benchmark,” with the former addressing audits and the latter related to clinical judgment.

This new rule changes the landscape of medical reviews. “If the patient is in the hospital for two midnights, RACs wouldn’t be looking at that issue at all,” George Mills, director of the CMS Provider Compliance Group, said at an Aug. 6 open door forum on the IPPS. “That issue has been taken off the table for RACs....In the future, reviews of inpatient claims should be substantially reduced because of this new rule, and they will be moving on to other areas.”

In an “interrelated” provision, CMS formalized Part B rebilling for Part A claims denied based on the lack of medical necessity for the setting. “The policies were designed to work together to reduce the frequency of extended observation care when it may be inappropriately furnished and provide payment to hospitals for the reasonable and necessary services they provide to inpatients,” CMS says.

IPPS Rule Refocuses Audits

The two-midnight standard “fundamentally changes how we will look at everything,” says Jeffrey Farber, M.D., chief medical officer at Mount Sinai Care and associate professor at Mount Sinai Medical Center in New York City. “The major change is the new rule eliminates the old, clear distinction between outpatient and inpatient services. That’s out the door, and all levels of care on the hospital premises are equivalent. Everything takes a back seat to time and the physician’s expectation of time spent in the hospital.”

In the regulation, CMS said the new policy isn’t that radical and provides flexibility. It represents “only a change in the inpatient admissions benchmark from an hourly expectation (24 hours) to a daily (2-midnights) expectation” and doesn’t “restrict the physician to a specific pattern of care.” When inpatients suddenly improve and can be discharged before two midnights, Medicare reviewers “will not presume that the inpatient hospital status was reasonable and necessary for payment purposes, but may instead evaluate the claim pursuant to the 2-midnight benchmark.” That includes looking at the physician order; physician certification (e.g., the reason for continued hospitalization, the estimated time the patient will need to be in the hospital and plans for post-discharge care); and documentation that
the admission is reasonable and necessary. At the same time, CMS acknowledged the magnitude of the two-midnight rule. “We understand this is a pretty significant change in medical review,” Jennifer Dupee, a nurse consultant in the CMS Provider Compliance Group, said at the Aug. 6 open-door forum.

CMS says physicians can include time in outpatient services, including observation, emergency room visits and outpatient procedures. “The decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpatient service,” the rule notes. But this concession is not unqualified. While the outpatient hours aren’t inpatient time, CMS says they “may be considered by physicians in determining whether a patient should be admitted as an inpatient, and during the medical review process for the limited purpose of determining whether the 2-midnight benchmark was met and therefore payment is generally appropriate under Part A.”

The regulation implements two medical-review policies: the two-midnight threshold and two-midnight benchmark. The presumption refers to CMS guaranteeing payment for stays that transcend two midnights after the inpatient order, with Medicare auditors tackling one-day stays. The benchmark is a goal post for physicians making clinical decisions.

Farber sees physicians as the buffer between the presumption and the benchmark. “The presumption is CMS saying they will not try to audit cases that have two-midnight stays, but benchmarks are used by clinicians,” he says. “The benchmark is for clinicians making these decisions.” Suppose a patient has chronic obstructive pulmonary disease (COPD) exacerbation that requires IV steroids and antibiotics. The physician believes an admission is prudent and will last two midnights. “If the patient winds up not needing both nights, that’s still OK. The judgment is documented, and the clinical reasons for two midnights are documented, so that should hold up under scrutiny,” Farber says. Auditors may still put the claim under the microscope for MS-DRG coding and complications and comorbidities or major CCs, but that’s another story.

Ralph Wuebker, M.D., chief medical officer for Executive Health Resources in Newtown Square, Pa., interprets the presumption vs. benchmark in a similar way. The presumption is for auditors looking backward while the benchmark is for physicians to determine patient status looking forward. He also sees this as raising the stakes for documentation. “Are you practicing according to the standard of care? That’s where I think CMS is going — that focus on documentation,” Wuebker says. If a patient comes in for chest pain but doesn’t get a stress test until the third day, perhaps because of scheduling problems, “those should not be situations to keep the patients in the hospital longer. They can get infections or fall or have complications,” he says. “If you can just improve the efficiency of the case, it will be a big step.”

Intensity of Service Is ‘Irrelevant’

In light of the two-midnight presumption and benchmark, hospital utilization review committees “will have to figure out an action plan on educating physicians to think differently,” Farber says. It’s a new world when the medical necessity of an admission doesn’t ride on location — ICU, a step-down unit or a med-surg floor, Farber says. “They are saying the whole range of clinical services and the provision of acuity is sort of irrelevant,” he says. What matters in terms of admission is how long a patient is expected to stay in the hospital.

While orders can make or break an admission, Medicare auditors won’t judge medical necessity on orders alone. “No presumptive weight” will be accorded physician orders or
certifications; they will be assessed in the context of the whole medical record. But in a departure from the proposed IPPS regulation, CMS acknowledges that in some circumstances, the ordering and treating physician may be different people (e.g., emergency room physician, hospitalists and residents). Either way, orders must be signed by qualified, licensed practitioners who have hospital admitting privileges and know about the patient’s condition and plan of care.

CMS also says that admissions may be appropriate when patients are transferred, leave against medical advice or die before staying for two midnights.

The two-midnight rule probably isn’t a cost-cutting measure, Farber says. CMS actuaries expect it to cause 400,000 more inpatient admissions while converting 360,000 short stays to observation. But Jeffrey Epstein, senior medical director for quality, case management and resource utilization at Stamford Hospital in Connecticut, is convinced the two-midnight rule is all about the desire to fill Medicare coffers. “Why not be honest? It is all about money because whether it is inpatient or outpatient, it is all the same,” he says. Some hospitals may be financially devastated. “Let’s say you have $200 million per year in Medicare revenue. If they take back 1%, that is $2 million,” Epstein says. “A hospital may only be making a $2 million profit, so that’s it. If they are only making $1 million, they may be in the red.”

Epstein agrees the “old rules” about observation and inpatient admission made sense. What’s changed is that RACs and MACs apply different rules to Medicare claims. “We threw a strike, and they called a ball,” he contends.

There will be elaboration on the two-midnight rule, with CMS planning one or two more open-door forums. It’s also updating Medicare manuals accordingly and developing educational materials. Dupee encourages providers to e-mail any questions to ippsadmissions@cms.hhs.gov.

Contact Farber at Jeffrey.farber@mssm.edu, Wuebker at rwuebker@ehrdocs.com and Epstein at jepstein1@stamhealth.org.

### Breaking Down the New Two-Midnight Rule


Hospitals are adapting to Medicare’s new standard for medically necessary inpatient admissions. Starting Oct. 1, CMS generally will assume admissions that cross two midnights are medically necessary unless they’re delayed on purpose. Auditors will focus their attention on shorter stays except when inpatients are having procedures on the Medicare inpatient-only list. This chart was developed by Wendy Trout, director of corporate compliance at WellSpan Health in York, Pa. Contact her at wtrout@wellspan.org.

<table>
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<tr>
<th>Key Item</th>
<th>Details</th>
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| Order    | • An order is still required for inpatients.  
• The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by state law, and who is knowledgeable about the patient’s hospital course, medical plan of care, and current condition.  
• Order must say admit “to inpatient,” “for inpatient services,” “as an inpatient” or something similar. “Admit to Tower 3” will not be acceptable. |
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<th>Key Item</th>
<th>Details</th>
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| Certification            | • Physician certification is required for ALL inpatient admissions.  
• Begins with the order to admit.  
• Certification statement may be entered on forms, notes, or records that the physician signs, or on a special separate form.  
• Statement must be signed and documented in the medical record prior to hospital discharge.  
• Verbiage: (1) the reason for the inpatient treatment or diagnostic study; (2) “special or unusual services” the patient will receive; (3) the estimated time the patient will stay in the hospital; and (4) plans for post-hospital care. |
| Expectation              | • Ordering provider must “expect” that the beneficiary will require care that crosses two midnights. If DON’T “expect” two midnights, then service will be an outpatient or observation. |
| Documentation            | • Ordering provider documentation should support the expectation that the beneficiary will require care spanning at least two midnights when the admission order is written.  
• The ordering provider should say, “I believe this patient will require a stay crossing two midnights because....”  
• Documentation should provide justification to support the medical necessity of the admission, which is based on many factors such as: risk of adverse event, assessment of services the patient needs, and co-morbid conditions. |
| Time Consideration       | • When providers are considering the "two-midnight" benchmark, they can consider all time in the ED and observation to make the decision. BUT this time does not ultimately count as "inpatient time" for the 3-day requirement for SNF benefits.  
• So, if patient starts in ED, then is placed in observation, then the physician admits the patient, the inpatient benchmark of "two-midnights" starts when the patient started receiving services in the ED. But the calculation for SNF benefits starts with the admission order.  
• This does allow a physician (when it is difficult to make a reasonable prediction) to start the patient as an observation, and then as they approach the "two-midnight" benchmark, admit them.  
• In all cases, patients should have an admission order before they cross two midnights.  
• Not even ICU stays are exempt from the two-midnight rule.  
• One interpretation indicates “intensity of service” no longer seems to be a significant contributor to the decision to admit. |
| Stay < two midnights     | • Inpatient MAY still be appropriate since it was based on the "expectation" that they would need to stay two midnights.  
• Documentation needs to support the initial expectation.  
• Unexpected events may occur, such as: patient could die, be transferred, leave AMA, or improve more rapidly than expected.  
• A stay of less than two midnights will most likely prompt a review by the MAC. |
| Stay > two midnights     | • Presumed to meet inpatient unless it appears facility is gaming the system by keeping patients longer than necessary.  
• However, even though it is "presumed" to meet inpatient, the comments to the rule indicate that the MAC may still review longer cases for "medical necessity" and coding issues irrespective of the inpatient or outpatient status to which the beneficiary was assigned.” This will not be their focus though.  
• CMS will focus its review efforts on the inpatient admissions that cross one midnight or less. Says they will "instruct contractors to review inpatient stays spanning less than two midnights after admission." |
| Surgical Patients        | • When a beneficiary enters a hospital for a surgical procedure, a diagnostic test, or any other treatment and the physician expects to keep the beneficiary in the hospital more than two midnights, this should be ordered as an inpatient. |
| Diagnostic Tests         |                                                                                                                                        |
| Treatments               |                                                                                                                                        |
| Inpatient Only           | • Inpatient Only procedures are still billed as inpatient regardless of the two-midnight benchmark.                                     |
| Condition Code 44        | • Condition Code 44 is not to be used for unexpected events or cases where the patient doesn't end up staying the “two midnights.”   
• This is still for the situation where UR determines that the physician has not appropriately admitted the patient. |
| IRF                      | • Does not apply to IRFs.                                                                                                             |
| Financial Impact         | • CMS actuaries estimate this change in policy will increase IPPS expenditures $220 million due to an increase in inpatient encounters for patient stays that span more than two midnights and move from OPPS to IPPS.  
• Commenters argued that they did not agree with this assessment. Many argued that more 1-day stays will now be observation cases instead thus decreasing payments.  
• CMS would not budget; therefore they are decreasing IPPS payment amounts by .2 percent.  
• AHA indicates that CMS ignores any of the financial "savings" of medical 0 or 1-day inpatient stays changing to outpatient.  
• AHA Indicates that a hospital can estimate the amount of revenue loss “excluded” from CMS’s neutrality calculation by following these steps: (1) tallying up the medical inpatient stays that were 0 or 1 day over a whole year; (2) exclude the ones that reach the two-midnight benchmark by virtue of outpatient midnights crossed; (3) multiply that number by the difference between your inpt and obs reimbursement for medical stays (probably about 4k for most hospitals). |
Physician certifications are about to become decisive documents for Medicare Part A reimbursement. CMS has made a connection between certifications and the medical necessity of admissions, although physicians have until discharge to complete them.

The physician certification requirement is part of the new two-midnight standard for inpatient admissions in the final 2014 inpatient prospective payment system regulation. Starting Oct. 1, CMS generally will assume admissions that cross two midnights are medically necessary unless they are delayed on purpose. Auditors will focus on shorter stays except when patients are having procedures on Medicare’s inpatient-only list.

“Having certification for all inpatient admissions is a condition of payment,” says Jessica Gustafson, with The Health Law Partners in Southfield, Mich. “Getting on board with filling out more paperwork will be a struggle, but I think hospitals need to keep in mind it is a requirement for payment and take a proactive approach for compliance rather than anticipate a defense for the appeals process.”

Inpatient stays must kick off with an admission order, but the rest of the certification is due at discharge. Certifications must spell out (1) the reason for the inpatient treatment or diagnostic study; (2) “special or unusual services” the patient will receive; (3) the estimated time the patient will stay in the hospital; and (4) plans for post-hospital care, according to the IPPS rule.

“I am less concerned about the two-midnight rule than I am about how to capture all the required certification documentation,” says Laura Ehrlich, compliance auditor at Hanover Hospital in Pennsylvania.

The different parts of the certification don’t have to be in the same place. As CMS says, they may be on records or notes (e.g., history and physical, progress notes) or a “special separate form.” Gustafson recommends the use of a “combined document,” with space for a signed and dated order and the elements of certification. “It makes sense to keep that information together,” says Gustafson, who also spoke Aug. 23 at a “Finally Fridays” webinar sponsored by the Appeal Academy. Physicians can circle back around to the paper or electronic sheet when they are ready to complete another section. But experts advise waiting for CMS guidance on certifications before making radical changes.

The certification mandate didn’t come totally out of left field. Under 42 CFR Sec. 424.13, physicians are required to certify and recertify services when hospital stays will cause cost outliers, says Ronald Hirsch, M.D., vice president of the regulations and accreditation group for Accretive Physician Advisory Services. “All along it has only been in this context. But in my 20 years of practicing, I never remember asking to sign a certification of an outlier stay.” As far as Gustafson is concerned, “certification for short hospital stays is just new.” The requirements don’t resemble the pre-IPPS version.

**Certification Has Its Gray Areas**

There are unknowns about certification, Hirsch says. For example, he wonders whether it’s compliant for physicians to give a range when estimating how long the inpatient will be
hospitalized (e.g., two to five days). Or is a definitive number of days required? “Does it matter as long as two midnights are passed?”

Because of the uncertainty, hospitals “want to be ready to act but not jump yet,” Hirsch says. That includes working with physicians to improve their documentation. “Get them to document why they could not be treated as outpatients,” he says. And involve the IT department now so the hospital doesn’t spend four months testing changes to computerized physician order entry. In fact, hard stops in electronic health records (EHRs) may help with certification compliance, says Michael Salvatore, M.D., physician adviser at Beebe Medical Center in Lewes, Del. Physicians won’t be able to close out the EHR until they answer the two-midnight question. “If you have a flexible EHR, you are in good shape,” he says.

CMS also formalized its requirement for admission orders as a condition of hospital payment, which until the IPPS rule was a condition of participation and mandated in the 2012 Medicare physician fee schedule. But say goodbye to specific orders, such as “Admit to tower four” or “Admit to ICU.” To prevent ambiguity about the patient’s destination, CMS is requiring physicians to include the word “inpatient” in their orders. “Physicians have to use the magic words — ‘Admit to inpatient’ and ‘I think they will be here for two midnights,’” Salvatore says. “That’s a big change in physician behavior.” Again, he says, EHR hard stops will be a boon because physicians can’t continue their documentation until they have used the magic words.

Physician orders and certifications aren’t a panacea for Part A claims. It’s a little confusing, but the IPPS regulation states that “no presumptive weight shall be assigned” to the order or certification “in determining the medical necessity of inpatient hospital services.” Salvatore doesn’t think that squares with the fact that “how sick you are no longer determines your admission status” under the two-midnight rule. He expects CMS to fall back on the Medicare Benefit Policy Manual (Chapter One), which states that “the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors,” including the severity of signs and symptoms and the risk of something bad happening to patients if they are discharged.

The two-midnight standard and its certification is “a great educational opportunity for hospitals,” says Minneapolis attorney David Glaser, with Fredrikson & Byron. The definition of an “inpatient” is clear and physicians just have to write why they think the patient will be in the hospital for two nights. If they have any doubt, they put patients in observation. There’s nothing to lose, Glaser says. When patients are moved from observation to inpatient, the hours count for two-midnight purposes. He thinks they also can be billed separately, citing this language from the regulation: “Those services that require an outpatient status that cannot be billed on a 12x claim — observation services, outpatient hospital visits, and outpatient DSMT— are payable if they were furnished to an outpatient during the 3 day (1-day for non-IPPS hospitals) payment window preceding the inpatient admission and are billed on a Part B outpatient (13x) claim.”

Because orders and certifications are now explicitly a condition of Part A payment, hospitals may not be able to bill Medicare if something is amiss. Instead, they should consider a self-audit and rebilling under Part B, Gustafson says, although she is “not an advocate of RAC-ing yourself”—especially when all required information can be found in the medical records even if it’s not documented in the “best” manner. It’s always better to get it right at the front end, but if necessary, the administrative law judge may approve Part A payment.
even if part of the certification is missing, says Sharon Easterling, president of Recovery Analytics in Charlotte, N.C. Hospitals should prepare a certification statement that explains where the pieces can be found, Ehrlich says. “Medicare is looking for a cohesive piece of information.”

Vincent Perron, M.D., associate chief medical officer for 1,000-bed Tampa General Hospital, isn’t looking forward to telling physicians about the two-midnight rule and its certification requirement. “Most physicians can’t define the difference between an observation patient and inpatient and it is something we struggle with daily,” he says. “It’s all Greek to them.” The hospital’s clinical documentation improvement team probably will educate physicians and Perron will meet with key physicians. Tampa General already does random chart reviews, giving physicians feedback on deficiencies. If there’s a pattern of poor documentation, a physician is referred to the health information management committee and rounds with the EPIC person to develop H&P and other templates, he says. For the “notoriously poor documenters,” the hospital may get voice recognition software. Perron notes that great clinicians can be lousy at documentation so there isn’t necessarily a correlation.

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**CMS Eases Up on Physician Certifications Under IPPS; Will Its Auditors Follow Suit?**


In new guidance, CMS softened the blow of the certification requirements for inpatient admission under the two-midnight standard, which was set forth in the 2014 inpatient prospective payment system (IPPS) regulation. The jury is out on whether auditors will deny claims based on the lower bar in the guidance or the higher bar in the regulation, but there’s no doubt that “subregulatory guidance” carries weight in the eyes of administrative law judges and federal courts, one lawyer says.

Starting Oct. 1, CMS generally will assume inpatient admissions that cross two midnights are medically necessary unless they are delayed on purpose, and auditors will turn their attention to shorter stays except for procedures on the inpatient-only list, according to the IPPS rule. As a condition of payment under Part A, physicians must document the medical necessity of an admission, which includes a certification with an admission order, the reason for the inpatient services, the estimated time the patient will stay in the hospital, and plans for post-hospital care. At critical access hospitals, physicians must certify they expect inpatients to be transferred or discharged within 96 hours.

Hospitals were shaken up by the certification requirements because it’s another demand on harried physicians. But CMS eased up in its Sept. 5 “subregulatory” guidance on the “hospital admission order and certification,” compliance experts say. For one thing, if hospitals don’t have a separate certification form, CMS and its contractors will consider a “default methodology for initial certification.” They will hunt and peck their way through the medical records to find support for the inpatient admission. The guidance appears to say that an admission order implies the physician expects the patient to stay in the hospital for two
midnights. “The estimated time requirement will be met by the inpatient admission order written in accordance with the two-midnight benchmark, supplemented by the physician notes and discharge planning instructions,” the guidance states.

That takes the pressure off hospitals as they brainstorm their way into compliance with the two-midnight rule and its certification and other requirements, says Ronald Hirsch, M.D., vice president of the regulations and accreditation group at Accretive Physician Advisory Services. “People are freaking out about how they get physicians to estimate length of stay,” he says. “The way I read the guidance is, if the physician writes the inpatient order based on his or her knowledge of the two-midnight benchmark, that serves as a de facto certification that the patient needs two or more midnights in the hospital and the physician does not need to estimate length of stay.” This was confirmed by a CMS official in an email sent to Hirsch.

The guidance also addresses the specificity of orders. The preamble to the regulation says that admission orders must include the word “inpatient” — either admit “as an inpatient,” “for inpatient services,” “to inpatient” or similar language. But physicians shouldn’t use specific destinations, such as “Admit to ICU” or “Admit to 4C.”

**CMS Answers Trigger New Questions**

While the guidance says it’s better when orders include the word “inpatient,” it opens another door. “In the event that explicit identification of the admission as ‘inpatient’ is not specified, the admission order may still be consistent with 42 CFR 412.3 provided that the intent to admit as an inpatient is clear,” CMS says. “Orders that specify admission to an inpatient unit (e.g., “Admit to 7W,” “Admit to ICU”), admission for a service that is typically provided on an inpatient basis (“Admit to Medicine”), or admission under the care of an admitting practitioner (“Admit to Dr. Smith”), and orders that do not specify beyond the word “Admit,” will be considered to specify admission to an inpatient status provided that this interpretation is consistent with the remainder of the medical record.”

Hirsch says the regulation and guidance give conflicting directions on orders. On top of that, the logic doesn’t always hold when it comes to intensive care units, which are not by definition “inpatient units.” According to the rule, if patients are expected to need only one night in the hospital and spend it in the ICU, they will be outpatients because they haven’t crossed the two-midnight threshold unless they had procedures on the inpatient-only list, he says. But if CMS is saying an ICU order implies it’s an inpatient, then it’s a contradiction, Hirsch contends.

Presumably hospitals will find the guidance easier to comply with. But can hospitals count on it? Or will RACs and other auditors hold them to the standards articulated in the regulation? “RACs will do whatever they want to do,” says Washington, D.C., attorney Andy Ruskin, with Morgan Lewis. Although they must base decisions on regulations, manual provisions, national and local coverage determinations and coding/coverage articles, RACs are sometimes unfamiliar with subregulatory guidance, he says. And once they’ve decided a provider is wrong, “there is some stickiness to their decision even if it’s clear the decision is not aligned with CMS policy,” Ruskin says.

If auditors deny claims based on the regulatory requirements for certification, hospitals probably would have to appeal their cases all the way to administrative law judges on the grounds that the guidance gave them more latitude, he says. Yet even at the ALJ level, judges are not always aware of how to determine the weight of an authority under federal law. But
hospitals definitely would win in federal court, Ruskin says. It’s well-established through
case law that subregulatory guidance is entitled to the deference of a regulation unless it
conflicts with it.

“The only way CMS can change the subregulatory guidance is through rulemaking. An
interpretation of a regulation is in effect considered to be like the regulation itself,” he says.
“Regulators have acknowledged they live by that principle.” That means CMS is bound by it.

He adds that language in the preamble carries less weight than the regulation. Therefore,
CMS’s provision on using the word “inpatient” in admission orders is not in conflict with its
guidance, which might make it more of a best practice.

The two-midnight stay and its certification don’t mean hospitals are home free in terms
of medical necessity. The certification is a prerequisite for a two-midnight stay, but the
documentation must support the medical necessity of the admission. That’s why the two-
midnight rule ducked a fundamental problem, says Larry Hegland, M.D., chief medical of-

ficer and system medical director for recovery audit and appeal services at Ministry Saint
Clare’s Hospital and Ministry Good Samaritan Health Center in Weston, Wis. “Auditors
are arbitrary,” he says. They use information not available to physicians at the time of ad-
mission, such as “the patient did well” or “there were no complications,” to determine the
patient should have been treated in observation, he says. “This rule doesn’t change that.
Unless CMS publishes clearer direction for RAC auditors, I don’t see how it will be any dif-
ferent under the new two-midnight process, although I am hopeful because I believe CMS is
well-intentioned.”

There is an advantage to the certification requirement, Hegland says. “It will drive a
lot more clinical documentation education toward physicians,” he says. Physicians use the
chart as a communication tool, but Medicare views it as a billing tool. “CMS wants it in a
format and at a level of detail that is clear to a layperson, so two different processes are go-
ing on at the same time,” Hegland says. Medicare auditors look for “linkage language.” For
example, if the physician writes “pneumonia, positive sputum culture, gram negative bacte-
ria” without the words “due to,” the claim will be denied. It seems obvious to physicians, but
auditors expect to see “pneumonia due to gram negative bacteria.” Without the words “due
to,” the coder is required by coding rules to code the less-specific, lower paying community-
acquired pneumonia, he says.

Physicians generally don’t grasp the distinction between documentation as a clinical
communication vs. a billing tool and are unfamiliar with documentation requirements for
hospital billing. “There is very little bandwidth left for learning documentation rules and the
quirks of coding and billing language,” he says.

Hegland educates physicians any place he can. He grabs them, one by one, and buys
them a sandwich so he can explain compliance issues. “I focus on the rationale of why we
have case managers and clinical documentation improvement specialists so when they come
to talk to them, the physicians understand [the case managers and CDI specialists] are there
to help.”

He also slips into department meetings, puts it on the Intranet, makes presentations to
the medical executive and case management committees and sends out newsletters. “It’s the
multiple-hit theory,” Hegland says. “I try to flood the airwaves with general information —
that a big change is coming. I rely on human curiosity.”
As for the new certification requirement, he doesn’t expect much trouble. “We are an all-digital hospital,” he says. “I can build screens in the computer physician order entry system.” Physicians can’t continue with their documentation unless they state they believe the patient requires two midnights. If hospitals are still using paper orders, they may want to turn the process over to case management.

Contact Hirsch at rhirsch@accretivehealth.com, Hegland at larry.hegland@ministry-health.org and Ruskin at aruskin@morganlewis.com. View the new guidance at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-09-05-13.pdf.

Example of Certification for Two-Midnight Stay


With two weeks to go until hospitals must comply with the 2014 inpatient prospective payment system regulation, they are drafting forms designed to comply with new physician certification requirements under the two-midnight rule. Ann Kunkel, director of case management at Wellspan Health in York, Pa., led the team that developed this draft certification. Contact her at akunkel@wellspan.org

- **Admit to inpatient care:** Based on my medical assessment, after consideration of patient’s risk factors — age, co-morbidities and patient presenting symptoms and acuity — I expect that this patient will remain in the hospital for greater than two midnights or that the services needed warrant inpatient care because:

  - Specify patient risk factors:
  - Services provided:
  - Estimated length of stay (LOS):
  - Post Hospital Care (if known):

- **Observation advancing to Admit to Inpatient:** This patient is advancing from an outpatient level of care to an inpatient level of care because:

  - There are continued needs for hospitalized care beyond the observation period due to:
  - Services provided (acuity):
  - Estimated LOS:
  - Post Hospital Care (if known)

I certify that my determination is in accordance with my understanding of Medicare’s requirements for reasonable and necessary inpatient services [42 CFR 412.39e]

| Provider Signature | Date | Supervising Provider (as appropriate) |
CMS’s Plan to Package Far More Outpatient Services Plays Into the Two-Midnight Rule


The “superpackaging” of outpatient procedures and the new two-midnight rule for inpatient admissions are moving parts of the same mechanism, with CMS shifting the gears to reward hospitals for quality and efficiency instead of performing more services, experts say.

The interdependence of the inpatient and outpatient prospective payment systems also affects audits. Auditors may get a leg up from CMS’s plan to package more HCPCS codes for goods and services into APCs, as set forth in the 2014 proposed outpatient prospective payment system (OPPS) regulation. In one fell swoop, they could deny claims for certain procedures if hospitals don’t establish medical necessity with the appropriate diagnosis code. On the inpatient side, auditors will focus more on one-day stays on the “presumption” that stays that cross two midnights are medically necessary if there’s supporting documentation and the hospital isn’t playing games.

“It’s a massive culture change,” said William Malm, senior data projects manager at Craneware in Atlanta, at the “Finally Fridays” webinar sponsored by the Appeal Academy on Aug. 30. “Outpatient has always operated more on an à la carte methodology while inpatient is more a buffet, and they are starting to close the loopholes on à la carte. They are saying ‘get out of the culture of separate payments.’ They want to see a continuum of care based on evidence-based medicine.”

CMS Rules Are Meshing

In the 2014 OPPS, CMS takes a giant step toward making the word “prospective” meaningful. Right now OPPS is a hybrid, with some goods and services packaged into APCs and others paid separately. But that is expected to change on Jan. 1, when Medicare would:

1. Pay a fixed price for 29 “device-dependent” procedures;
2. Package payment for seven categories of integral, ancillary, supportive, dependent or adjunctive items and services;
3. Replace the two observation APCs with a new, streamlined version, and
4. Pay a flat facility fee for emergency room and provider-based clinic visits instead of letting hospitals choose from five levels of service.

Meanwhile, if patients are headed for a stay that will last for two midnights, they are admitted under the new benchmark in the 2014 inpatient prospective payment system regulation. In between is observation, Malm said, which becomes more of a true outpatient event.

“The two rules seem to dovetail and are a significant sea change in the direction Medicare is moving,” says Larry Hegland, M.D., chief medical officer and system medical director for recovery audit and appeal services at Ministry Saint Clare’s Hospital and Ministry Good Samaritan Health Center in Weston, Wis. “You start to see the lines blurring with the inpatient rules — around observation status and the outpatient bundling.”

Self-Administered Drugs to Be Bundled

The final OPPS, which is due out in November, probably won’t deviate much from the proposed rule because it’s key to making the other regulations work properly, Malm said.
“In the last two years, we have found a change in the way CMS approaches things. It’s interrelated — you can’t read just one rule and follow the money. You have to look at the inpatient rule and [Medicare physician fee schedule] rule and outpatient rule.”

Under the OPPS proposal, Medicare creates “comprehensive” APCs for 29 of the 39 device-dependent procedures, which means the device is the most expensive part. The 29 APCs encompass 136 HCPCS codes and include implantation of infusion devices, replacement of pacemakers, insertion of cardiac defibrillators and female reproductive procedures. All kinds of services would be bundled in and some are eye-openers. For example, CMS plans to include room and board charges. “That’s a big change operationally,” Malm said. “People who use chargemasters are not used to billing room and board on the outpatient side and now they have to do that to make sure the rate setting is [accurate]. They want to incorporate room and board into the outpatient payment of the future, because they will do so many more bundled types of payments.” It’s unclear, however, that Medicare administrative contractors are equipped to deal with these data.

But it was the inclusion of self-administered drugs in the comprehensive APCs that “threw me for a loop,” Malm said. According to the proposed regulation, drugs ordered by the physician as a supply would be packaged in the 29 device-dependent APCs. That allows CMS to sidestep the Social Security Act mandate that beneficiaries pay for self-administered drugs, said Malm, who is a physician assistant.

Also included in the comprehensive APCs are “integral, ancillary, supportive, dependent, and adjunctive services.” They include diagnostic tests and procedures, lab tests, visits and evaluations, certain outpatient therapy services, durable medical equipment, and other “components” reported by HCPCS codes.

“One thing that keeps coming through is this will take you up to the two-midnight rule,” he says.

Hospitals will use a new status indicator (J1) when billing for 29 device-dependent procedures. “J1 is king of the prom,” Malm said. “If any HCPCS code with J1 appears on the claim, the entire procedure-based claim will be packaged.”

Comprehensive APCs are a dream for auditors. They won’t have to connect all the HCPCS dots to determine if a procedure was reasonable and necessary by Medicare standards. “If the whole payment is based on the J1 status indicator, the diagnosis code and medical necessity will have to support the procedure,” Malm said. For example, recovery auditors could easily identify dual-chamber pacemakers with a diagnosis code for diabetes. Claims would be denied, with no payment for any of the services that are now part of the superpackaged APCs. “They enhance the government’s ability to do automated and semi-automated reviews based on medical necessity because [Medicare] will pay based only on one thing,” Malm says.

**Bundling May Add to Infusion Confusion**

In the rule, CMS proposed another kind of packaging. Payment for seven categories of “integral, ancillary, supportive, dependent, and adjunctive services” would be bundled into the APCs they support. The categories include drugs and biologicals for tests/procedures, certain clinical lab tests, add-on codes, ancillary services with the status indicator “X,” diagnostic tests on the bypass list, and device removal procedures.
That means, for example, all add-on codes, such as concurrent and subsequent infusions and injections, would be packaged. Medicare would pay only for the initial infusion and for hydration. “This will make hospitals crazy,” Malm said. They have spent a bundle on consultants and software to ensure they bill infusions and injections in compliance with Medicare rules (i.e., initial and sequential infusions, hydration and injections). “While the add-on codes must be reported correctly, they won’t result in additional payment. Anything with a plus in the CPT book is packaged to the primary procedure,” he said. Malm worries hospitals won’t bother, since they’re spread so thin with the government mandates and audits. But that’s not a good move. Coding all services is required, and CMS needs the data to ensure payment rates are accurate, he said.

Malm predicts that commercial payers will follow Medicare’s lead and shift to packaged payments because if they don’t, the Affordable Care Act probably will be less effective, he said. Already several major commercial payers don’t pay separately for infusions and injections and he sees more future bundling of ancillary services.

**Full-Fledged PPS Is the Objective**

The march toward a full-fledged prospective payment system continues with observation and facility fee coding. CMS would do away with the two composite observation APCs for “extended assessment and management” and replace them with one (APC 8009). And CMS is ditching the five evaluation and management (E/M) codes for emergency room and provider-based clinic visits. Instead, hospitals will select one code, although there will be different codes for clinic visits vs. Type A or Type B emergency room visits.

If the rule is finalized more or less as is, hospitals may want to reconfigure their revenue cycle process to focus more on the front end rather than the back end. The typical revenue cycle department depends too heavily on “magical edits” to keep bills clean, he said. Instead, there are denials and additional data requests and appeals, and hospitals are reaching the breaking point. It doesn’t help that registration employees aren’t paid much, so usually they don’t attract the college-educated crowd, Malm said. Some hospitals “that are doing it right are putting college grads at registration.” Also, hospitals have to ditch “convenience ordering,” he said. Nurses may order EKGs and chest X-rays on patients with chest pain, who often leave before seeing a physician.

As CMS pushes for efficiency on the outpatient side, the inpatient stays have gotten shorter, Hegland notes. “We are a highly efficient hospital,” he says. Average Medicare lengths of stay are about three days. Emergency-room physicians order tests and initiate therapies quickly, going beyond the role of triage. “You get to the point where you wonder, what is inpatient vs. outpatient status? In terms of how we care for patients, it doesn’t matter — there is a continuum of care. You start to see CMS driving in the direction of simplification, where they can fold the inpatient and outpatient together.” But the government also is afraid of tempting hospitals to delay discharges so their patients cross the two-midnight threshold and they collect MS-DRGs, which often pay more than outpatient services. “It’s human nature to follow the incentives,” he says. “That’s why you need a review process.”

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CMS’s New Two-Midnight Rule for Inpatient Admissions: Strategies for Hospital Compliance

Thursday, September 26, 2013

Supplemental Materials

Regulatory Language, 42 CFR §412.3, §412.46 and §424.13

Preamble, Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals etc., 78 Fed. Reg. 50496, 50938 (Aug. 19, 2013)

CMS: Hospital Inpatient Admission Order and Certification (Sept. 5, 2013)

Transcript: CMS Special Open Door Forum: Inpatient Hospital Admission and Medical Review Criteria (2-Midnight Provision) and Part B Inpatient Billing in Hospitals (Aug. 15, 2013)
§ 412.3 Admissions.
(a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A. In addition to these physician orders, inpatient rehabilitation facilities also must adhere to the admission requirements specified in § 412.622 of this chapter.
(b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges applicable to that patient by the hospital’s medical staff.
(c) The physician order also constitutes a required component of physician certification of the medical necessity of hospital inpatient services under subpart B of Part 424 of this chapter.
(d) The physician order must be furnished at or before the time of the inpatient admission.
(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 hospital payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights. The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.
(2) If an unforeseen circumstance, such as a beneficiary’s death or transfer, results in a shorter beneficiary stay than the physician’s expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and hospital inpatient payment may be made under Medicare Part A.
§ 412.46 Medical review requirements.
(a) Physician acknowledgement. (1) Basis. Because payment under the prospective payment system is based in part on each patient’s principal and secondary diagnoses and major procedures performed, as evidenced by the physician’s entries in the patient’s medical record, physicians must
complete an acknowledgement statement to this effect.

(2) **Content of physician acknowledgement statement.**
When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice: Notice to Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(3) **Completion of acknowledgement.** The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(b) **Physician’s order and certification regarding medical necessity.** No presumptive weight shall be assigned to the physician’s order under § 412.3 or the physician’s certification under Subpart B of Part 424 of the chapter in determining the medical necessity of inpatient hospital services under section 1862(a)(1) of the Act. A physician’s order or certification will be evaluated in the context of the evidence in the medical record.

§ 424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities.

(a) **Content of certification and recertification.** Certification begins with the order for inpatient admission. Medicare Part A pays for inpatient hospital services (other than inpatient psychiatric facility services) only if a physician certifies and recertifies the following:

(1) That the services were provided in accordance with § 412.3 of this chapter.

(2) The reasons for either—

(i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or

(ii) Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of Part 412 of this chapter).

(3) The estimated time the patient will need to remain in the hospital.

(4) The plans for posthospital care, if appropriate.

(b) **Timing of certification.** For all hospital inpatient admissions, the certification must be completed, signed, and documented in the medical record prior to discharge. For outlier cases under subpart F of Part 412 of this chapter that are not subject to the PPS, the certification must be signed and documented in the medical record and as specified in paragraphs (e) through (h) of this section.

(c) **Certification of need for hospitalization when a SNF bed is not available.** (1) The physician may certify or recertify need for continued hospitalization if he or she finds that the patient could receive proper treatment in a SNF but no bed is available in a participating SNF.

(2) If this is the basis for the physician’s certification or recertification, the required statement must so indicate; and the certifying physician is expected to continue efforts to place the patient in a participating SNF as soon as a bed becomes available.

(d) **Signatures.**—(1) **Basic rule.** Except as specified in paragraph (d)(2) of this section, certifications and recertifications 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.

(2) **Exception.** If the intermediary requests certification of the need to
admit a patient in connection with dental procedures, because his or her underlying medical condition and clinical status or the severity of the dental procedures require hospitalization, that certification may be signed by the dentist caring for the patient.

(e) **Timing of certifications and recertifications: Outlier cases not subject to the prospective payment system (PPS).**

(1) For outlier cases that are not subject to the PPS, certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories.

(2) The first recertification is required no later than as of the 18th day of hospitalization.

(3) Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses) but not less frequently than every 30 days.

(f) **Timing of certification and recertification: Outlier cases subject to PPS.** For outlier cases subject to the PPS, certification is required as follows:

(1) For day outlier cases, certification is required no later than 1 day after the hospital reasonably assumes that the case meets the outlier criteria, established in accordance with § 412.80(a)(1)(i) of this chapter, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses) but not less frequently than every 30 days.

(2) For cost outlier cases, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier. If possible, certification must be made before the hospital incurs costs for which it will seek cost outlier payment. In cost outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses).

(g) **Recertification requirement fulfilled by utilization review.** (1) At the hospital’s option, extended stay review by its UR committee may take the place of the second and subsequent recertifications required for outlier cases not subject to PPS and for PPS day-outlier cases.

(2) A utilization review that is used to fulfill the recertification requirement is considered timely if performed no later than the seventh day after the day the recertification would have been required. The next recertification would need to be made no later than the 30th day following such review; if review by the UR committee took the place of this recertification, the review could be performed as late as the seventh day following the 30th day.

(h) **Description of procedures.** The hospital must have available on file a written description that specifies the time schedule for certifications and recertifications, and indicates whether utilization review of long-stay cases fulfills the requirement for second and subsequent recertifications of all outlier cases not subject to PPS and of PPS day outlier cases.
Preamble, Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, etc.

C. Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A

1. Background
As we discussed in section XI.A. of the preamble of this final rule, in response to concerns about the provision of observation services for increasingly long periods of time albeit in a small percentage of cases, and in response to stakeholders' concerns about the clarity and appropriateness of Medicare's hospital inpatient admission and medical review guidelines, we proposed several clarifications and changes in policy in the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27644 through 27650). In this section of this final rule, we discuss the public comments we received in response to our proposals and provide our final policies after consideration of the public comments we received.

2. Requirements for Physician Orders

a. Statutory Basis, Relationship to Physician Certification, and Timing
In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27646 through 27647), we clarified that a beneficiary becomes a hospital inpatient if formally admitted as such pursuant to a physician order for hospital inpatient admission. While the requirement for a physician order for hospital inpatient admission has long been clear in the hospital CoPs, we proposed to state explicitly in our payment regulations that admission pursuant to this order is the means whereby a beneficiary becomes a hospital inpatient and, therefore, is required for payment of hospital inpatient services under Medicare Part A. We stated that a beneficiary becomes a hospital inpatient when admitted as such after a physician (or other qualified practitioner as provided in the regulations) orders inpatient admission in accordance with the CoPs, and that Medicare pays under Part A for such an admission if the order is documented in the medical record. We stated that the order must be supported by objective medical information for purposes of the Part A payment determinations.

Accordingly, we proposed new 42 CFR 412.3(a), which states, “For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital.” We stated that this physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A (78 FR 27647).

In addition, in the proposed rule, we discussed the statutory requirement for certification of hospital inpatient services for payment under Medicare Part A. The certification requirement for inpatient services other than psychiatric inpatient services is found in section 1814(a)(3) of the Act, which provides that Medicare Part A payment will only be made for such services “which are furnished over a period of time, [if] a physician certifies that such services are required to be given on an inpatient basis.” The regulation implementing this requirement is found at 42 CFR 424.13(a).

The requirement for certification and recertification of inpatient psychiatric services as a condition of payment are found in section 1814(a)(2) of the Act and 42 CFR 424.14. We did not propose to exclude any hospitals from our proposed clarification of the requirement for the physician order and physician certification for Part A payment of hospital inpatient services.

Comment: One commenter asked CMS to clarify what is meant by physician “certification.” Some commenters believed that CMS did not articulate a statutory authority for requiring the physician order as a condition of Part A payment. The commenters stated that the proposed rule implied that the physician order requirement flows from section 1814(a)(3) of the Act, which sets forth conditions and limitation on payment, one of which is a requirement for a physician certification that hospital inpatient services furnished over a period of time are required on an inpatient basis for such individual's medical treatment. Other commenters assumed that, in the proposed rule, CMS was equating the physician order with the physician certification that is required for payment under section 1814(a)(3) of the Act, stating that in the Social Security Amendments of 1967 to this section of the Act, Congress found that admission “orders” are not required for Medicare payment because hospital admissions are almost always medically necessary.

These commenters objected to the proposal to clarify that inclusion of the inpatient admission order in the medical record is a condition of payment. The commenters acknowledged that the hospital CoPs already require as a health and safety measure that the inpatient admission decision be made upon the “recommendation” of a physician. However, they believed it would be duplicative to also require an order as a condition of payment, and were concerned that the requirement would become the basis for hospital liability under the False Claims Act. One commenter stated that CMS' proposal crossed the line in dictating the practice.
of medicine. Some commenters believed that CMS proposed a new requirement that is not supported in the statute and is contrary to longstanding practice under the Medicare program. These commenters argued that the statutory reference to services furnished “over a period of time” as well as the regulation’s lack of any specific deadline for physician certifications in nonoutlier cases indicate that no certification is required for short-stay cases.

In support of their argument, the commenters cited the legislative history of section 1814(a)(3) of the Act, which they interpret to apply only to certain long-term stays. They noted that, in the Social Security Amendments of 1967, Congress amended the statutory language from requiring physician certification of hospital inpatient services to requiring physician certification only for “inpatient hospital services . . . which are furnished over a period of time.” Moreover, the commenters cited congressional reports explaining this statutory change by stating that it “eliminat[ed] the requirement for hospital insurance payments that there be a physician’s certification of medical necessity with respect to admissions to hospitals which are neither psychiatric nor tuberculosis institutions” and that such a certification is required “only in cases of hospital stays of extended duration.” The commenters suggested that the House report also explains the reason for the change, stating that “admissions to general hospitals are almost always medically necessary and the requirement for a physician’s certification of this fact results in largely unnecessary paperwork” (H.R. Rep. No. 90–544, at 38 (1967)). Based upon all of the above factors, the commenters argued that, since 1967, the agency has not had authority to require a physician order as a condition of payment for hospital inpatient stays other than extended stays.

Response: We do not agree that these arguments mandate the conclusion that the physician certification requirement only applies to long-stay cases. The statute does not define “over a period of time,” and further provides that “such certification shall be furnished only in such cases, and with such frequency, and accompanied by such supporting material . . . as may be provided by regulations.” By this language, Congress explicitly delegated authority to the agency to elucidate this provision of the statute by regulation. Accordingly, CMS is authorized to interpret the statutory phrase “over a period of time” as long as its interpretation is not arbitrary, capricious, or manifestly contrary to statute (Chevron U.S.A. Inc. v. Natural Resources Defense Council, 467 U.S. 837 (1984)).

Section 424.13 of the regulations does not contain any length-of-time restrictions on the applicability of the certification requirement. Instead, §424.13(a) provides that Medicare Part A payment will only be made for inpatient hospital services (other than inpatient psychiatric services) if a physician certifies or recertifies “the need for continued hospitalization of the patient for medical treatment or medically required inpatient diagnostic study.” Therefore, in its implementing regulations, CMS interpreted the statute’s requirement of a physician certification for inpatient hospitals services furnished “over a period of time” to apply to all inpatient admissions. While this is not the only possible interpretation of the statute, we believe that it is a permissible interpretation.

We recently reiterated our requirement of a physician order for all inpatient admissions in the preamble to the CY 2012 Medicare Physician Fee Schedule final rule. In a discussion regarding whether services furnished to a patient who is at the hospital overnight, but for less than 24 hours, should be billed as outpatient or inpatient services, CMS stated that “[u]nless a treating physician has written an order to admit the patient as an inpatient, the patient is considered for Medicare purposes to be a hospital outpatient, not an inpatient” (76 FR 73106). In addition, the CoPs illustrate that CMS’ policy requires a physician order in order to justify inpatient hospitalization (including inpatient psychiatric hospitalizations). Under 42 CFR 482.12(c)(2), a hospital’s governing body must ensure that “[p]atients are admitted to the hospital only on the recommendation of a licensed practitioner responsible for a patient’s medical care at the hospital and not actually use a hospital bed overnight.” In addition, Section 10 provides that “[t]he physician or other practitioner responsible for a patient’s care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.

CMS’ policy is also reflected in the Medicare Claims Processing Manual (MCPM) (Pub. 100–04), Chapter 3, Section 40.2.2(K), which discusses the circumstance where a patient is admitted to an inpatient hospital, but dies or is discharged before being assigned to a room. Certainly, this circumstance would not qualify as a long stay, but CMS still requires a physician order to justify the admission, stating that “[a] patient of an acute care hospital is considered an inpatient upon issuance of written doctor’s orders to that effect.” Finally, Chapter 4 of the Medicare General Information, Eligibility, and Entitlement Manual also addresses the certification requirement. Section 10 of Chapter 4 provides that “[p]ayments may be made for covered hospital services only if a physician certifies and recertifies to the medical necessity for the services at designated intervals of the hospital inpatient stay.” As members of the hospital community have noted in the past, this section also states that “[f]or patients admitted to a general hospital, a physician certification is not required at the time of admission.” However, this merely means that the certification need not be contemporaneous with the admission, rather than indicating that no certification is required.

Therefore, our longstanding policy, as reflected in our regulations and other guidance, has been that a physician order is required for all inpatient hospital admissions, regardless of the length of stay. We believe that this policy is a legally supportable interpretation of section 1814(a) of the Act. In order to clarify this policy going forward, we are finalizing § 412.3(a) to include the proposed language as well as the provision we described in the proposed rule (78 FR 27647) that the order must be present in the medical record and supported by the physician admission and progress notes. We are adding this preamble language from the proposed rule to the regulation text to improve clarity and provide consistency with our policy on medical review of inpatient admissions (section XLC.3. of the preamble of this proposed rule) that,
while the physician order and the physician certification are required for all hospital inpatient admissions in order for payment to be made under Part A, the physician order and the physician certification are not considered by CMS to be conclusive evidence that an inpatient hospital admission or service was medically necessary. Rather, the physician order and physician certification are considered along with other documentation in the medical record. As finalized, §412.3(a) reads: "For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A. In addition to these physician orders, inpatient rehabilitation facilities also must adhere to the admission requirements specified in §412.622 of this chapter."

To provide further clarity and to more closely mirror the authorizing statutory language, we are deleting the word “continued” and adding the word “inpatient” before the phrase “medical treatment” in §424.13(a)(2), to reflect that the content of the certification of inpatient services (other than inpatient psychiatric services) includes the reason for inpatient hospital services. The amended paragraph reads, “(a) **Content of certification and recertification.** Certification begins with the order for inpatient admission. Medicare Part A pays for inpatient hospital services (other than inpatient psychiatric facility services) only if a physician certifies and certifies the following:

1. That the services were provided in accordance with §412.3 of this chapter
2. The reasons for either—
   i. Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or
   ii. Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of Part 412 of this chapter)."

We believe this language better reflects the statutory content of the certification required by section 1814(a)(3) of the Act “[i]f such services are required to be given on an inpatient basis for such individual’s medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose.”

We note that the particular elements of the certification, for example, the order for inpatient services and documentation of the reason for continued hospitalization (diagnosis) should be documented within the medical record. Therefore, we are not finalizing any new documentation requirements. The existing provisions in §424.11 continue to apply, for example paragraphs (b) and (c) which provide that no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. The preceding sections of Part 424, subpart B set forth specific information required for different types of services. If that information is contained in other provider records, such as physicians’ progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found.

To clarify the relationship between the physician order and the physician certification, we are adding new 42 CFR 412.3(c) which states that “The physician order also constitutes a required component of the physician certification of the medical necessity of hospital inpatient services under Part 424 of this chapter.” Similarly, we are revising paragraph (a) of §424.13 to include in the content of the certification for inpatient hospital services (other than inpatient psychiatric services): “(1) [t]hat the services were provided in accordance with §412.3 of this chapter [the order].” We are adding parallel provisions in 42 CFR 424.14(b) and 424.15(a) to include in the content of the physician certification for payment of inpatient psychiatric services and inpatient CAH services, respectively, that the services were provided in accordance with §412.3. We discuss additional rules for certification that apply to inpatient services furnished in IRFs in section XI.C.2.c. of the preamble of this final rule.

To further clarify the relationship between the physician order and the physician certification, and our requirement that, like the order, the certification applies to all hospital inpatient admissions (not just extended stays), we are adding new provisions to the regulations regarding timing of the certification. In §424.13, we are providing that the certification must be signed and documented in the medical record prior to the hospital discharge (except for certifications of extended stays, which are required earlier). We are redesignating existing paragraphs (b) through (g) of §424.13 as paragraphs (c) through (h), respectively, in order to add a new paragraph (b). We are requiring under new §424.13(b) that, for inpatient services other than inpatient psychiatric services: “For all hospital inpatient admissions, the certification must be completed, signed, and documented in the medical record prior to discharge. For outlier cases under subpart F of Part 412 of this chapter that are not subject to the FPS, the certification must be signed and documented in the medical record and as specified in paragraphs (e) through (h) of this section.”

For inpatient psychiatric services, we are adding the phrase “and must be completed and documented in the medical record prior to discharge” at the end of §424.14(d)(1) so that the paragraph reads, “Certification is required at the time of admission or as soon thereafter as is reasonable and practicable, and must be completed and documented in the medical record prior to discharge.” We will continue to provide under paragraph (d)(2) of §424.14 that the first recertification is required as of the 12th day of hospitalization. Subsequent recertifications are required at intervals established by the utilization review committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.

Like other components or elements of the physician certification, the physician order reflects affirmation by the ordering practitioner that hospital inpatient services are medically necessary. However, the order serves the unique purpose of initiating the inpatient admission and documenting the physician’s (or other qualified practitioner as provided in the regulations) intent to admit the patient, which impacts its required timing. Therefore we are specifying in new paragraph (d) of §412.3 that “The physician order must be furnished at or before the time of the inpatient admission” (unlike the rest of the certification which may be completed prior to discharge, except for the outlier
developed over a period time, and we regarding verbal orders were carefully developed our requirements regarding practitioner who gave the verbal order. Properly countersigned by the order for inpatient and authenticated order for inpatient physician and hospital staff but it is not a substitute for a properly documented payment. A verbal order is a temporary substitute for a properly documented physician order as a technical requirement for medical necessity and payment. The admission order is evidence of the decision by the physician (or other practitioner who can order inpatient services) to admit the beneficiary to inpatient status. In very rare circumstances, the order to admit is missing, yet the physician intent and physician recommendation to admit to inpatient can clearly be derived from the medical record, for example if a medically necessary inpatient-only service was furnished, the contractor should consider these rather than requiring the physician order as a technical requirement for medical necessity and payment.

Response: The admission order is evidence of the decision by the physician (or other practitioner who can order inpatient services) to admit the beneficiary to inpatient status. In very rare circumstances, the order to admit is missing, yet the physician intent and physician recommendation to admit to inpatient can clearly be derived from the medical record. In these rare situations, we have provided contractors with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the physician order, there can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these rare situations, we have provided contractors with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the physician order, there can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these rare situations, we have provided contractors with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the physician order, there can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these rare situations, we have provided contractors with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the physician order, there can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient can clearly be derived from the medical record.
inpatient services. In this example, the beneficiary is admitted and becomes an inpatient pursuant to the physician’s order and could not be admitted without it, although there may be a time lag between when the order to admit is written and the time of formal admission. The physician order cannot be effective retroactively. In this final rule, we are not changing our definition of a “hospital inpatient.” Inpatient status only applies prospectively, starting from the time the patient is formally admitted pursuant to a physician order for inpatient admission, in accordance with our current policy.

Comment: Several commenters expressed the opinion that physicians should not have to divide their attention between providing patient care and understanding Medicare’s admission rules, which the commenters viewed as mere billing distinctions. Some commenters believed that CMS should allow physicians to delegate the determination of patient status to the hospital or its utilization review committee, while the physician focuses on ordering and providing the necessary clinical care. Further, some commenters stated that this is their current practice. Some commenters commented that their current processes provide for admission “to case management” or “to utilization review” rather than specifying inpatient admission.

Response: As we discussed above, many public comments from physicians indicated that they believed the physician should be involved in the determination of patient status, and we agree. To reinforce this policy and reduce confusion among hospitals, beneficiaries, and physicians on the differences between outpatient observation and inpatient services, we are providing in this final rule that the order for inpatient admission must specify admission “to or as an inpatient.” In previous discussions, stakeholders have indicated that often physician orders only specify admission to a certain location in the hospital (for example, “Admit to Tower 7”) or do not clarify whether the physician’s intent is to “admit” the beneficiary for outpatient observation services or for hospital inpatient services. Therefore, we are providing that, for payment of hospital inpatient services under Medicare Part A, the order must specify the admitting practitioner’s recommendation to admit “to inpatient,” “as an inpatient,” “for inpatient services,” or similar language specifying his or her recommendation for inpatient care. In addition, as discussed in proposed rule (78 FR 27646), we remind hospitals that patients are admitted to the hospital only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital, provided that the practitioner, either a physician or other licensed practitioner, has been granted such privileges by the hospital to do so. Hospitals and physicians routinely must work together to comply with billing, coding, and admission rules not just for Medicare, but also for Medicaid and private payers.

b. Authorization to Sign the Physician Order

We proposed new regulation provisions in 42 CFR 412.3(b) which state that, as a condition of payment, the order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is responsible for the inpatient care of the patient at the hospital. The practitioner could not delegate the decision (order) to another individual who is not responsible for the care of that patient, is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital’s medical staff.

Comment: Commenters in the physician and Medicare contractor medical review communities generally supported the proposal to require the inpatient admission order, and to provide that it could not be delegated to another individual who does not possess the authority to order inpatient admission in his or her own right. In addition, some commenters representing hospitals did not object to this requirement because it is already standard practice. However, the commenters described a number of situations in which the ordering practitioner would appropriately not be the individual who takes responsibility for the inpatient care of the beneficiary, or for the entirety of the inpatient care. According to the commenters, these included emergency department physicians, hospitalists and other types of physicians in group practices who care for patients in the hospital, and residents working under the supervision of attending physicians. The commenters requested that if CMS finalizes a requirement for the inpatient order as a condition of Part A payment, CMS should allow it to be issued by any physician in the hospital who is knowledgeable about the beneficiary’s condition and has admitting privileges at the hospital.

Response: We agree with the comment that it would be appropriate to allow practitioners who may not be responsible for the inpatient hospital care of the beneficiary but are otherwise qualified to admit patients at that hospital and are knowledgeable about the case to order the inpatient admission. Therefore, we are deleting the proposed language in paragraph (b) of §412.3 that would have required the order to be issued by a practitioner who is responsible for the inpatient care of the patient at the hospital. We are replacing this language with new language to specify that, although the ordering practitioner need not be responsible for the patient’s inpatient care, he or she must be knowledgeable about the patient’s hospital course, medical plan of care, and current condition.

We are finalizing all of the other proposed qualifications in paragraph (b) of §412.3 for the ordering practitioner. The final language reads, “(b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient’s hospital course, medical plan of care, and current condition. 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 applicable to that patient by the hospital’s medical staff.” We discuss the application of these final policies to IRFs in section XI.C.2.c. of the preamble of this final rule.

c. Applicability to Inpatient Rehabilitation Facilities (IRFs)

We note that IRFs that are excluded from the IPPS and paid under the IRF prospective payment system (IRF PPS) specified in 42 CFR 412.1(a)(3) have certain requirements in 42 CFR 412.622(a)(3), (a)(4), and (a)(5) that govern an inpatient admission to an IRF. These requirements specify the admission criteria that must be documented in the medical record for an IRF admission of a Medicare Part A fee-for-service beneficiary to be considered reasonable and necessary under section 1862(a)(1) of the Act. For example, the documentation requirements contained in these regulations specify that a comprehensive preadmission screening must be conducted and must serve as the basis for the initial determination of whether or not the patient meets the requirements for admission to an IRF. A rehabilitation physician, defined as a licensed physician with specialized training and experience in rehabilitation, must document that he or she has reviewed and concurs with the preadmission screening prior to the
admission. However, we note that Chapter 1, Section 110.1.4 of the MBPM also specifies that, at the time each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient’s care.

Therefore, although the required physician orders discussed in section XLC.2.a. of the preamble of this final rule apply to all inpatient hospital admissions, including inpatient admissions to an IRF, they do not determine the timing of an IRF admission, nor are they used to determine whether the IRF admission was reasonable and necessary. These determinations are governed by the requirements in §§ 412.622(a)(3), (4), and (5) of the regulations. To clarify this, we have included a provision under new § 412.3 in this final rule that the IRF requirements at § 412.622 also must be met in order for the IRF to be paid for hospital inpatient services under Medicare Part A. However, due to the aforementioned inherent differences in the operation of and beneficiary admission to IRFs, such providers are excluded from the 2-midnight admission guidelines and medical review instruction, as provided under XLC.3. of the preamble of this final rule.

3. Inpatient Admission Guidelines

CMS is authorized under section 1893 of the Act to implement the Medicare Integrity Program to conduct medical review of claims and ensure appropriateness of Medicare payment. Medicare review contractors, such as Medicare Administrative Contractors (MACs), Recovery Auditors (formerly known as the Recovery Audit Contractors, or RACs), the Comprehensive Error Rate Testing (CERT) Contractor, and other review contractors are hired by CMS to review claims on a pre-payment or post-payment basis to determine whether a claim should be paid or denied or whether a payment was properly made under Medicare payment rules. Following documentation reviews, many claim denials are made or improper payments identified because either—

- The claim was incorrectly coded (for example, the provider did not appropriately assign the individual or group inpatient and/or outpatient coding for the care documented); or
- The services were not medically necessary (that is, the review indicates that the services billed were not reasonably necessary based upon Medicare payment policies or that the documentation was insufficient to support the medical necessity of the services billed).

CMS developed the CERT program to calculate the annual Medicare FFS program improper payment rate. The CERT program considers any claim that was paid when it should have been denied or paid at another amount (including both overpayments and underpayments) to be an improper payment. Hospital claim errors are identified more frequently for shorter lengths of stay. In 2012, the CERT contractor found that Medicare Part A inpatient hospital admissions for 1-day stays or less had an improper payment rate of 36.1 percent. The improper payment rate decreased significantly for 2-day or 3-day stays, which had improper payment rates of 13.2 percent and 13.1 percent, respectively. The improper payment rate further decreased to 8 percent for those beneficiaries who were treated as hospital inpatients for 4 days.

Hospital claim errors are identified more frequently for shorter lengths of stay. The majority of improper payments under Medicare Part A for short-stay inpatient hospital claims have been due to inappropriate patient status (that is, the services furnished were reasonable and necessary, but should have been furnished on a hospital outpatient, rather than hospital inpatient, basis). Inpatient hospital short-stay claim errors are frequently related to minor surgical procedures or diagnostic tests. In such situations, the beneficiary is typically admitted as a hospital inpatient after the procedure is completed, monitored overnight as an inpatient, and discharged from the hospital in the morning. Medicare review contractors typically find that while the underlying services provided were reasonable and necessary, the inpatient hospitalization following the procedure was not (that is, the services following the procedure should have been provided on an outpatient basis).

In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27644 through 27650), we sought to clarify our longstanding policy on how Medicare review contractors review inpatient hospital admissions for payment under Medicare Part A. We also issued proposed guidance to physicians and hospitals regarding when a hospital inpatient admission should be ordered for Medicare beneficiaries. In this final rule we discuss the public comments we received in response to our proposals relating to admission guidance and medical necessity and provide our final policies after considerations of those public comments.

a. Correct Coding Reviews

We did not propose any changes to coding review strategies for hospital claims. Reviewers will continue to ensure that the correct codes were applied and are supported by the medical record documentation.

b. Complete and Accurate Documentation

When conducting complex medical review, we proposed that Medicare review contractors would continue to employ clinicians to review practitioner documented procedures and ensure that they are supported by the submitted medical record documentation. Such has been the case for complex medical review as historically performed, and will continue to be the case per this final rule instruction.

c. Medical Necessity Reviews

(1) Physician Order and Certification

In the proposed rule (78 FR 27647), we proposed to codify in 42 CFR 412.46(b) the longstanding requirement that medical documentation must support the physician’s order and certification, as prescribed by CMS Ruling 93–1. Under the proposed new paragraph (b) titled “Physician’s order and certification regarding medical necessity,” CMS reiterated that “No presumptive weight shall be assigned to the physician’s order under § 412.3 or the physician’s certification under Subpart B of Part 424 of this chapter in determining the medical necessity of inpatient hospital services under section 1862(a)(1) of the Act. A physician’s order and certification will be evaluated in the context of the evidence in the medical record.” We also stated that current requirements for practitioner documentation of services ordered and furnished would remain unchanged. That is, while the physician order and the physician certification are required for all inpatient hospital admissions in order for payment to be made under Part A, the physician order and the physician certification are not considered by CMS to be conclusive evidence that an inpatient hospital admission or service was medically necessary. Rather, the physician order and physician certification are considered along with other documentation in the medical record.

Comment: Some commenters disagreed with the proposal for reviewing the physician order and certification in accord with the documentation in the medical record. Rather, the commenters suggested that an assumption of medical necessity for the inpatient stay would more
appropriately stem from the physician order to admit to inpatient, particularly due to its requirement for admission purposes.

Response: Satisfying the requirements regarding the physician order and certification alone does not guarantee Medicare payment. Rather, in order for payment to be provided under Medicare Part A, the care must also be "reasonable and necessary," as specified under section 1862(a)(1) of the Act. In addition, section 1869(a) of the Act provides that determinations regarding entitlement to benefits are under the authority of the Secretary. As stated in our proposed rule, the instruction for reviewers to account for all documentation in the medical record, in addition to the actual order for inpatient admission, is consistent with statutory instruction and our prior policy as outlined in Medicare Ruling 93–1, and is being codified for transparency and consistency.

Comment: Commenters requested that CMS define what constitutes "objective medical information," which is required to support the order for a hospital inpatient admission.

Response: We appreciate the commenters’ suggestions that additional documentation guidelines would be helpful. We will consider them as we develop implementation instructions and manual revisions.

(2) Inpatient Hospital Admission Guidelines

In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27648), we indicated that longstanding Medicare policy has recognized that there are certain situations in which a hospital inpatient admission is rarely appropriate. We have stated in the MBPM that when a beneficiary receives a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for only a few hours (less than 24), the services should be provided as outpatient hospital services, regardless of the hour the beneficiary comes to the hospital, whether he or she uses a bed, and whether he or she remains in the hospital past midnight (Section 10, Chapter 1 of the MBPM). In applying this benchmark, we have been clear that this instruction does not override the clinical judgment of the physician to keep the beneficiary at the hospital, to order specific services, or to determine appropriate levels of nursing care or physical locations within the hospital. Rather, this instruction provided a benchmark to ensure that all beneficiaries received consistent application of their Part A benefit to whatever clinical services were medically necessary.

Due to persistently large improper payment rates in short-stay hospital inpatient claims, and in response to requests to provide additional guidance regarding the proper billing of those services, we proposed to modify and clarify our general rule and provide at §412.3(c)(1) that, in addition to services designated by CMS as inpatient only (which are appropriate for inpatient admission without regard to duration of care), surgical procedures, diagnostic tests, and other treatments would be generally appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least 2 midnights and admits the beneficiary to the hospital based upon that expectation. Conversely, when a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under §419.22(n), a diagnostic test, or any other treatment and the physician expects to keep the beneficiary in the hospital for only a limited period of time that does not cross 2 midnights, the services would be generally inappropriate for payment under Medicare Part A. This would be the case regardless of the hour that the beneficiary came to the hospital or whether the beneficiary used a bed.

In the proposed rule, we provided inpatient hospital admission guidance specifying that a physician or other qualified practitioner (herein we will refer to the physician, with the understanding that this can also pertain to another qualified practitioner) should order admission if he or she expects that the beneficiary’s length of stay will exceed a 2-midnight benchmark or if the beneficiary requires a procedure specified as inpatient-only under §419.22. We proposed that the starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional hospital services would be provided. We also sought public comment regarding alternative methods of calculating the start time for the 2-midnight instruction.

In the proposed rule, we stated that the judgment of the physician and the physician’s order for inpatient admission should be based on the expectation of care surpassing 2 midnights, with both the expectation of time and the determination of the underlying need for medical care at the hospital considered in complex medical factors such as history and symptoms, current medical needs, and the risk of an adverse event. We also indicated that, in accordance with current policy, factors that may result in an inconvenience to a beneficiary or family would not justifiy an inpatient hospital admission. The factors that lead a physician to admit a particular beneficiary based on the physician’s clinical expectation are significant clinical considerations and must be clearly and completely documented in the medical record. Because of the relationship that develops between a physician and his or her patient, the physician is in a unique position to incorporate complete medical evidence in a beneficiary’s medical records, and has ample opportunity to explain in detail why the expectation of the need for care spanning at least 2 midnights was appropriate in the context of that beneficiary’s acute condition. We stated in the proposed rule that a reasonable expectation of a stay crossing 2 midnights, which is based on complex medical factors and is documented in the medical record, will provide the justification needed to support medical necessity of the inpatient admission, regardless of the actual duration of the hospital stay and whether it ultimately crosses 2 midnights. As such, we acknowledged in the proposed rule that there may be an unforeseen circumstance that results in a shorter beneficiary stay than the physician’s expectation of surpassing 2 midnights. We stated that we would expect that the majority of such inpatient hospital admissions would occur when an inpatient hospital admission is appropriately ordered, but a beneficiary’s transfer or death interrupts the beneficiary’s hospital stay that would have otherwise spanned at least 2 midnights. Therefore, we provided in proposed §412.3(c)(2), that “If an unforeseen circumstance, such as beneficiary death or transfer, results in a shorter beneficiary stay than the physician’s expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and the hospital inpatient payment may be made under Medicare Part A.” We indicated that documentation in the medical record of such a circumstance would be required for purposes of supporting whether the inpatient hospital admission was reasonable and necessary for Medicare Part A payment. In addition, we explained that the physician must certify that inpatient hospital services were medically necessary in accordance with section 1814(a) of the Act and 42 CFR Part 424, Subpart B.
Comment: Commenters pointed to CMS’ guidance that time should not be the leading factor in the decision to admit a beneficiary and that the decision should rely on the physician’s clinical judgment and evaluation of the beneficiary’s needs based on the severity of illness, the intensity or complexity of care, and the predictability of high-risk adverse outcomes. The commenters stated that there are many beneficiaries who stay in a hospital for less than 2 midnights but still require an inpatient level of care.

Response: In our existing guidance, we stated that the decision to admit a patient as an inpatient is a complex medical decision based on many factors, including the risk of an adverse event during the period considered for hospitalization, and an assessment of the services that the beneficiary will need during the hospital stay. The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits to some other care. Our previous guidance also provided for a 24-hour benchmark, instructing physicians that, in general, beneficiaries who need to stay at the hospital less than 24 hours should be treated as outpatients, while those requiring care greater than 24 hours may usually be treated as inpatients. Our proposed 2-midnight benchmark, which we now finalize, simply modifies our previous guidance to specify that the relevant 24 hours are those encompassed by 2 midnights. While the complex medical decision is based upon an assessment of the need for continuing treatment at the hospital, the 2-midnight benchmark clarifies when beneficiaries determined to need such continuing treatment are generally appropriate for inpatient admission or outpatient care in the hospital.

Contrary to the commenters’ suggestion, we do not refer to “level of care” in guidance regarding hospital inpatient admission decisions. Rather, we have consistently provided physicians with the aforementioned time-based admission framework to effectuate appropriate inpatient hospital admission decisions. This is supported by recent findings by the Office of Inspector General (OIG) (OIG, Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, OEI–02–12–00040, July 2013). The OIG found that the reasons for short inpatient stays and for outpatient observation stays were often the same. They further noted that the relative use of short inpatient stays versus outpatient observation stays varied widely between hospitals, consistent with medical review findings that identical beneficiaries may receive identical services as either inpatients or outpatients in different hospitals. We believe that this supports our proposed continuation of our existing policy that there are no prohibitions against a patient receiving any individual service as either an inpatient or an outpatient, except for those services designated by the Outpatient Prospective Payment System (OPPS) Inpatient-Only list as inpatient-only services. We further believe that this supports our proposed policy that the physician is expected to continue to use his or her complex clinical judgment in determining whether a beneficiary needs to stay at the hospital, what services and level of nursing care (for example, low-level, monitored, or one-on-one) the beneficiary will need, and what location (unit) is most appropriate. This does not require that the physician memorize complex billing or utilization guidelines; rather, the physician should generally order an inpatient admission when he or she has determined that the beneficiary requires care at the hospital that is expected to transcend at least 2 midnights or that it will involve a procedure designated by the OPPS Inpatient-Only list as an inpatient-only procedure.

Comment: Commenters asserted that making a time-based prediction is difficult for the physician. They stated that making such a determination is contradictory to medical professionals’ training, which is centered on the assessment of patients and the development of treatment plans, as opposed to focusing on the utilization review process. The commenters also stated that predicting length of stay is difficult because individual patients respond differently to care provided. Commenters suggested that a physician often does not have enough information about a patient at the onset of treatment to make an informed decision regarding anticipated length of stay. For example, a hospitalist admitting a beneficiary through the emergency department likely will not be familiar with the patient and may not have access to extensive medical history documentation on which to make a decision. Commenters suggested that beneficiaries with unknown or uncertain diagnoses should be kept under observation status until their diagnosis and course of treatment become clear. At that point, the commenters added, the hospital would be in the best position to determine the length of treatment, make the decision to admit to inpatient status, or discharge the patient home.

Response: It has been longstanding Medicare policy to require physicians to admit a beneficiary as a hospital inpatient based on their expected length of stay. However, we recognized when we published our definition of observation services that long-term predictions are inherently more difficult than short-term predictions. Therefore, we revised our guidance to indicate that, when it was difficult to make a reasonable prediction, the physician should not admit the beneficiary but should place the beneficiary in observation as an outpatient. As new information becomes available, the physician must then reassess the beneficiary to determine if discharge is possible or if it is evident that an inpatient stay is required. We believe that this principle still applies and have reiterated this in the final rule. For those hospital stays in which the physician cannot reliably predict the beneficiary to require a hospital stay greater than 2 midnights, the physician should continue to treat the beneficiary as an outpatient and then admit as an inpatient if and when additional information suggests a longer stay or the passing of the second midnight is anticipated.

Comment: Commenters pointed out that although the proposal is framed as a presumption, the proposed rule would, in effect, inappropriately establish a per se rule that inpatient admissions that are not expected to last at least 2 midnights are not medically reasonable and necessary (unless the beneficiary is receiving an inpatient-only service or procedure). The commenters stated that the proposed rule offers no legal or medical support for the idea that a 1-day stay that is expected to be a 1-day stay is not medically reasonable and necessary as an inpatient admission. Other commenters requested that CMS clarify that no per se rule would be created that inpatient payment is always inappropriate following procedures not on the inpatient-only list.

Response: The proposed rule did not create a per se standard; rather, consistent with historical instruction, the proposed rule continues the use of a benchmark to ensure a uniform understanding of the circumstances under which an inpatient admission should be ordered or when the care should be provided on an outpatient basis. This common standard is not a per se rule but a necessary reference to ensure similar beneficiary cost-sharing and hospital reimbursement for similar
The 2-midnight benchmark, rather, provides 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 to be further detailed in sub-regulatory instruction. In applying this benchmark, we have been clear that this instruction does not override the clinical judgment of the physician to keep the beneficiary at the hospital, to order specific services, or to determine appropriate levels of nursing care or physical locations within the hospital. Rather, this instruction provides a benchmark to ensure that all beneficiaries received consistent application of their Part A benefit to whatever clinical services were medically necessary.

Comment: Commenters urged CMS to consider situations that result in a shorter beneficiary stay than the physician’s expectation of care transcending 2 midnights. The commenters stated that in the proposed rule, CMS indicated that it would expect that the majority of such cases to be due to beneficiary death or transfer. Commenters expressed concern that these exceptions are too restrictive and urged CMS to recognize other exceptions, such as when a beneficiary leaves against medical advice (AMA) before reaching the 2-midnight benchmark, when the beneficiary improves more rapidly than expected, or when the beneficiary requires care in the intensive care unit (ICU). One commenter inquired whether a beneficiary who receives intensive services and expires prior to crossing 2 midnights would automatically be classified as appropriately outpatient.

Response: We appreciate industry feedback, and believe the rule, as finalized, provides for sufficient flexibility because of its basis in the physician’s expectation of a 2-midnight stay. Such would include situations in which the beneficiary improves more rapidly than the physician’s reasonable, documented expectation. Such unexpeced improvement may be provided and billed as inpatient care, as the regulation is framed upon a reasonable and supportable expectation, not the actual length of care, in defining when hospital care is appropriate for inpatient payment. We do not believe beneficiaries treated in an intensive care unit should be an exception to this standard, as our 2-midnight benchmark policy is not contingent on the level of care required or the placement of the beneficiary within the hospital. In addition, while we did not specify the situation in which a beneficiary leaves AMA as an exception under the proposed rule, we acknowledge that an AMA departure is usually an unexpected event and that an inpatient admission could still be appropriate provided that the medical record demonstrates a reasonable expectation of a 2-midnight stay when the admission order is written. As we develop our manual guidance to implement this proposed rule, we will identify those unusual situations in which we expect that the 2 midnight benchmark does not apply.

Comment: Commenters voiced concerns that the use of observation would increase under the proposed policy, regardless of CMS’ intent to reduce the incidence of long observation stays. Some commenters believed that if the physician would have to predict a greater than 2 midnight stay, only the sickest individuals and those receiving procedures on the inpatient-only list would be admitted as inpatients, while many more beneficiaries would be placed in observation so as to avoid an inaccurate length of stay determination and subsequent short-stay audits. Other commenters believed that because an increase in observation stays will happen, many hospital stays that would generally be appropriate for an inpatient admission under CMS’ current 24-hour guidance would now be generally inappropriate for Part A payment unless the 2-midnight benchmark is met. Commenters voiced concern that the increase in observation will lead to a strain in outpatient beds and resources, leading the hospitals to use outpatient beds for beneficiaries in outpatient status who need more intense monitoring than is currently available in outpatient areas without a proportionate increase in outpatient reimbursement from Medicare. Commenters also urged CMS to recalibrate its outpatient payment so that hospitals will be adequately compensated for handling the increase in observation cases, particularly for those stays requiring complex monitoring and intervention. The commenters believed that as beneficiaries have the potential for greater cost-sharing for an observation stay than an inpatient stay, this may lead to greater financial liability for beneficiaries.

Response: While previous guidance provided a 24-hour benchmark to be used in making inpatient admission decisions, we now specify that the 24 hours relevant to inpatient admission decisions are those encapsulated by 2 midnights. As we provide in this final rule, we expect that the decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpatient service. In other words, if the physician makes the decision to admit after the beneficiary arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the beneficiary’s total expected length of stay. For example, if the beneficiary has already passed 1 midnight as an outpatient observation patient or in routine recovery following outpatient surgery, the physician should consider the 2 midnight benchmark met if he or she expects the beneficiary to require an additional midnight in the hospital. This means that the decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in medically necessary hospitalizations should not pass a second midnight prior to the admission order being written. The potential increase in very short (less than 2 midnights) observation stays should be balanced by a significant decrease in long (2 midnights or more) observation stays. Because we expect that this revision should virtually eliminate the use of extended observation, we also anticipate it will concurrently limit beneficiary cost-sharing for outpatient services. We are not expecting any change in the utilization of specific beds or facilities, as the expectation of the duration of needed care is independent of the beneficiary’s location at the hospital.

Comment: One commenter inquired about the appropriate use of Condition Code 44 in a situation when the physician expected a stay that did not meet the 2-midnight standard but the beneficiary experienced an unanticipated recovery.

Response: We refer commenters to the instruction provided at section XI.B. of the preamble of this rule, in which we expanded on Condition Code 44 requirements and application. Under this section, we state that providers may continue to change patient status to outpatient during the hospital stay upon meeting the Condition Code 44 requirements. However, we note that Condition Code 44 is not to be used for unexpected events because, as described above, those situations can remain appropriately inpatient. Thus, a beneficiary who experiences an unexpected recovery during a medically necessary stay should not be converted to an outpatient but should remain an inpatient if the 2-midnight expectation was reasonable at the time the inpatient order was written, but unexpectedly the stay did not fully transpire. In contrast, Condition Code 44 is specifically for the situation when the utilization review or management committee determines that the physician has not appropriately
admitted a patient and the physician concurs that the status should be converted to outpatient prior to beneficiary discharge.

Comment: Commenters indicated that inpatient-only procedures that require a 1-day length of stay would be affected by this proposed policy and may not be adequately reimbursed under Medicare Part B. The commenters requested that CMS specify that all services on the inpatient-only list should automatically be deemed to meet inpatient service criteria, even if the beneficiary is in the hospital for less than 2 midnights. Conversely, another commenter suggested that excluding inpatient-only procedures, which may or may not require 2-midnight stays, contradicts a time-based policy.

Response: In the proposed rule, we stated that procedures on the OPPS inpatient-only list are always appropriately inpatient, regardless of the actual time expected at the hospital, so long as the procedure is medically necessary and performed pursuant to a physician order and formal admission. Procedures designated as inpatient-only are deemed statutorily appropriate for inpatient payment at § 419.22(n). As such, we believe that inpatient-only procedures are appropriate for exclusion from the 2-midnight benchmark. Under this final rule, inpatient-only procedures currently performed as inpatient 1-day procedures will continue to be provided as inpatient 1-day procedures, and therefore this rule will not result in any change in status or reimbursement.

Comment: Commenters recommended that CMS remove the 2-midnight guidance for certain procedures, allowing physicians to continue admitting as inpatient high risk, complex beneficiaries who are to undergo a surgery with added complexity, regardless of the expected length of stay. The commenters stated that many Medicare beneficiaries have multiple comorbidities, and the execution of seemingly simple procedures may require more pre-, intra-, and post-operative services than would be necessary for younger or healthier patients, even when there is no expectation that the beneficiary will require a stay of at least 2 midnights. Commenters added that the provision of such services may exceed the level of care typically associated with observation care. Other commenters suggested that CMS explicitly preclude from further review any services that are not typically available in an outpatient setting, such as telemetry. We agree with commenters that factors such as the procedures being performed and the health status of the beneficiary are important considerations in the decision to keep the beneficiary in the hospital. However, as we note above, the beneficiary’s required “level of care” is not part of the guidance regarding hospital inpatient admission decisions. Rather, we provide physicians with a 2-midnight admission framework to effectuate appropriate inpatient hospital admission decisions. More specifically, we have stipulated that factors such as the procedures being performed and the beneficiary’s condition and comorbidities apply when the physician formulates his or her expectation regarding the need for hospital care, while the decision of whether to admit a beneficiary as an inpatient or keep as an outpatient is based upon the physician’s expectation of the beneficiary’s required length of stay. In this rule, we have not identified any circumstances where the 2-midnight benchmark restricts the physician to a specific pattern of care, as we have specified that the 2-midnight benchmark, like the previous 24-hour benchmark, does not prevent the physician from providing any service at any hospital regardless of the expected duration of the service. Rather, this policy provides guidance on when the hospitalized beneficiary is appropriate for coverage under Part A benefits as an inpatient, and when the hospitalized beneficiary should receive that treatment as a registered outpatient subject to Part B benefits. On the other hand, we also specify that certain procedures may have intrinsic risks, recovery impacts or complexities that would cause them to be appropriate for inpatient coverage under Part A regardless of the expected length of hospital time a specific physician expects a particular patient to require. We believe that the OPPS Inpatient-Only List identifies those procedures and we have proposed that this is a specific exception to the generally applicable 2 midnight benchmark. We may also specify other potential exceptions to the generally applicable benchmark as we revise our manuals to implement this proposed rule.

Comment: Commenters recommended that the risk of an adverse event as being a determinant in the inpatient admission decision should be removed, qualified as “high” or “unreasonable,” or narrowly defined to only include risks during the beneficiary’s course of treatment that can be addressed or managed by the hospital. The commenters pointed to an errant trend of inconsistency in the use of risk as a factor in the inpatient admission decision by hospitals and appeal entities. Commenters suggested that, at most, the beneficiary’s risk of morbidity or mortality should be a factor considered when making the decision of whether the keep the beneficiary in the hospital or send the beneficiary home, not when determining the appropriate patient status as inpatient or outpatient.

Response: We believe that, due to the nature of the Medicare population, coexisting or concurrent medical conditions are a frequent occurrence. As a result, admission decisions centered around risk must relate to current disease processes or presenting symptoms, and not merely be part of the beneficiary’s benign or latent past medical history. We note that “risk” in common usage describes an unacceptable probability of an adverse outcome, as in “risky behavior.” We reiterate our stance that the decision to hospitalize a beneficiary is a complex medical decision made by the physician in consideration of various risk factors, including the beneficiary’s age, disease processes, comorbidities, and the potential impact of sending the beneficiary home. It is up to the physician to make the complex medical decision of whether the beneficiary’s risk of morbidity or mortality dictates the need to remain at the hospital because the risk of an adverse event would otherwise be unacceptable under reasonable standards of care, or when the beneficiary may be discharged home. If the resultant length of stay for medically necessary hospitalization is expected to surpass 2 midnights, the physician should admit the patient as an inpatient.

Comment: Commenters pointed out that the complexity of caring for the elderly beneficiary and the limited access to resources in the community continues to be challenging. While a beneficiary may not meet the screening criteria for an inpatient admission, the beneficiary’s complex needs and lack of access to medical therapies outside the hospital require the admitting physician to make a judgment as to whether such patients are in greater danger of serious illness or death if they are discharged than if they are admitted, and may result in the hospital being unable to release a beneficiary into the community. Conversely, a commenter wanted to remind CMS that convenience factors or nonmedically necessary care violate the Social Security Act, which excludes custodial care from Medicare coverage.

Response: While we will not dictate the hospital or physician admission decision, we also note that Medicare is statutorily prohibited under section
1862(a)(1)(A) of the Act from paying for services that are not reasonable and necessary. Therefore, we have identified so-called “social admissions” and admissions to avoid inconvenience as inappropriate from Medicare payment per the aforementioned statutory exclusion. This is consistent with current manual instructions. We will look for opportunities to offer additional guidance addressing these types of medical necessity decisions as we update our policy manuals.

Comment: Commenters requested that CMS provide clarification for how hospitals receiving beneficiaries from another hospital should make the admission decision under the proposed policy.

Response: We recognize that, in addition to the occurrence of unexpected transfers out of a hospital, there are a number of possible scenarios involving transfers into a hospital that may impact the length of stay determination under this policy. We noted in the proposed rule that an unexpected transfer out of the sending hospital is one reason why an inpatient stay that lasts less than 2 midnights may still be appropriately inpatient. Due to the complexity of the possible transfer scenarios, we believe that explicit guidance should be reserved for manual instruction. Drafting these instructions will be one of the highest priorities as we develop our implementation instructions.

Comment: Commenters pointed out that, under this proposal, the distinction between inpatient and outpatient may come down to small time discrepancies. For example, a beneficiary whose hospital stay begins shortly before midnight and lasts just over 48 hours will be considered an inpatient because the stay will cross 2 midnights, while a beneficiary whose hospital stay begins shortly after midnight and lasts just under 48 hours will be considered an outpatient because the stay will only cross 1 midnight.

Response: The application of 2 midnights was proposed for the purpose of providing both consistency and clarity. We have expected and continue to expect that physicians will make the decision to keep a beneficiary in the hospital when clinically warranted and will order all appropriate treatments and care in the appropriate location based on the beneficiary’s individual medical needs. We also expect that physicians will apply the revised benchmark as they have previously applied the existing benchmark, providing medically necessary services in an inpatient status whenever the benchmark is met and in all other instances providing identical services to patients staying at the hospital in a day or overnight outpatient status. While we have historically referenced a 24-hour benchmark, we now specify that the 24 hours relevant to inpatient admission decisions are those encapsulated by 2 midnights. This distinction is consistent with our application of Medicare utilization days, which are based on the number of midnights crossed. Medicare charges beneficiaries for utilization days and pays hospitals for utilization days when it applies per diem adjustments, such as the transfer adjustment. A beneficiary who is admitted just before midnight and discharged 36 hours later is currently charged 2 utilization days, while a beneficiary admitted just after midnight is charged 1 day. In addition, the use of 2 midnights is an easy concept for beneficiaries to understand in assessing the appropriateness of their assigned status, associated coverage, and impacts.

Comment: Commenters provided alternate proposals for guiding inpatient admissions and medical review. Some commenters suggested that physicians are not apprised of admission criteria, but rather the medical treatment necessary for the beneficiary, and suggested that case management be permitted to make inpatient admission determinations, which could be concurred or nonconcurred to by the treating physician. Conversely, other commenters believed the physician was most apprised of the patient condition and, therefore, the need for inpatient admission, once spanning 2 midnights. As such, some commenters believed the physician order should trigger a presumption of appropriate payment for medical review purposes. One commenter suggested good faith protections for facilities in strict adherence to their hospital comprised utilization review plan. Another commenter disagreed with the need for any change to the current medical review policy.

Response: In the proposed rule, we focused on clarifying and modifying the distinction between hospitalization as an outpatient and hospitalization as an inpatient. While the proposed approach arose out of significant consideration for provider impact, ease in implementation and operationalization, we will assess commenter feedback falling within the scope of CMS’ policy in implementing changes to our manual provisions.

Comment: Commenters requested further guidance to clarify what criteria support a reasonable and necessary inpatient admission. The commenters’ suggested sources of such guidance included evidence-based guidelines offered through the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse and the various medical specialty societies and commercial hospital screening guidelines. Some commenters also suggested that inpatient admissions be deemed reasonable and necessary based on the use of such sources. Another commenter indicated that a time-based policy contradicts CMS instructions contained in the Program Integrity Manual pertaining to the use of screening tools as part of the review of inpatient hospital claims. Regardless of the criteria chosen, commenters iterated that CMS and its contractors must update existing inpatient admission guidance and policies to ensure consistency in application by all Medicare review contractors. Commenters also inquired whether providers would have the opportunity to comment on any additional guidance that will be created to implement this rule.

Response: Medicare review contractors must abide by CMS policies in conducting payment determinations, but are permitted to take into account evidence-based guidelines or commercial utilization tools that may aid such a decision. We also acknowledge that this type of information may be appropriately considered by the physician as part of the complex medical judgment that guides his or her decision to keep a beneficiary in the hospital and formulation of the expected length of stay. As we update our manuals and take additional steps to implement this rule, we anticipate using our usual processes to develop and release subregulatory guidance such as manual instructions and educational materials, which may include open door forums, regional meetings, correspondence and other ongoing interactions with stakeholders; and that our contractors will continue to involve local entities as they implement these rules.

Comment: Several commenters indicated that CMS should delay enforcement of the revised admissions criteria until a time after October 1, 2013, due to the significant system changes and educational efforts that will be required. Some commenters indicated that CMS should use this delay in order to conduct further research and collaborate with providers, while others suggested that CMS conduct a thorough analysis of current payment policy and planned payment reforms that could affect inpatient admission decisions, including those
with implications for patient safety, quality, and beneficiary cost-sharing, before finalizing its guidance. Other commenters suggested that claim reviews for inpatient stays of greater than 2 midnights should continue without evidence of gaming for a period of time following implementation of the new policy to ensure that hospitals are properly billing under the revised criteria. The commenters stated that after that time has passed, reviews of inpatient stays longer than 2 midnights would be based on evidence of overutilization.

Response: We proposed only a change in the inpatient admissions benchmark from an hourly expectation (24 hours) to a daily (2-midnights) expectation. We do not believe that delays in implementation are necessary or desirable, and we expect, through collaboration with stakeholders, to develop additional guidance and instruction as part of that implementation.

Comment: Commenters questioned the applicability of the proposed rule to differing types of hospital facilities. Commenters specifically requested clarity regarding application of the rule to IRFs and IPFs. Commenters further asserted that this distinction may conflict with State laws requiring inpatient admissions post 24 hours, and such States should be granted exception.

Response: In the proposed rule, our reference to section 1861(o) of the Act was intended to specify that CAHs were included in the proposed policies, not that we were proposing that IPFs or non-IPPS hospitals should be excluded. Having considered the public comments to the proposed rule, we believe that all hospitals, LTCHs, and CAHs, with the exception of IRFs, would appropriately be included in our final policies regarding the 2-midnight admission guidance and medical review criteria for determining the general appropriateness of inpatient admission and Part A payment. Due to the inherent differences in the operation of and beneficiary admissions to IRFs, such providers must be excluded from the aforementioned admission guidelines and medical review instruction. We disagree with the commenters’ assertion that the 2-midnight admission and medical review policies conflict with existing state laws regarding observation. The 2-midnight benchmark does not prohibit physicians from ordering inpatient admission in accordance with state law; rather, this policy in Medicare payment will be deemed appropriate. To the extent that State law requires admission in situations where Medicare payment would not be appropriate, providers should work with their States to resolve those discrepancies.

Comment: Commenters indicated that the proposed policy, which clarifies when a beneficiary becomes an inpatient, promotes the integrity and accuracy of the 340B program. They stated that the 340B program creates an incentive for hospitals to keep beneficiaries in observation status for the purpose of obtaining the deeply discounted 340B acquisition price that would otherwise be unavailable. Thus, they added, the 340B spread creates a financial incentive for 340B hospitals to keep beneficiaries in outpatient/observation status for the sole purpose of administering drugs.

Response: We appreciate the observation of the commenters and concur that this policy promotes consistent application of an inpatient status to all stakeholders.

(3) Medical Review of Inpatient Hospital Admissions Under Part A

Under this revised policy, services designated by the OPPS Inpatient-Only list as inpatient-only, would continue to be appropriate for inpatient hospital admission and payment under Medicare Part A. In addition, surgical procedures, diagnostic tests, and other treatments would be generally deemed appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights and admits the patient to the hospital based upon that expectation. We proposed, and are now finalizing, two distinct, though related, medical review policies, a 2-midnight presumption and a 2-midnight benchmark. Under the 2-midnight presumption, inpatient hospital 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 absent evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the 2-midnight presumption (that is, inpatient hospital admissions where medically necessary treatment was not provided on a continuous basis throughout the hospital stay and the services could have been furnished in a shorter timeframe). Beneficiaries should not be held in the hospital absent medically necessary care for the purpose of satisfying the 2-midnight benchmark. Review contractors will also continue to assess claims in which the beneficiary span of care after admission crosses 2 midnights:
- To ensure the services provided were medically necessary;
- To ensure that the stay at the hospital was medically necessary;
- To validate provider coding and documentation as reflective of the medical evidence;
- When the CERT Contractor is directed to do so under the Improper Payments Elimination and Recovery Improvement Act of 2012 (Pub. L. 112–248); or
- If directed by CMS or other authoritative governmental entity (including but not limited to the HHS Office of Inspector General and Government Accountability Office).

Conversely, under this revised policy, CMS’ medical review efforts will focus on inpatient hospital admissions with lengths of stay crossing only 1 midnight or less after admission (that is, only 1 Medicare utilization day, as defined in 42 CFR 409.61 and implemented in the MBPM, Chapter 3, Section 20.1). As previously described, such claims have traditionally demonstrated the largest proportion of inpatient hospital improper payments under Medicare Part A. If the physician admits the beneficiary as an inpatient but the beneficiary is in the hospital for less than 2 midnights after the order is written, CMS and its medical review contractors will not presume that the inpatient hospital status was reasonable and necessary for payment purposes, but may instead evaluate the claim pursuant to the 2-midnight benchmark. Medicare review contractors will (a) evaluate the physician order for inpatient admission to the hospital, along with the other required elements of the physician 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, in order to determine whether payment under Part A is appropriate.

In their review of the medical record, Medicare review contractors will consider complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2-midnight benchmark. The decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the
time period for which hospitalization is considered. In other words, if it was reasonable for the physician to expect the beneficiary to require a stay lasting 2 midnights, and that expectation is documented in the medical record, inpatient admission is generally appropriate, and payment may be made under Medicare Part A; this is regardless of whether the anticipated length of stay did not transpire due to unforeseen circumstances such as beneficiary death or transfer (so long as the physician’s order and certification requirements are met). As discussed above, an inpatient admission is appropriate and Part A payment may also be made in the case of services on Medicare’s inpatient-only list, regardless of the expected length of stay.

Comment: Some commenters shared concerns regarding the proposed method of calculating the length of stay for purposes of the 2-midnight benchmark, beginning when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided. Commenters noted that hospital capacity issues can lead to situations in which a beneficiary is boarded in the emergency department until a bed becomes available, which can be hours after the admission order is written. In other instances, the commenters added, an inpatient admission may be planned after a surgical procedure and the beneficiary becomes an inpatient when he or she reports to the operating room for preoperative assessment and preparation. Commenters pointed out that if the clock does not start until beneficiary movement to another area of the hospital occurs, the beneficiary may not meet the 2-midnight benchmark although he or she was receiving treatment in the hospital for greater than 2 midnights. Commenters provided various alternate suggestions for when the clock should start. Many commenters suggested that CMS start the clock the earliest of: (1) When the physician writes an order for admission or observation; (2) when the beneficiary is treated in the emergency department; or (3) when the beneficiary is placed in a bed for observation. Other commenters suggested that the clock should begin when the beneficiary meets inpatient admission criteria or when the nursing intake notes specify the time the beneficiary is admitted to the floor and is put in a bed. Regardless of the decision CMS made on this point, commenters requested that clarification be provided on when the inpatient order should be written and how the time should be counted for medical review purposes.

Response: We agree with the concerns noted by commenters, and are revising the proposed rule accordingly. In this final rule, we specify that the ordering physician may consider time the beneficiary spent receiving outpatient services (including observation services, treatments in the emergency department, and procedures provided in the operating room or other treatment area) for purposes of determining whether the 2-midnight benchmark is expected to be met and therefore inpatient admission is generally appropriate. For beneficiaries who do not arrive through the emergency department or are directly receiving inpatient services (for example, inpatient admission order written prior to admission for an elective admission or transfer from another hospital), the starting point for medical review purposes will be from the time the patient starts receiving any services after arrival at the hospital. We emphasize that the time the beneficiary spent as an outpatient before the inpatient admission order is written will not be considered inpatient time, but may be considered by physicians in determining whether a patient should be admitted as an inpatient, and during the medical review process for the limited purpose of determining whether the 2-midnight benchmark was met and therefore payment is generally appropriate under Part A. Claims in which a medically necessary inpatient stay spans at least 2 midnights after the beneficiary is formally admitted as an inpatient will be presumed appropriate for inpatient admission and inpatient hospital payment and will generally not be subject to medical review of the inpatient admission, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.

Comment: Commenters requested clarification regarding the distinction between inpatient time and outpatient time for purposes of meeting the 2-midnight benchmark, specifically for those beneficiaries who are first treated in observation status and then later as hospital inpatients pursuant to a physician’s order. Commenters recommended that CMS consider observation care to count toward the 2-midnight rule when complications arise that lead to previously unanticipated extended care in accord with requirements for skilled nursing facility eligibility.

Response: As noted above, we will allow the physician to consider time spent in the hospital as an outpatient in making their inpatient admission decision. This is consistent with CMS existing instructions and medical review guidance, which allow physicians and Medicare review contractors to account for the beneficiary’s medical history and physical condition prior to the inpatient admission decision. Therefore, if upon beneficiary presentation, the physician is unable to make an evaluation and corresponding expected length of stay determination, the physician may first monitor the beneficiary in observation or continue to perform diagnostics in the outpatient arena. If the beneficiary’s medical needs and condition after 1 midnight in outpatient status dictate the need for an additional midnight within the hospital receiving medically necessary care, the physician may consider the care in the outpatient setting when making his or her admission decision. Medicare review contractors would similarly apply the 2-midnight benchmark to all time spent within the hospital receiving medically necessary services in their claim evaluation.

We reiterate that the physician order, the remaining elements of the physician certification, and formal inpatient admission remain the mandated means of inpatient admission. While outpatient time may be accounted for 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. Inpatient status begins with the admission decision. This is consistent with CMS existing instructions and medical review contractors would similarly apply the 2-midnight benchmark to all time spent within the hospital receiving medically necessary services in their claim evaluation.

Comment: Commenters expressed concern about the additional scrutiny that 1-day inpatient hospital stays would undergo under this policy. Commenters also were particularly interested in how the review contractors would review inpatient stays that lasted less than 2 midnights, including whether current review criteria would continue to be utilized for such reviews. The commenters requested that CMS define situations in which a hospital stay lasting less than 2 midnights would properly qualify as inpatient.

Response: If the physician admits the beneficiary as an inpatient but the beneficiary is in the hospital for less than 2 midnights after the admission begins, CMS and the Medicare review contractors will not presume that the inpatient hospital admission was reasonable and necessary for payment purposes, but will apply the 2-midnight benchmark in conducting medical review. In making their determination of whether the inpatient admission is appropriate, Medicare review
contractors will evaluate: (a) The physician order for inpatient admission to the hospital, along with the other required elements of the physician certification; (b) the medical documentation supporting that the order was based on an expectation of need for care spanning 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. In their review of the medical record, Medicare review contractors will consider complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2-midnight benchmark. These include such factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event.

Comment: Commenters asserted that the proposed rule penalizes efficiency, as those hospitals that are able to treat beneficiaries in less than 2 midnights will be able to admit fewer beneficiaries than those less efficient hospitals who do not have the same resources. Other commenters expressed concern that the new proposed policy would encourage hospitals to hold beneficiaries in the hospital solely for the purpose of meeting the 2-midnight presumption and avoid audits of their claims. The commenters stated that consequences of such practices on the beneficiaries could include prolonged exposure to additional medical risks and would also lead to increased costs to the Medicare program, due to medically unnecessary time in the hospital. Conversely, some commenters indicated that they did not believe that hospitals would not hold patients for longer than necessary to meet inpatient requirements.

Response: We have noted that the decision to admit is based on an expectation of medically necessary care transcending the 2-midnight benchmark resulting from the practitioner’s consideration of the beneficiary’s condition and medical needs. We will monitor all hospitals for intentional or unwarranted delays in the provision of care, which may result in increased inpatient admissions secondary to the 2 midnight instruction. We are also cognizant of concerns related to unnecessarily elongated hospital admissions, and will be monitoring for such patterns of systemic delays indicative of fraud or abuse. If a hospital is unnecessarily holding beneficiaries to qualify for the 2-midnight presumption, CMS and/or its contractors may conduct review on any of its inpatient claims, including those which surpassed 2 midnights after admission.

Comment: One commenter stated that while it is reasonable that a medically necessary hospital stay crossing 2 midnights may be appropriately billed as inpatient, there should be no presumption that such a 2-midnight stay was itself medically necessary simply because a patient was in the hospital 2 consecutive nights. The commenter stated that the proposed rule includes a requirement that review will only be permitted when the error rate is sufficient to warrant auditing activity; however, the audit that would establish this error would itself be precluded under CMS’ presumption. The commenter stated that, alternatively, data analysis of the claims should remain the foundation for selection of claims for medical record review to determine whether the documentation supports the claim as billed. The commenter believed that a presumption of medical necessity based on the time a beneficiary stays in the hospital places the Medicare trust fund and taxpayers at risk.

Response: 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. We have discussed in response to other comments that, in accordance with our statutory obligations, some medical review is always necessary to ensure that services provided are reasonable and necessary, and that we will continue to review these longer stays for the purposes of monitoring, determining correct coding, and evaluating the medical necessity for the beneficiary to remain at the hospital, irrespective of the inpatient or outpatient “status” to which the beneficiary was assigned. In addition, claims that evidence that a hospital is effectuating systematic abuse of the 2-midnight presumption, such as unexplained delays in the provision of care or aberrant billing, may be subject to medical review despite surpassing 2 midnights after admission.

Comment: Commenters voiced concerns that while CMS proposed that those inpatient hospital admissions meeting the 2-midnight benchmark would be generally appropriate for Part A payment, there is no guarantee that the Medicare contractors would follow this guidance. Some commenters expressed apprehension that the time-based policy would not result in fewer reviews, as the policy stated that contractors could review whether the physician’s expectation was reasonable, while others thought the doors would be opened to more hospital claim audits focusing on the need for the beneficiary to stay in the hospital for greater than 2 midnights. Commenters also sought assurance from CMS that reviews would be conducted based on the information the physician had available at the time the decision was made. The development of a 2-midnight stay and wrote the order pursuant to that expectation.
Response: We acknowledge that it is very important that clear and consistent instructions are provided to facilities, physicians, and Medicare review contractors. We intend to quickly develop implementation instructions, manual guidance, and additional education to ensure that all entities receive initial and ongoing guidance in order to promote consistent application of these changes and repeatable and reproducible decisions on individual cases. We intend to ensure that our instructions to providers and reviewers alike emphasize that the decision to admit should be based on and evaluated in respect to the information available to the admitting practitioner at the time of the admission.

After consideration of the public comments we received, we are including in this final rule several revisions and clarifications to the proposed policy. First, we are finalizing at § 412.3(e)(1) the 2-midnight benchmark as proposed at § 412.3(c)(1), that services designated by the OPPS Inpatient-Only list as inpatient-only would continue to be appropriate for inpatient hospital admission and payment under Medicare Part A. In addition, surgical procedures, diagnostic tests, and other treatments would be generally deemed appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights and admits the patient to the hospital based upon that expectation. We proposed at § 412.3(c)(2), and are finalizing at § 412.3(e)(2), that if an unforeseen circumstance, such as beneficiary death or transfer, results in a shorter beneficiary stay than the physician’s expectation of at least 2 midnights, the patient may still be considered to be appropriately treated on an inpatient basis, and the hospital inpatient payment may be made under Medicare Part A. Proposed at § 412.3(c), and now finalizing, two distinct, although related, medical review policies, a 2-midnight benchmark and a 2-midnight presumption. The 2-midnight benchmark represents guidance to admitting practitioners and reviewers to identify when an inpatient admission is generally appropriate for Medicare coverage and payment, while the 2-midnight presumption directs medical reviewers to select claims for review under a presumption that the occurrence of 2 midnights after admission appropriately signifies an inpatient status for a medically necessary claim. The starting point for the 2-midnight benchmark will be when the beneficiary begins receiving hospital care on either an inpatient basis or outpatient basis. That is, for purposes of determining whether the 2-midnight benchmark will be met and, therefore, whether inpatient admission is generally appropriate, the physician ordering the admission should account for time the beneficiary spent receiving outpatient services such as observation services, treatments in the emergency department, and procedures provided in the operating room or other treatment area. From the medical review perspective, while the time the beneficiary spent as an outpatient before the admission order is written will not be considered inpatient time, it may be considered during the medical review process for purposes of determining whether the 2-midnight benchmark was met and, therefore, whether payment is generally appropriate under Part A. For beneficiaries who do not arrive through the emergency department or are directly receiving inpatient services (for example, inpatient admission order written prior to admission for an elective admission or transfer from another hospital), the starting point for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital. We proposed that both the decision to keep the patient at the hospital and the expectation of needed duration of the stay would be based on such factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In this final rule, we now are clarifying that risk (or probability) of an adverse event relates to occurrences during the time period for which hospitalization is considered.

We are finalizing that inpatient hospital 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 absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. We also are clarifying in this final rule how we will instruct contractors to review inpatient stays spanning less than 2 midnights after admission. Such claims would not be subject to the presumption that services were appropriately provided during an inpatient stay rather than an outpatient stay because the total inpatient time did not exceed 2 midnights. However, upon medical review, the hospital stay will be counted toward meeting the 2-midnight benchmark that the physician is expected to apply to determine the appropriateness of the decision to admit. In other words, even though the inpatient admission was for only 1 Medicare utilization day, 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. We will continue to use our existing monitoring and audit authority, such as the CERT program, to ensure that our review efforts focus on those subsets of claims with the highest error rates and reduce the administrative burden for those subsets that have demonstrated compliance with our clarified and modified guidance.

4. Impacts of Changes in Admission and Medical Review Criteria

In the FY 2014 IPPS/LTC PPS proposed rule (78 FR 27649 through 27650), we discussed our actuaries’ estimate that our proposed 2-midnight policy (referred to in this final rule as the 2-midnight benchmark and the 2-midnight presumption) would increase IPPS expenditures by approximately $220 million. These additional expenditures result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving to the IPPS from the OPPS, and some encounters of less than 2 midnights moving from the IPPS to the OPPS. Specifically, our actuaries examined FY 2009 through FY 2011 Medicare claims data for extended hospital outpatient encounters and shorter stay hospital inpatient encounters and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters. These estimated shifts of 400,000 encounters from outpatient to inpatient and 360,000 encounters from inpatient to outpatient represent a significant portion of the approximately 11 million encounters paid under the IPPS. The net shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under the IPPS. Because shorter stay hospital inpatient encounters generally represent approximately 17 percent of the IPPS expenditures, our actuaries estimated...
that 17 percent of IPPS expenditures would increase by 1.2 percent under our proposed policy. These additional expenditures are partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. Our actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the hospital inpatient encounters. In light of the widespread impact of the proposed 2-midnight policy on the IPPS and the systemic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, we stated our belief that it is appropriate to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to propose to offset the estimated $220 million in additional IPPS expenditures associated with the proposed policy. This special exceptions and adjustment authority authorizes us to provide “for such other exceptions and adjustments to [IPPS] payment amounts . . . as the Secretary deems appropriate.” We proposed to reduce the standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount by 0.2 percent.

Comment: Commenters generally did not support the proposed -0.2 percent payment adjustment. Comments included the following assertions: CMS actuaries’ estimated increase in IPPS expenditures of $220 million was unsupported and insufficiently explained to allow for meaningful comment; CMS did not provide sufficient rationale for the use of our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act; CMS should not be adjusting the IPPS payment rates for expected shifts in utilization between inpatient and outpatient; CMS did not take into account the impact of the Part B Inpatient Billing proposed rule in developing its estimates; CMS should provide parallel treatment regarding the financial impact of both the medical review policy in the FY 2014 IPPS/LTCH PPS proposed rule and the policies in the Part B Inpatient Billing proposed rule and offset and restore the $4.8 billion dollar reduction to hospital payments over 5 years contained in the Part B Inpatient Billing proposed rule; and CMS’ proposed policy was a coverage decision and CMS should not adjust IPPS rates for coverage decisions.

Response: We disagree with commenters who indicated that our actuaries’ estimated increase in IPPS expenditures of $220 million was unsupported and insufficiently explained to allow for meaningful comment. In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27649), we specifically discussed the methodology used and the components of the estimate. Our actuaries examined FY 2009 to FY 2011 claims data. Based on this examination, we stated the number of encounters our actuaries estimated would shift from inpatient to outpatient (360,000) and the number of encounters they estimated would shift from outpatient to inpatient (400,000). We described the methodology we used to translate this net shift of 40,000 encounters into our $220 million estimate, including an estimate of the increase these 40,000 encounters represent in shorter stay hospital inpatient encounters (1.2 percent), the share that expenditures for shorter stay hospital inpatient encounters represent of IPPS expenditures (17 percent), and our estimate of the payment difference between OPPS and IPPS for these encounters (OPPS payment for these encounters was estimated to be 30 percent of the IPPS payment for these encounters). In addition to the opportunity to comment on the estimate, any component of the estimate, or the methodology, commenters had an opportunity to provide alternative estimates for us to consider.

In determining the estimate of the number of encounters that would shift from outpatient to inpatient, our actuaries examined outpatient claims for observation or a major procedure. Claims not containing observation or a major procedure were excluded. The number of claims spanning 2 or more midnights based on the dates of service that were expected to become inpatient was approximately 400,000. This estimate did not include any assumption about outpatient encounters shorter than 2 midnights potentially becoming inpatient encounters.

In determining the estimate of the number of encounters that would shift from inpatient to outpatient, our actuaries examined inpatient claims containing a surgical MS–DRG encounter spanning more than 2 midnights based on the dates of service that were expected to become outpatient. The improper payment rate rate decreased significantly for 2-day or 3-day stays, which had improper payment rates of 13.2 percent and 13.1 percent, respectively. We stated that we fully expect that not every single outpatient observation stay or major surgical encounter spanning more than 2 midnights will shift to inpatient.

We also disagree with commenters who indicated that we did not provide sufficient rationale for the use of our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act. We discussed that the issue of patient status has a substantial impact on improper payments under Medicare Part A for short-stay inpatient hospital claims, citing the fact that the majority of improper payments under Medicare Part A for short-stay inpatient hospital claims have been due to inappropriate patient status. In 2012, for example, the CERT contractor found that inpatient hospital admissions for 1-day stays or less had a Part A improper payment rate of 36.1 percent. The improper payment rate decreased significantly for 2-day or 3-day stays, which had improper payment rates of 13.2 percent and 13.1 percent, respectively. We stated that we believe the magnitude of these national figures demonstrates that issues surrounding the appropriate determination of a beneficiary’s patient status are not isolated to a few hospitals. We also noted that the RAs had recovered more than $1.6 billion in improper payments because of inappropriate beneficiary patient status.

While we agree with commenters that our exceptions and adjustments authority should not be routinely used in the IPPS system, we believe that the systemic and widespread nature of this issue justifies an overall adjustment to the IPPS rates and such an adjustment is authorized under section 1886(d)(5)(I)(i) of the Act.

For similar reasons, while we generally agree with commenters that it is not necessary to routinely estimate utilization shifts to ensure appropriate IPPS payments, this is a unique situation. Policy clarifications such as
this do not usually result in utilization shifts of sufficient magnitude and breadth to significantly impact the IPPS. In this situation, we believe it would be inappropriate to ignore such a utilization shift in the development of the IPPS payment rates.

With respect to the comments we did not take into account the impact of the Part B Inpatient Billing proposed rule in developing our estimates, we note that our actuaries did take those impacts into account in developing our proposed adjustment. Our estimate of the net shift in FY 2014 encounters between inpatient and outpatient would have been substantially higher in the absence of the policies discussed in the Part B Inpatient Billing proposed rule, in particular the discussion of timely filing. Specifically, in the absence of the timely filing requirement, there would have been fewer inpatient encounters estimated to become outpatient encounters, which would have resulted in a larger cost than our estimated $220 million.

With respect to the comment that CMS should provide parallel treatment regarding the financial impact of the medical review policy in the FY 2014 IPPS/LTCH PPS proposed rule and the interrelated Part B Inpatient Billing proposed rule by offsetting and restoring the estimated $4.8 billion dollar reduction to hospital payments contained in that rule, we note that, although we estimated a decrease in expenditures as a result of our proposed Part B inpatient billing policy, this decrease in expenditures is offset by the costs of a significant number of related administrative appeal decisions as well as CMS Rule 1455–R, which allows hospitals to seek payment of Part B inpatient services on claims filed outside the timely filing period. As discussed in greater detail in the Regulatory Impact Analysis in the Part B Inpatient Billing proposed rule (78 FR 16643), the combined impact of the appeals decisions, CMS Rule 1455–R, and Part B inpatient billing policy, to which the 12-month timely filing requirement applies, is an estimated cost to the Medicare program of $1.03 billion over the CY 2013 to CY 2017 time period. We estimate in the Regulatory Impact Analysis of the final Part B inpatient payment policy in this final rule that the combined impact of the appeals decisions, CMS Rule 1455–R, and the Part B inpatient billing policy will cost the Medicare program $1.260 billion over the CY 2013 to CY 2017 time period.

Finally, we disagree with those comments asserting that the modification and clarification of our current instructions regarding the circumstances under which Medicare will generally pay for a hospital inpatient admission in order to improve hospitals’ ability to make appropriate admission decisions are actually coverage decisions in the context of this adjustment. As we clearly stated in the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27648), we will continue to review individual claims to ensure the hospital services furnished to beneficiaries are “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,” as required by section 1862(a)(1) of the Act. Any hospital service determined to be not reasonable or necessary may not be paid under Medicare Part A or Part B. In the context of this adjustment, these are not new hospital services.

Our actuaries continue to estimate there will be approximately $220 million in additional expenditures resulting from our 2-midnight benchmark and 2-midnight presumption medical review policies. The net increase in hospital inpatient encounters is due to some encounters spanning more than 2 midnights moving to the IPPS from the OPPS, and some encounters of less than 2 midnights moving from the IPPS to the OPPS. Therefore, after consideration of the comments we received, and for the reasons described above, we are finalizing a reduction to the standardized amount, the hospital-specific rates, and the Puerto Rico-specific amount of –0.2 percent to offset the additional $220 million in expenditures.

XII. MedPAC Recommendations

Under section 1886(e)(4)(B) of the Act, the Secretary must consider MedPAC’s recommendations regarding hospital inpatient payments. Under section 1886(e)(5) of the Act, the Secretary must publish in the annual proposed and final IPPS rules the Secretary’s recommendations regarding MedPAC’s recommendations. We have reviewed MedPAC’s March 2013 “Report to the Congress: Medicare Payment Policy” and have given the recommendations in the report consideration in conjunction with the policies set forth in this final rule. MedPAC recommendations for the IPPS for FY 2014 are addressed in Appendix B to this final rule.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7226, or visit MedPAC’s Web site at: http://www.medpac.gov.
Hospital Inpatient Admission Order and Certification

As a condition of payment for hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis. The order to admit as an inpatient (“practitioner order”) is a critical element of the physician certification, and is therefore also required for hospital inpatient coverage and payment under Part A. The physician certification, which includes the practitioner order, is considered along with other documentation in the medical record as evidence that hospital inpatient service(s) were reasonable and necessary. The following guidance applies to all inpatient hospital and critical access hospital (CAH) services unless otherwise specified. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B and 42 CFR 412.3.

Physician Certification of inpatient services of hospitals other than inpatient psychiatric facilities:

1. **Content:** The physician certification includes the following information:
   a. Authentication of the practitioner order: The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and in the case of services not specified as inpatient-only under 42 CFR 419.22(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark under 42 CFR 412.3(e).
   b. Reason for inpatient services: The reasons for either—(i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for cost outlier cases under the inpatient prospective payment system (IPPS);
   c. The estimated time the beneficiary requires or required in the hospital.
   d. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.
   e. CAHs: For inpatient CAH services, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

2. **Timing:** Certification begins with the order for inpatient admission. The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13, and certification of CAH inpatient services which is required no later than 1 day prior to the date on which the claim for payment for the inpatient CAH services is submitted (§ 424.15).
3. **Authorization to sign the certification:** The certification or recertification may be signed only by one of the following:
   (1) A physician who is a doctor of medicine or osteopathy.
   (2) A dentist in the circumstances specified in 42 CFR 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.

   Certifications and recertifications 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 (or by the dentist as provided in 42 CFR 424.11). Medicare considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician: the admitting physician of record (“attending”) 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; a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the State and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above.

4. **Format:** As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered 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.

5. **Default Methodology for Initial Certification:** In the absence of specific certification forms or certification statements, CMS and its contractors will look for the following medical record elements in order to meet the initial inpatient certification requirements.
   a. The authentication requirement for the practitioner order will be met by the signature or countersignature of the inpatient admission order by the certifying physician.
   b. The requirement to certify the reasons that hospital inpatient services are or were medically required 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 the 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.
   e. The CAH 96 hour expectation requirement will be met either by physician notes or by actual discharge within 96 hours.
**Practitioner Order:** A Medicare beneficiary is considered an inpatient of a hospital, including a CAH, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner.

1. **Content:** The practitioner order contains the instruction that the beneficiary should be formally admitted for hospital inpatient care. The order must specify admission for inpatient services. Inpatient rehabilitation facilities (IRFs) also must adhere to the admission requirements specified in 42 CFR 412.622, and the 2-midnight benchmark does not apply in IRFs.

2. **Qualifications of the ordering/admitting practitioner:** The order must be furnished by a physician or other practitioner (“ordering 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, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision. The ordering practitioner may be, but is not required to be, the physician who signs the certification.

At some hospitals, practitioners who lack the authority to admit inpatients under either State laws or hospital by-laws may nonetheless frequently write the sets of admitting orders that define the initial inpatient care of the patient. In these cases, the ordering practitioner need not separately record the order to admit. Following discussion with and at the direction of the ordering practitioner, the order (including a verbal order) may be documented by an individual who does not possess these qualifications (such as a physician assistant, resident, or registered nurse), as long as that documentation (transcription) of the order is in accordance with State law including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. In this case, the order must identify the qualified “ordering practitioner”, and must be authenticated by the ordering practitioner (or by another practitioner with the required admitting qualifications) prior to discharge. A transcribed and authenticated order also satisfies the order part of the physician certification as long as the ordering practitioner also meets the requirements for a certifying physician.

Example: “Admit to inpatient v.o. (or t.o.) Dr. Smith” and “Admit to inpatient per Dr. Smith” would be considered acceptable methods of identifying the ordering practitioner and would meet the order requirement if they are appropriately authenticated by Dr. Smith. This method is also acceptable for residents and students who are not licensed or do not have privileges to admit inpatients, and may be used by all residents and fellows working within their GME program. If Dr. Smith meets the qualifications for a certifying physician, then the authentication of this order by Dr. Smith also meets the requirement for the order component of the certification.

**Verbal orders:** In accordance with 42 CFR 482.24(c), the inpatient order to admit may also be directly communicated to staff as a verbal (not standing) order. A verbal inpatient admission order may be initially documented in the medical record by the staff receiving the order as provided above, including identification of the ordering practitioner. A verbal or telephone inpatient admission order must be authenticated (signed, dated and timed) by the ordering practitioner (or by another practitioner with the required admitting qualifications in his or her own right) in the medical record prior to discharge, unless the hospital or the State requires an earlier timeframe. An authenticated verbal order also satisfies the order part of the physician
certification as long as the ordering practitioner also meets the requirements for a certifying physician.

3. **Knowledge of the patient:** Medicare considers only the following practitioners to have sufficient knowledge about the beneficiary’s hospital course, medical plan of care, and current condition to serve as the ordering practitioner: the admitting physician of record (“attending”) 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 the primary care practitioner, 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 the inpatient admission decision. Although a utilization review committee physician may sign the certification on behalf of a non-physician admitting practitioner, a practitioner functioning in that role does not have direct responsibility for the care of the patient and is therefore not considered to be sufficiently knowledgeable to order the inpatient admission. The order must be written by one of the above practitioners directly involved with the care of the beneficiary, and a utilization committee physician may only write the order to admit if he or she also fulfills one of the direct patient care roles, such as the admitting physician of record.

4. **Timing:** The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (e.g., for a pre-scheduled surgery), but the inpatient admission does not occur until formal admission by the hospital. Conversely, in the unusual case in which a patient is formally admitted as an inpatient prior to an order to admit, the inpatient stay should not be considered to commence until the inpatient admission order is documented. Medicare does not permit retroactive orders or the inference of orders. Authentication of the order is required prior to discharge and may be performed and documented as part of the physician certification.

5. **Specificity of the Order:** The regulations at 42 CFR 412.3 require that, as a condition of payment, an order for inpatient admission must be present in the medical record. The preamble of the FY 2014 IPPS Final Rule at 78 FR 50942 specifies that, “the order must specify the admitting practitioner’s recommendation to admit ‘to inpatient,’ ‘as an inpatient,’ ‘for inpatient services,’ or similar language specifying his or her recommendation for inpatient care.” The purposes of this requirement are to reinforce the policy that the physician should be involved in the determination of patient status and to improve clarity among hospitals, beneficiaries, and ordering practitioners regarding whether the beneficiary is being treated as a hospital inpatient or hospital outpatient.

The specificity requirements outlined in the FY 2014 IPPS Final Rule are most clearly met by the inclusion of the term “inpatient” in the admission order, as illustrated above. However, in the event that explicit identification of the admission as “inpatient” is not specified, the admission order may still be consistent with 42 CFR 412.3 provided that the intent to admit as an inpatient is clear. Orders that specify admission to an inpatient unit (e.g., “Admit to 7W”, “Admit to ICU”), admission for a service that is typically provided on an inpatient basis (“Admit to Medicine”), or admission under the care of an admitting practitioner (“Admit to Dr. Smith”), and orders that do not specify beyond the word “Admit,” will be considered to specify admission to an inpatient status provided that this interpretation is consistent with the remainder of the medical record.
Treatment of such admission orders as properly inpatient is consistent with CMS’ historical interpretation of inpatient admission orders and hospitals’ historical standards of practice. However, if the usage of the order to specify inpatient or outpatient status is ambiguous, the hospital is encouraged to obtain and document clarification from the physician before initial Medicare billing (ideally before the beneficiary is discharged). Under this policy, CMS will continue to treat orders that specify a typically outpatient or other limited service (e.g., admit “to ER,” “to Observation,” “to Recovery,” “to Outpatient Surgery,” “to Day Surgery,” or “to Short Stay Surgery”) as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.
CMS Special Open Door Forum:
Inpatient Hospital Admission and Medical Review Criteria (2-Midnight Provision) and Part B Inpatient Billing in Hospitals

Thursday, Aug. 15, 2013

The transcript, which is reproduced on the following pages, as well as the audio file, of the special open door forum are posted on the CMS website at http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODFSpecialODF.html.
Operator: Good afternoon, my name is (Denise) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services IPPS Rule 1599, Two Midnight Provision Special Open-door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers’ remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

(Jennifer Dupee), you may begin your conference.

(Jennifer Dupee): Hi, good afternoon everybody. My name is (Jennifer Dupee), I’m Nurse Consultant in the Provider Compliance Group here at the Centers for Medicare & Medicaid Services, and I just wanted to go around the room here at CMS just to give you all an idea of who we have attending today. I know we also have a couple of people on the line, so start …

(Dan Duvall): (Dan Duvall), Medical Officer, Payment Policy.
Mike Handrigan: Mike Handrigan, Medical Officer for Provider Compliance Group.


George Mills: George Mills, Director, Provider Compliance Group.

(Jennifer Dupee): And on the line from CMS.

John McInnes: John McInnes, Director of the Division of Outpatient Care.

(Jennifer Dupee): All right, thank you very much. So the purpose of today’s call is to give an overview of three related policies that were published as part of the 2014 Inpatient Prospective Payment System Final Rule. The first being the Part B Inpatient Billing and Hospitals, the second being the Physician Order and Certification Requirements for Inpatient Admission, and the third is the Inpatient Hospital Admission and Medical Review Criteria. We’re also going to be discussing future plans for implementing these policies in the coming weeks, and discussing how we’re hoping to involve stakeholders in these plans and also how we will be addressing any questions and concerns as they may arise in the coming weeks.

We will begin our discussion today with an overview of the Part B and Patient Billing and Hospitals and the Physician Order and Certification Requirements, both of which will be presented by John McInnes, the Director of Division of Outpatient Care and the CMS Ambulatory Policy Group. So I am going to go ahead and hand it over to John, thank you.

John McInnes: Thank you. John McInnes here, the Division of Outpatient Care. I am just going to briefly summarize the provisions dealing with the rebilling of services as under Part B for reasonable and necessary denials, Part A claims. And I’m also going to briefly discuss the requirements for an order in inpatient certification.

So very briefly, it’s been a long-standing policy in Medicare when a Part A claim is denied, the hospitals can re-bill for some of the services under Part B. You know, up until this most recent activity including an administrator ruling
and then this final rule, the number of services have been quite limited such that the amount of Part B rebilling has been very limited.

But what this rule does is it greatly expands the different benefit categories and number of different services that can be re-billed under the Part B rebilling, so if a hospital has a Part A claim that is denied, or they proclaim a self-audit and determine that a Part A claim is not appropriate, they can bill just about all the services that can be provided as an outpatient on a Part B inpatient claim to Medicare and get paid for those services. There are some exceptions and there are a few caveats.

Some of the exceptions are – in other words, services that cannot be re-billed are services that cannot be provided as an inpatient and need to be provided only – or can be provided only to outpatients. And that includes observation services, that’s uniquely an outpatient service, possible outpatient visits, those reports can only be provided in hospital outpatient departments.

And something known as Outpatient Diabetes Self-Management Training, the description of that benefit category is limited to outpatient, but it’s actually a fairly small list of exceptions and so this expansion of rebilling really includes just about (inaudible) the patient could receive in the hospital.

Now for dates of service admissions after the effective date of the final rule, which is October 1st, the normal restriction on the filing of claims, one year timely filing will apply. So any rebilling will have to take place within one year of the date of service.

So with that, I’ll just move briefly to the requirements for an order and certification. Now this – in the IPPS final rule represented a codification of law standing requirements of course an order has been required for inpatient admission for a long time, and also the statute has required certification of the inpatient stay, but we’ve made the requirements more clear and put them in regulation, and I’ll just briefly describe what is required.

So the regulations say that a patient is formally admitted as an inpatient pursuant to the inpatient – pursuant to an order for inpatient admission, and
this must be provided by a physician or other qualified practitioner, and it must be documented in the medical record.

So what we mean is that the order must be furnished by somebody’s who is a qualified and licensed practitioner who has admitting privileges as the hospital as permitted by state law and someone who is knowledgeable about the patient’s hospital course medical plan and current condition. So somebody who is going to be involved in the care of the patient, and that can’t be delegated to somebody who is not described by those requirements.

And with respect to the certification, these requirements are outlined in CFR 424 and we specify that the certification begins with the order for admission in the medical record and the other items of the certification as listed in the regulation 424.13, beginning with the order but also including reasons for the hospitalization and the estimated time that the patient will remain in the hospital and plans for the post-operative care, if that’s necessary. And that needs to be completed, except for in some special circumstances for outliers by the date of discharge. And again, so those are now in regulations.

And that concludes my brief summary of those parts of the IPPS final rule and after the two-midnight summary, we’ll take questions on those.

So with that, I’ll hand it back over to (Jen Dupee).

(Jennifer Dupee): Great, thank you, John. So I am going to give a brief overview of the inpatient hospital admission and medical review criteria.

To start things off, we just wanted to provide a little bit of background about some of the issues that we’ve had with the inpatient/outpatient hospital claims in the past years. Reviews of inpatient hospital claims by Medicare review contractors have consistently shown high improper payment rates, because while the underlying service is provided in the hospital were reasonable and necessary, the services could have been provided on an outpatient basis.

More specifically, in 2012, the comprehensive error rate testing contractor, which is responsible for calculating the improper payment rate and the Medical fee for service program found that inpatient hospital admissions for
one day stays or less had an improper payment rate of 36 percent. The rate then dropped for two-day stays to approximately 13.2 percent, and three day stays to 13.1 percent. And these improper payments that have been identified by the comprehensive error rate testing program have been supported by similar findings by the Office of Inspector General and also the Department of Justice.

In addition, CMS has recognized that the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours, while still small, has increased from approximately 3 percent in 2006 to 8 percent in 2011. And this trend is concerning to CMS because of the potential financial impact on Medicare beneficiaries.

So now I am going to go over what the regulation that was published as part of the 2014 IPPS final rule outlines. So the final rule specifies that surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital payments under Medicare Part A when first the physician expects the patient to require a stay that crosses at least two midnights and second, the physician admits the patient to the hospital based on that expectation.

And conversely, surgical procedures, diagnostic tests and other treatments are generally inappropriate for inpatient hospital payment under Medicare Part A when the physician does not expect the patient – when the physician expects to keep the patient in the hospital for a limited period of time, but does not cross two midnights. Because this guidance is based on the physician’s expectation of the beneficiary’s length of stay, CMS recognizes that there may be unforeseen circumstances that may result in (a) length of stay that is shorter than the physician’s original expectation at the time the inpatient order was written.

Such circumstances may include the beneficiary being transferred to another hospital, beneficiary death, or the beneficiary leaving against medical advice. We emphasize in the final rule that it is very important that the occurrence of these circumstances be clearly documented in the medical records so that we
can understand upon review what exactly happened during that beneficiary’s stay.

An exception to these time based criteria is the inpatient only procedures. These procedures will not be subject to the two-midnight admission guidance; an admission associated with these procedures will always be deemed reasonable and necessary provided that the procedure itself was reasonable and necessary.

We emphasize in the final rule that the physician’s expectation for a two-midnight stay or less must be based on medical factors and physician judgment, and these also must be documented. Such factors would include the patient history and co morbidities, the severity of signs and symptoms, the current medical needs of the beneficiary, and the risk of an adverse event happening during the time period for which hospitalization is being considered.

This final rule is applicable to all acute care hospitals, critical access hospitals, long term care hospitals, and inpatient psychiatric facilities. This policy does not apply to inpatient rehabilitation facilities, which have separate and distinct admission guidelines. The effective date for these guidelines will be for dates of admission that occur on or after October 1st of 2013.

I wanted to get into a couple of concepts that are encompassed in this rule that have promoted a few questions lately from the public, and that we also tried to address in the final rule as best as we could to differentiate these concepts. The first is what we refer to as the benchmark. The benchmark refers to the time that may be taken into account by the physician when he or she makes a determination of when an inpatient order should be written, based upon the expectation of the beneficiary should be admitted as an inpatient.

And we specify in the final rule that the two-midnight benchmark clock begins when the beneficiary begins receiving hospital services. Now this can include observation care and care that the beneficiary receives in the emergency department, operating room or other treatment areas in the hospital.
So in other words, the physician is able to take into account the time that the patient was receiving hospital care as an outpatient, when deciding whether the two midnights of hospital care will be required and therefore an inpatient admission is generally appropriate.

Now while the physician may take into account the time the beneficiary spent as an outpatient for this purpose, this will not turn into inpatient time once the order is written. The order will still begin the inpatient admission, and the time preceding the order will remain outpatient time. This means that outpatient time does not count as inpatient time for purposes of qualifying for skilled nursing facility coverage and rather this time may only be considered for the limited purpose for determining if the expectation of a stay less than at least two midnights in the hospital is reasonable.

The other concept that we introduced in the final rule is what we refer to as our presumption. And basically, this refers to how medical review will be conducted under the revised inpatient hospital admissions policy.

Under the presumption, CMS medical review contractors will not focus on claims that are more than two midnights after the admission order is written and the inpatient admission begins, because it will be presumed that these inpatient stays were medically necessary. Instead, the focus of medical reviews will be on inpatient hospital claims with lengths of stay lasting less than two midnights. However, we did emphasize that the presumption may be lifted and inpatient claims of greater than two midnights may still be the focus of inpatient status medical review efforts if there is evidence of abuse of systematic delay for purposes of surpassing the two midnight threshold.

We also recognize that there are claims that may fall outside of the presumption, because part of the hospitalization was spent as an outpatient, such as when the inpatient order was written after the first night was spent in observation status. Medicare review contractors will review these claims under the same guidance CMS has given to providers and that the outpatient time may be taken into consideration when admitting a patient based on the reasonable expectation that they will require a stay lasting at least two midnights.
So that is basically our overview that we wanted to provide you today of the inpatient admission guidelines. We would now like to shift our focus to the plans that we have regarding implementation of the medical review criteria. First, as many of you know, we have set up a special e-mail address, ippsadmissions@cms.hhs.gov, and that is in the announcement for this open door forum, to which we encourage all stakeholders to submit questions and comments. We are working our way through these messages on a daily basis and are using them as one of several bases for question and answer documents, our Medicare manual guidance, and other educational materials we are developing as part of implementing this rule.

We also understand that October 1st is quickly approaching, and various issues do need to be addressed. Early and thorough direction is our goal as we work our way through this process, so this may include additional open door forums, Listserv messages, lists of questions received to date, and other forms of outreach and also keeping you updated on time frames for important milestones.

So our overall goal is to effectuate an intensive and nationally coordinated education program, and as part of this it is really important that we receive feedback from all stakeholders about (inaudible) methods, education and outreach that you think would be most effective in making this as clear as possible.

So with that, we did want to open up the lines for some basic questions that maybe did not – that maybe were not covered during our discussion. As we said, most of our questions we are actually receiving into our IPPS admissions mailbox, and we are putting all of those together and formulating our responses so we make sure that we are responsive and are able to circulate those questions among all the areas of CMS that need to give their input into these various questions. So I think we’ll go ahead and open up the lines.

Operator: And as a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other
participants time for questions. If you require any further follow-up, you may press star, one again to rejoin the queue.

Your first question comes from (Kate Tow), University of Rochester. Your line is open.

(Kate Tow): Based on what you just said, is the patients, if they’re not – if they are going to be admitted, the expectation is that they are going to be here for more than two midnights; if they don’t meet InterQual criteria, but their provider still wants them to be an inpatient admission and expects that they are going to be there for two midnights, will that still be OK?

(Jennifer Dupee): This is a question that we’ve received from several people; we are actually working on coming up with a response that addresses this issue, because we recognize that with the two-midnight expectation, and the use of InterQual or other review guidelines, it may be approached in a different manner than is approached by the hospital with other commercial payers. So that is one question and answer that we will be addressing in the near future.

Operator: OK. Your next question comes from the line of Joanna Kim with – I’m sorry, yes, Joanna Kim with American Hospital. Your line is open.

Joanna Kim: Hi, well we really appreciate the sensitivity around getting this guidance out as quickly as possible since October 1st is approaching very quickly; an obviously the sooner it comes out the better for hospitals. Do you have any sort of idea on when exactly the guidance has been released? And then also in follow-up to that, going forward, will there be a way for hospitals and other stakeholders to provide input on how the implementation is going on an ongoing basis? That’s all.

Jennifer Phillips: Hi, yes, this is Jennifer Phillips, and we definitely appreciate that October 1st date is quickly approaching and so as just mentioned, we are daily monitoring that IPPS admissions mailbox. And so, you know, this call is really a first in a series of, you know, educational forums. We do understand that the more stakeholder input and stakeholder understanding that we effectuate with the rule, the better the rule will be.
So with that being said, you know, within that next couple of months, expect additional information. And the IPPS mailbox can be used on a continuing basis, just to keep an open line of communication with CMS, because we do consider your input very valuable.

Joanna Kim: OK, thank you.

Jennifer Phillips: Thank you.

(Operator): Your next question comes from (Kathleen Massey) with Arnett Health. Your line is open.

(Kathleen Massey): Can you hear me?

(Jennifer Dupee): Yes, we can.

(Kathleen Massey): Oh, OK. My question is with the two-midnight rule – and I just want to clarify, if you admit a patient to the hospital for observation, and then that patient continually gets worse, and you realize you are on the second or third day of observation, which observation is only intended to be 48 hours or less; and at that time, you change the patient to an inpatient, because it becomes obviously they are going to need a longer length of stay.

Well, according to the rules, then the patient really doesn’t become an inpatient until that order is written on the second or third day and then if they are discharged on the third or fourth day, they won’t have the two-midnight stay. How is CMS going to deal with those issues? Because we’ve seen a lot of our denials in the – in the RAC recovery – the recovery auditor system, a result of that; that they looked like a one-day stay, according to when the admission order was written, but the patient had actually been here for a day or two prior, and you know, best guess that the patient would do well, and they did not, and ended up actually requiring inpatient status.

(Jennifer Dupee): So under the final rule, and it’s somewhat difficult, you know, examples are good, but, you know, we can’t be too specific because it depends on some circumstances. But in the situation that you described, under our policy, we would expect that the physician, once he or she develops the expectation that
that beneficiary needed to stay that second midnight, the inpatient order should have been written, meaning that the inpatient stay would have started on that – before the second midnight. So if it’s the – the inpatient order under our guidance, should not have been written on the third day, it should have been written on the second day, before the beneficiary stayed for the second midnight.

George Mills: Yes, and – this is George Mills – but the thing people need to understand is that yes, there is going to be some short one day stays that will now be outpatient, but there is going to be a greater number of observation situations just like you described. The actual net effect of this regulation is to increase the number of inpatient stays; that is part of what we’re trying to deal with with this reg, is to get away from people being in observation for long periods of time.

And as (Jen) said, after that first midnight, if there is an expectation that they need to additional midnight, write the order to admit and then that would be acceptable under our rule, because they will have been there two midnights.

(Kathleen Massey): So this is a patient overall that needs three nights in the hospital, but you don’t realize that until the second day. So then they still may not have the two midnights if they end up going home late on the third or fourth day. I just think that it makes it pretty confusing for hospitals, and really this happens when patients come in on a weekend and you don’t have the case management and the utilization review team at full strength that you might have during, you know, during a Monday through Friday scenario.

I guess what I’m hearing from you is, this patients needs to be totally evaluated on their second day so that they don’t go into that second midnight, and you’re absolutely sure whether that’s an in-patient or an observation patient.

George Mills: Right – this is George – again, what we’re saying is, is that when we talk about two midnight, it also can include the midnight that they were on observation. So that is one midnight, so then the next morning, the doctor looks at the patient and says I know they are going to be here at least another midnight, and then writes an order to admit. And then the two-midnight rule
has been met. That is why we’re saying, we don’t believe that there should be observation periods that are really more than a day under this policy, if there is an expectation you are going to stay an additional midnight.

That is the point I am trying to make is that another fact of this rule is actually that Medicare admissions will increase, not decrease. What will decrease will be short day, one day surgeries where the person comes in, has a minor surgery, stays overnight and is discharged first thing in the morning. That is outpatient under this rule.

(Kathleen Massey): So when you do your data mining to pull out those less than two-midnight stays, how are you going to know which one of those are really two midnights, because the first midnight was observation?

(Jennifer Dupee): And this is what we were trying to describe between the benchmark and the presumption. If we have a case like that, with the presumption, you are correct, that if the inpatient order is written not until the second day, that will be on our system, potentially a one day stay. However, when we do the claims review, our contractors are given the same directive that we are giving to all of the hospitals and providers, that that outpatient time can be appropriately be counted towards that expectation of a two-midnight stay.

(Kathleen Massey): OK, that’s it, thank you.

George Mills: We’re working on a way to identify that easier than through the claim.

(Jennifer Dupee): Yes, and any suggestions that anybody may have about this very issue going forward, we’d be more than happy to accept those into our email box.

Operator: OK. Your next question comes from (Andrew Walker) with (Walker and Associates). Your line is open.

(Andrew Walker): Thank you. One of the questions I had with regard to the benchmark is to what extent will reviewers then look behind the two midnights and look at the medical records to evaluate the medical condition of the patient, the risk of adverse consequences.
Right now, we have a 24-hour benchmark which says if you are over 24 hours, you should admit; but the reviewers tend to ignore that benchmark and focus on medical conditions, the potential for adverse consequences; those types of issues. Are providers still at risk under the circumstances that a patient is in observation, the next morning the physician believes it is going to be over 24 hours, orders inpatient – we now are in the benchmark, not the presumption. Are reviewers going to come back and now start arguing in each of those cases that they could have remained in observation based upon those other factors?

George Mills: Well, that’s specifically not what we’ve said we were going to do in the reg; that we will count the observation day as one midnight and the one midnight as an inpatient towards meeting the two-midnight presumption. So that is our plan, I mean, we keep getting this question like, what are you going really do with the auditors? We’re not going to tell auditors to look at one day stays; because under this rule, other than the exceptions, inpatient only (less) the other exceptions, most of those don’t meet the presumption. So those are going to be potentially there.

But under the rules that will be given to auditors, those will be two midnights, and they should not be denying those, saying that they should have been outpatients.

(Jennifer Dupee): And we’re also developing guidance on how these clinical factors should be taken into account as part of the development of the expectation of the beneficiary needs to stay in the hospital for two midnights.

(Andrew Walker): OK, thank you.

(Jennifer Dupee): Thank you.

Operator: Again, to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow-up question to allow other participants time for questions.
Your next question comes from the line of (Ashton Shots) with the Mayo Clinic. Your line is open.

(Ashton Shots): Hi, I actually withdrew my question; I think that our questions were e-mailed to the IPPS web address, it really goes to having that reasonable expectation of the midnights as well as if it is going to be – if crossing over (inaudible) …

(Jennifer Dupee): I’m sorry, we’re having a really hard time hearing you.

(Ashton Shots): … midnight is going to impact us if we really believe that they don’t meet inpatient criteria. So we really look forward to additional transmittals and correspondence with CMS going forward.

(Jennifer Dupee): OK, we did receive your questions and we do – and we will definitely get back to you, and thank you for forwarding those to us.

Operator: Your next question comes from the line of (Patty Dockey) with Memorial Hospital. Your line is open.

(Patty Dockey): Hi, you mentioned before the special circumstances of transfer, death, or AMA, but what you didn’t say is what you are going to do with those. You did say that death needed to be clearly documented; how are those going to be handled?

(Jennifer Dupee): Those are the circumstances in which, if a beneficiary comes in and is admitted based upon the expectation that they would require a two-midnight stay and then one of these things happens in the interim, that interrupts that projected time of care, we are saying that that can be taken into consideration upon medical review. Because this is based upon an expectation, those types of things can happen, that – you know, unexpectedly shortened the anticipated length of stay.

So when the reviewers are taking a look at that, they can take that into account and deem that that actually was inappropriate inpatient admission.

(Patty Dockey): That’s your instruction to the reviewer?

George Mills: Yes.
(Jennifer Dupee): That is the instruction to the providers and to the reviewers, and we are developing more concrete guidance as we’re going along here.

(Patty Dockey): Thank you.

(Jennifer Dupee): Thank you.

Operator: Your next question comes from the line of (Carlton Diller) with Woods Hospital. Your line is open.

(Carlton Diller): Yes, thank you for your time. My question pertained to the order and certification requirements. A lot of time we have advance practice nurses or residents who are not yet – they don’t have independent admitting privileges putting in orders. Does it need to be the attending of record or somebody that has admitting privileges that puts in the order? And if so, can the residents and/or advance practice nurses put it in under the attending physician’s name after talking to him or her?

John McInnes: Yes, hi, this is John McInnes. There has been a question already regarding the residents and we’re going to issue a question and answer on that. I think that the hang up might be regarding the language in the regulation that says a practitioner who has admitting privileges at the hospital and how that is being interpreted. So the – we’re going to have to address that, because I think that it is anticipated that certainly residents working with attending, you know, physicians could admit the patient. And these regulations weren’t designed to not allow that.

(Carlton Diller): Because in the case of physician extenders, like advanced practice nurses, or physician’s assistants that do not have admitting privileges?

John McInnes: Yes, that is a little bit – I think that’s a little bit trickier and we’ll have to address that through guidance. If there is – if the hospital does not permit that, then it may not be – there may be situations that may not be in compliance with the regulation. But there also may be ways in which they can assist the attending physician if the attending physician comes later and
countersigns or provides some documentation in the medical record that, you know, indicates that they would be the genesis of the order to admit.

(Carlton Diller): Even if it would be done after the first midnight?

John McInnes: Well, yes – I think what we’re getting into here is sort of a situation similar to what we had anticipated with a verbal order – it’s similar to that, where you know, there was an instruction in the medical record, and that is – the initial documentation is provided by someone who is, you know, documenting what amounts to a verbal order or instruction and later on that – the countersignature, the acknowledgement in the medical record is provided.

Now if the patients is formally admitted, then you know, you know, the first midnight really wouldn’t effect whether or not the regulations for admissions were satisfied. We are going to have to entertain, I think, some of these more common situations in Q&A; but thanks for your question.

Operator: Your next question comes from the line of (Tammy Lockary) with Union General Hospital. Your line is open.

(Gayle): Yes, my nam’s (Gayle) and I work in the Medicare billing department, and I was wondering about observations and outpatient billing, can anyone there answer a question about like surgeries and observation hours being billed under 131 or 121?

John McInnes: I think that is outside of the scope of the call, but if you send an e-mail in, we can answer your question.

(Gayle): Thank you, and what was the address again, the …

(Jennifer Dupee): It’s ippsadmissions – that’s one word – @cms.hhs.gov.

(Gayle): Thank you so much.

Operator: Your next question comes from the line of (Emily Ackerman) from Sharp HealthCare. Your line is open.

Hello, (Emily Ackerman). Your line is open.
(Emily Ackerman): Hi, yes, sorry about that. Considering that you are appropriately expecting in-patient (admission) volumes to go up and observation to go down in this – with this new rule. Can you give us any guidance on what data you would be looking at to identify abuse or systematic delay that might cause the revocation of the two-midnight presumption and will that revocation be listed at the individual provider level, or just in general?

George Mills: Well, it would be at the individual provider level, and people on the phone might be familiar with our PEPPER reports that are sent to facilities throughout the year from our PEPPER resources contractor. So we would be using data like from there to look. I mean, it is not going to be day one or even the first month that in terms of the two midnight, because again, part of it is that we are expecting that there will be an increase in two-day stays because of this rule.

So it is something that we will be working on and I would not expect it to be immediate where we are starting to look at it, because that is one of the questions. We are expecting some increase, but the question is – we’re going to look at our data and see those that look different from the, you know, the peer group. So it won’t be like October 1st we’ll start looking at the two days, but we will use data and we will also use the CERT contractor who pulls a systematic random sample to inform us as to what to look for.

So we are going to use data, it is not going to be right off the get go, but we will use data, like historical billing data, and the PEPPERs an other kind of data to look for those changes in billing behavior.

(Emily Ackerman): Thank you.

Operator: Your next question comes from (Andrea Dawns) from Memorial Hospital. Your line is open.

(Andrea Dawns): I have a question on the Part B; is the final rule the one that CMS 1455-R proposal replaces, and then if that is the case, on these RAC reviews where they review the case they have up to three years to review it and they come back and we want to bill Part B, we can’t do that because it is not under timely
(inaudible) for example. A case that’s reviewed from 2010 is now 2013, they’ve denied it for not meeting inpatient criteria, we agree in one of those Part B’s, is that not – is it going to be a (over timely) filing – on the RAC reviews also?

George Mills: Well, again, this is George – and John chime in. OK, people have to remember, under this rule admissions on – I mean before October 1st can be re-billed after a denial regardless of how long that it occurs after the claim – you know, the date of the claim. For admissions on or after October 1st, where we have this new policy, the two-midnight policy, it is only 12 months. So our expectation is we have better to guidance, it is much clearer, that is a lynchpin date, so that’s why it is only the 12 months to re-bill based on the new two-midnight policy.

But for the older – before October 1st, it is more expansive the rebilling rights, after October 1st, after the implementation of this new rule, it is only 12 months. And I didn’t know if John wanted to add anything?

John McInnes: No, I think that that is correct. And that is what we said in the final rule, so if the patient is admitted prior to October 1st and of course the denial comes later, then the expanded time frame that is in effect under the ruling, the rebilling ruling, is in effect, but for admissions October 1st, it is one year timely filing.

(Andrea Dawns): OK, thank you for that clarification.

Operator: Your next question comes from the line of (Anne Marie Courtesy) with Medical Center. Your line is open.

(Anne Marie Courtesy): Hi, I just want a little clarification regarding the certification. I understand that you are going to look for an inpatient order, so but for the certification, do you expect documentation in the record that speaks to the reasons for the hospitalization, the estimated time we expect the patient to be in inpatient status? Is that what you are looking for?

John McInnes: Well, that’s how the – that is what is specified in the regulation and that comes from a statutory requirement. We are going to develop that a bit more
in guidance in terms of you know, how we believe that could be satisfied in the record.

(Anne Marie Courtesy): OK, look forward to that. Thank you.

Operator: Again, to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Your next question comes from Ben Reynolds from UPMC. Your line is open.

Ben Reynolds: Yes, I am sorry; I thought I withdrew my question. But since I have a little bit of time, I just want to be clear as I am – I’ll make sure that I get my mind around the intent of the regulation as it related to ordering of the initial in-patient admission. The language is very clear about the licensed practitioner has to have admitting privileges at the hospital as permitted by state law. Is there – do we anticipate that there will be any – do we anticipate that the clarification on this will allow our residents and advance practice providers to be able to do this, I just want to make sure that I was hearing this correctly. Thank you.

John McInnes: Yes, well, I don’t know at this point whether it is going to allow for every type of – I don’t think it would allow for every type of physician extender, but I think what we are going to have to do is provide some sort of definition around our interpretation of admitting privileges, if that term means something different in the context of specific hospitals and that becomes too much of a limitation. So I don’t – at this point, I do not know because we have not decided that, (inaudible) that is what we intend to do. I don’t know at this time know to what extent and how many different types of folks that that will cover.

Operator: OK. Your next question comes from (Heather Clarke) with Fulton County Health. Your line is open.

(Heather Clarke): Hi; we are a critical access hospital and while we are not under IPPS, we do – we are subject to RAC audits and other types of audits; and so with the two-
midnight stay presumption, our two midnights are going to be on different claims, possibly. Because the outpatient is billed on 851 and the inpatient portion on the 111 type of bill, so is there any way that you are going to be able to cross match and be able to tell without pulling an audit and reviewing records that the two midnights was actually met?

George Mills: Well, yes, we will. But second of all RACs have not audited any (CAHs) because (CAHs) aren’t paid under the prospective payment system and so the count audit that would be done would be significantly different that the audit as it – compared to an IPPS hospital. There is this impression that RACs has been auditing (CAHs) and they haven’t audited one in terms of this short day stay. There have been claims that have been denied, but those have generally been coding issues and things like that.

I don’t expect there to be much (CAHs) audits of inpatient short stays by RACs at any time in the near future at all, but if there was, there is this data to do exactly what you are saying.

(Heather Clarke): OK, well we have had DRG reviews for inpatient stays from our RACs.

George Mills: OK, well we can look into that, but (CAHs) haven’t been approved because of the way that (CAHs) are paid is not the same as a DRG paid hospital.

(Heather Clarke): OK, thank you.

George Mills: Yes, because they could – because it might have been a coding issue. So, I mean, what we are talking about here is short stays, whether it has been inpatient or outpatient. So that is what I am referring to there. But it doesn’t mean coding or that there is a duplicate payment or an automated review, those are the thing that we’ve seen (CAHs) reviews by RAC. But in terms of the short case stay issue, our data shows that there has been none. So I am not sure how that is happening, but – thank you.

Operator: Your next question comes from the line of Rick Lash with Cedars-Sinai Medical. Your line is open.
Rick Lash: Thank you. Our question is, for expanded Part B billing for facility self-audited accounts, is the ability to bill based upon a specific date of service, or is it after the implementation date of October 1st?

John McInnes: I’m sorry, can you say that again – I didn’t understand.

Rick Lash: Yes. OK. We are talking about self-audited accounts, and the question is, when can we start billing for them? Is it based on a specific date or is it after the implementation date of October 1st?

John McInnes: Yes, after the implementation date.

Rick Lash: OK, great. Thank you.

John McInnes: Yes.

Operator: Your next question comes from the line of (Bridgett Sully) with – I’m sorry (Inaudible) Medical. Your line is open.

(Bridgett Sully): Thank you. My question is about the patient who comes in as an observation and then they are going to be there another 24 hours, do they have to meet criteria to be changed to an inpatient, or just because of the fact that they are going to stay another 24 hours make them an inpatient?

(Jennifer Dupee): Based on our guidance, we would expect that if the beneficiary needs to be in the hospital, receiving hospital services, in the expected length of stay, it should be greater than two midnights, that is an appropriate inpatient admission. Like we’ve said, we are going to come out with more concrete guidance about how these other clinical judgment factors that have, you know, sometimes been part of the determination of inpatient versus outpatient will factor into this new policy.

But like I said, it is based on the expected length of stay, and there requirement that the beneficiary needed hospital (services).

George Mills: Yes, so if (any stayed) one night in observation, but then the beneficiary’s daughter had to fly from Detroit to come and pick them up – unless you are getting some services, then that wouldn’t count.
(Bridgett Sully): Right.

George Mills: (Inaudible) policy, so if the records show they needed medical care, then and there was an expectation and an order then it would meet the two night presumption.

(Bridgett Sully): So a CHF patient that just needs another day of IV diuretics doesn’t meet the inpatient level of care, according to InterQual, but still needs to be in the hospital, the physician could write an order, change them to an inpatient and would just – the fact that they need to stay another 24 hours wouldn’t be enough?

Daniel Duvall: Right. As long as the patient medically needs to stay for an additional 24 hours, it does not matter whether InterQual criteria or Milliman or any other types of criteria say it should be an outpatient level of care, inpatient level of care, an ICU level of care. What matters is that the patient needs to stay at the hospital for medical reasons, and that stay is going to cross the second midnight.

(Bridgett Sully): OK, well, we have a lot of RAC audits related to a patient being in observation one day and then getting admitted as an inpatient on that second day, and that – the RAC auditors are saying that even that second day of care should have been provided as an outpatient.

Daniel Duvall: Yes, well – that is why we are having this rule and we are clarifying it …

(Bridgett Sully): OK, great.

(Inaudible)

(Bridgett Sully): Thank you.

George Mills: … InterQual and Milliman are just tools, they are not Medicare policy; the RACs and MACs and CERT use them, but they are not definitive on Medicare rules and regulations and coverage decisions are what is definitive, not the InterQual or Milliman. So – but again, as – this question came up earlier, but
we’ll get more definitive, written advice about what happens when there is a conflict with InterQual or Milliman tools.

George Mills: And remember that we are specifically giving instructions for how we are implementing the revised benchmark, starting October 1st, so what we are talking about on this call does not apply to existing audits, existing reviews of past services. This is strictly talking about applying these guidelines after October 1st.

(Bridgett Sully): Thank you.

Operator: Your next question comes from the line of Jennifer Wheeler with Baptist St. Anthony. Your line is open.

Jennifer Wheeler: Hi. I actually sent several questions but I would like this one answered. It is my understanding that the physician cannot write just admit, it has to specify inpatient, is that correct?

Daniel Duvall: We have not issues any guidance to that effect. So far we have said that there must be an order for admission. We will be working on continued guidance on exactly what needs to identify that order as intending for inpatients, but we have not said anything along those lines.

Jennifer Wheeler: OK, can I – can you answer one more question?

Daniel Duvall: You get two.

Jennifer Wheeler: OK, good deal. So If a patient begins as observation and then they convert to inpatient, because we – the doctor says they are going to be here longer than two midnights, we’ll still go back and add the observation hours to that claim – to that inpatient claim like we are currently doing, correct?

Daniel Duvall: You are still adding the costs of the observation hours to it, you make sure that the date of admission is the date that the order is actually written, so …

Jennifer Wheeler: Correct.

Daniel Duvall: … so (continue) what you are doing right now.
Jennifer Wheeler: OK, same thing. But we can count midnight as far as when they become an inpatient, like the girl – the example earlier. But that does not count for (SNF) qualifying stay, until they become an inpatient?

(Jennifer Dupee): Correct.

George Mills: Yes, you are not an inpatient until there is an order.

Jennifer Wheeler: OK, thank you.

George Mills: Yes, you know, that is – it does not address that, and it is not retroactive. There is no retroactive application here.

Jennifer Wheeler: Thank you.

George Mills: Thank you. Before you take the next call, I know there has been a lot of RAC questions, and this is George – I just wanted to go over what our expectations are going to be for RAC.

We made it clear to RAC that we believe that this rule will clarify our policy, and we believe that people will move forward and we are preparing the RACs to have a significant decline over time in the number of inpatient cases that they are reviewing, and in fact, you will see as new record limit going up within the next week or so in terms of record reviews, in terms of post and then pre-pay. People have asked us, we’ve got a lot of questions in the inbox, well what are the RACs going to look at?

Again, we will MACs and RACs both will probably look at one day stays because there is a two-night presumption, but they will be able to sort out things like transfers, deaths, discharge against medical advice, because that is on the claim in terms of when we are looking at that. So in terms of what MACs and RACs will look at, they will be looking at one day stays, two-day stays; we’ll use data to look at people who look like they are aberrant, but we do agree that there is going to be some increase in admission; two-day admission for sure, because of the change in rules, so we will do that.
I will say RAC – people will say, what are they going to do, continue to look at in the past, before October 1st. I will tell you that our guide is to focus one day short minor surgery. That has always been our policy, that that is outpatient. They have been focusing on it, they will continue to focus on it.

So bill one day minor surgery, you are going to get audited. So that is the advice here, but we are going to put things up in writing, I know everybody keep saying are you really going to do what you said in the (reg) and yes, we will.

But again, our expectation is that over time, RAC inpatient review will decline, and I just wanted to make people clear of that, and we are going to put something up in writing on the internet in the near future, so I will refer it back to the operation. Thank you.

Operator: Your next question comes from the line of (Karen Smith) from Main Line Health. Your line is open.

(Karen Smith): Thank you. The initial speaker said that certification per inpatient admission begins with the order includes reasons and the record must include reason for hospitalization and estimated time and that it must be documented by the time the patient is discharged; but something else that I’m hearing when the second speaker said that the order needs to include all of those items. So can you clarify what you would expect to see when the order for inpatient – the order for inpatient admission is written in the record?

John McInnes: Yes, the certification is something more than just the order, it actually – the order is the beginning for the first part of the certification.

(Karen Smith): Yes.

John McInnes: So the order is, you know, the instruction in the medical record to admit the patient as an inpatient and that is the beginning of certification. So it is a part of the certification, but it is not the entire certification. Does that answer your question?
(Karen Smith): It does, but with the order, should it be documented at that time, the estimated time the patient is expected to be in the hospital, or if the contactor see that the account is two midnights long, would that be OK?

(Jennifer Dupee): From the medical review standpoint, this is one thing that we are going to by clarifying in the near future; exactly what type of documentation we are going to be expecting to see to support this two-midnight expectation. So definitively look out for that.

(Karen Smith): OK, thanks.

(Jennifer Dupee): Sure, thank you.

Operator: Your next question comes from the line of (Bob Bakins) from University. Your line is open.

(Bob Bakins): Good afternoon; there was a lot of discussion, or some discussion, with respect to the transferring in hospital, but I am not finding guidance with respect to the receiving hospital.

So for example, by way of illustration, if there is an acute to acute transfer and then upon arrival and after additional work up, the attending physician determines that the patient in fact turns out not to be a clinical candidate for the intervention they were planning, and subsequently not two midnights in our hospital. Is this an outpatient? Is this an inpatient? Do the days in hospital one count towards the days in hospital two, the recipient?

(Jennifer Dupee): These scenarios are some – are scenarios that we have been discussing internally and what I would ask is actually, I think that it would be helpful for us to receive even more examples of certain situations that we probably need to address in the coming weeks. You know, we just haven’t gotten that far yet as far as the transfer are concerned, but we definitely intend on addressing all of those different types of situations.

(Bob Bakins): I appreciate it, thank you.

(Jennifer Dupee): Thank you.
Operator: Your next question comes from the line of (Angela Cummings) from (Lakeson) Health. Your line is open.

(Angela Cummings): Hi, there. I have a question for patients who are admitted as an inpatient from the beginning, but then get better and then the next day they are able to go home to another setting for whatever reason. Should be by trying to downgrade those to observation prior to the patient leaving and going through the Code 44 process, or if it was just that the patient got better but they were expected to stay there two nights from the beginning, should we leave them as inpatients?

Jennifer Phillips: Hi, this is Jennifer, and we actually did receive similar questions to this during the comment period. We would just remind you that two-midnight benchmark is based on the physician’s expectation. And so if the physician’s expectation is one that the facility finds a reasonable one and, you know, there was, for instance an interruption of care or some other unforeseen circumstance that, you know, did not interrupt that reasonable expectation, but otherwise they did not have a two-midnight length of stay, we would not anticipate that you would have to use condition Code 44. However, if you did for some reason determine that the physician disagreed with their own original decision and you know, the condition Code 44 conditions were met, then of course, you could follow those guidelines.

(Angela Cummings): OK, and in follow-up to that. What if we discover after the patient has already been discharged, that the inpatient order wasn’t substantiated through internal audit. We at that point can’t meet condition Code 44, but as part of the rebilling, our understanding is that potentially we could re-bill those cases as observation, is that possible, and if so, would we still have to notify that patient or would there be an obligation to give that outpatient notice even once the patient is gone?

Daniel Duvall: In an instance like that, the patient was an inpatient, you didn’t use condition Code 44 prior to discharge, therefore, you can’t bill it as an observation, because the inpatient stay was an established fact. That would be one that you could bill as a Part B inpatient, and then you are going to follow the guidance
that we would be – we were giving out in terms of a case that is identified through self-audit and being billed as a Part B inpatient.

(Angela Cummings): OK, OK, great. So we can do that and we don’t have to meet Code 44 then?

Daniel Duvall: If Code 44 is applicable, you should use Code 44 before discharge. If Code 44 is not applicable, and the expectation was a valid expectation support in the records, you would leave the patient as an inpatient. If you find out after discharge that it really should not have been inpatient, then that is when you would re-bill. So it is three separate possibilities depending on the individual case.

(Angela Cummings): Great, thank you very much.

(Jennifer Dupee): Thank you. And I think we’ll probably have that be our last question, we have kind of gone over our time. Again, this is (Jennifer Dupee), on behalf of all of us here at CMS, I just want to really thank everybody for attending this afternoon’s call. We’ve had a really great turn out and we are really looking forward to working with all of you in the future and encourage you to please send us your questions and comments to the IPPS address, ippsadmissions@cms.hhs.gov; and you’ll definitely be hearing from us in the coming weeks. Thank you.

Operator: This concludes today’s conference call. You may now disconnect.
CMS Delays RAC Review of Claims With Stays of Less Than Two Midnights

In a set of frequently asked questions released Sept. 26, CMS told providers that between Oct. 1 and Dec. 31, 2013, RACs will not be permitted to review inpatient admissions of one midnight or less. The FAQs are in response to concerns by the Congress and associations about implementation of the 2-midnight rule. A copy of the frequently asked questions follows.

They also are posted at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html. This website will post all additional guidance related to the 2-midnight rule.
SEP 26 2013

Mr. Rich Umbdenstock  
President and CEO  
American Hospital Association  
325 7th Street, NW  
Washington, DC 20004

Dear Mr. Umbdenstock:

Thank you for your recent inquiries forwarding the concerns of hospitals to the Centers for Medicare & Medicaid Services (CMS) for review.

CMS and the hospital associations have been in an open dialogue for the past two years to determine an appropriate response to these issues. Over the past several years, four main issues have caused CMS to consider issuing a clarification/modification to CMS’ inpatient hospital policy. These issues are:

- An increase in the average length of observation stays;
- An increase in the Comprehensive Error Rate Testing (CERT) error rate for short inpatient stays;
- An increase in the number of inpatient appeals; and
- Requests from the hospital industry requesting clarification on inpatient review policy.

Through discussions with your organizations, providers and CMS experts, CMS released the FY 2014 hospital inpatient prospective payment system proposed and final rule. CMS continues to provide additional guidance to providers and has supplied providers with opportunities to request guidance through Open Door Forums and email. In an effort to provide additional guidance on the medical review activities of the review entities during this time of transition, CMS will be posting the attached information to the medical review website at www.cms.gov/medical-review. CMS believes this information and format will assist providers as they begin to follow the new guidance.

I appreciate your efforts to assist Medicare providers and suppliers in addressing issues related to audits and Medicare program integrity. Please do not hesitate to contact me if you have any further thoughts or concerns.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner
Q: Will CMS direct the Medicare review contractors to apply the 2-midnight presumption—that is, contractors should not select inpatient claims for review if the inpatient stay spanned two midnights from the time of admission?

A: Yes. The 2-midnight presumption directs medical reviewers to select claims for review under a presumption that the occurrence of 2 midnights after formal inpatient hospital admission signifies an appropriate inpatient status for a medically necessary claim. CMS will instruct the Medicare Administrative Contractors (MACs) and Recovery Auditors that they are not to review claims spanning more than two midnights after admission for a determination of whether the inpatient hospital admission and patient status was appropriate. In addition, for a period of 90 days, CMS will not permit Recovery Auditors to review inpatient admissions of one midnight or less that begin on or after October 1, 2013.

Q: Will Medicare contractors base their review of the physician’s expectation of medically necessary care surpassing 2 midnights upon the information available to the admitting practitioner at the time of admission?

A: Yes. CMS’ longstanding guidance has been that Medicare review contractors should evaluate the physician’s expectation based on the information available to the admitting practitioner at the time of the admission. This remains unchanged and CMS will provide clear guidance and training to our contractors on this medical review instruction.

Q: What steps will CMS take to provide guidance and education about the inpatient rule, to ensure hospital understanding and compliance with the revised instruction?

A: CMS will instruct the MACs to review a small sample of inpatient hospital claims spanning less than two midnights after admission to determine for medical necessity of the patient status in accordance with the two midnight benchmark. CMS will establish a specific probe sample prepayment record limit of 10 to 25 claims per hospital.

The probe reviews will be completed by the MAC on inpatient hospital claims spanning less than two midnights after admission with dates of admission October 1, 2013 through December 31, 2013.

• This probe sample will determine each hospital’s compliance with the new inpatient rule and provide important feedback to CMS for purposes of jointly developing further education and guidance.

• Since the probe reviews will be conducted on a prepayment basis, hospitals can rebill denied inpatient hospital admissions in accordance with the inpatient rule.
• If a MAC identifies no issues during the probe review, the MAC will cease further such reviews for that hospital from October –December 2013, unless there are significant changes in billing patterns for admissions.

• If a MAC identifies issues, the MAC will conduct education for that hospital and then conduct further follow up, as necessary.

During the implementation period of October 1, 2013 until December 31, 2013, CMS will instruct the MACs and Recovery Auditors not to review claims spanning more than two midnights after admission for appropriateness of patient status. MACs and Recovery Auditors will not review any claims related to Critical Access Hospitals. In addition, during this period, CMS will not permit Recovery Auditors to review inpatient admissions of one midnight or less that occur on or after October 1. CMS reminds hospitals that while medical review will not be focused on claims spanning 2 midnights or more after formal inpatient admission, physicians should make inpatient admission decisions in accordance with the 2 midnight provisions in the final rule. If at any time there is evidence of systematic gaming, abuse or delays in the provision of care in an attempt to surpass the 2-midnight presumption could warrant medical review.