Two Midnight Rule and Admission Certifications: Tips, Tricks and Traps

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New Inpatient Admission Rule

§ 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.

§ 412.3 Admissions cont.

(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.

§ 412.3 Admissions cont.

(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.

§ 412.3 Admissions cont.

(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 payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed.

§ 412.3 Admissions cont.

Surgical procedures, diagnostic tests, and other treatment are generally appropriate 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.

§ 412.3 Admissions cont.

(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.

§ 412.46 Medical Review Requirements

(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.

§ 412.46 Medical Review Requirements

(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.

§ 412.46 Medical Review Requirements

(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.

Physician certification of admission

Social Security Act 1814(a)(3) – Payment will be made for inpatient hospital 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 . . . [C]ertification shall be furnished only in such cases, and with such frequency, and accompanied by such supporting material . . . as may be provided by regulations."

Physician certification of admission

- Current regulation § 424.13 requires, for all inpatient services, certification (and recertification, if applicable) of
  - The reasons for inpatient treatment;
  - The estimated time of hospitalization; and
  - Plans for post-hospital care, if appropriate.
- Must be signed by the physician responsible for the case prior to discharge.
- Inpatient admission order is a part of the certification.

Physician certification of admission

- 2015 OPPS Proposed Rule
  - Interpreting SSA § 1814(a)(3) to not apply to short stays.
  - Recognizing most of the medical necessity justification is already in the admission order, progress note, medical record.
  - Proposing to remove § 412.3(c) reference to physician certification.
  - Physician certification under § 424.13 still needed for outliers and stays that are 20+ days.

FAQs

- CMS Guidance
  - "Hospital Inpatient Admission Order and Certification," January 30, 2014
  - Frequently Asked Questions, 2 Midnight Inpatient Admission Guidance and Patient Status Reviews for Admissions on or after October 1, 2013

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html

Physician expectation

Q1.2: Will Medicare review contractors base their review of a physician's expectation of medically necessary care surpassing 2 midnights upon the information available to the admitting practitioner at the time of admission?

Physician expectation

A1.2: 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 inpatient admission**. This remains unchanged and CMS will provide clear guidance and training to our contractors on this medical review instruction.

Screening tools

Q4.5: Does the beneficiary's hospital stay need to meet inpatient level utilization review screening criteria to be considered reasonable and necessary for Part A payment?

A4.5: If the beneficiary requires medically necessary hospital care that is expected to span 2 or more midnights, then inpatient

Screening tools

admission is **generally** appropriate. If the physician expects the beneficiary's medically necessary treatment to span less than 2 midnights, it is **generally** appropriate to treat the beneficiary in outpatient status. If the physician is unable to determine at the time the beneficiary presents whether the beneficiary will require 2 or more

Screening tools

midnights of hospital care, the physician may order observation services and reconsider providing an order for inpatient admission at a later point in time . While utilization review (UR) committees may continue to use commercial screening tools to help evaluate the inpatient admission decision, the tools are not binding on the

Screening tools

hospital, CMS or its review contractors. In reviewing stays lasting less than 2 midnights after formal inpatient admission (i.e., those stays not receiving presumption of inpatient medical necessity), Medicare review contractors will assess the reasonableness of the physician's expectation of the need for and duration of care based on complex

Screening tools

medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which must be clearly documented.

Calculating time

Q2.1: Can CMS clarify when the 2 midnight benchmark begins for a claim selected for medical review, and how it incorporates outpatient time prior to admission in determining the general appropriateness of the inpatient admission?

Calculating time

A2.1: For purposes of determining whether the 2-midnight benchmark was met and, therefore, whether inpatient admission was generally appropriate, the Medicare review contractor will consider time the beneficiary spent receiving outpatient services within the hospital. This will include services such as observation services, treatments in the emergency department, and procedures

Calculating time

provided in the operating room or other treatment area. From the medical review perspective, while the time the beneficiary spent as a hospital outpatient before the beneficiary was formally admitted as an inpatient pursuant to the physician order will not be considered inpatient time, it will be considered during the medical review process for purposes of determining whether the

Calculating time

2-midnight benchmark was met and, therefore, whether payment for the admission is generally appropriate under Medicare Part A. Whether the beneficiary receives services in the emergency department (ED) as an outpatient prior to inpatient admission (for example, receives observation services in the emergency room) or is formally admitted as an inpatient upon arrival at the hospital

Calculating time

(for example, inpatient admission order written prior to an elective inpatient procedure or a beneficiary who was an inpatient at another hospital and is transferred), the starting point for the 2 midnight timeframe for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital. CMS notes that this instruction excludes wait times prior to the

Calculating time

initiation of care, and therefore triaging activities (such as vital signs before the initiation of medically necessary services responsive to the beneficiary's clinical presentation) must be excluded. A beneficiary sitting in the ED waiting room at midnight while awaiting the start of treatment would not be considered to have passed the first midnight, but a beneficiary receiving services

Calculating time

in the ED at midnight would meet the first midnight of the benchmark. The Medicare review contractor will count only medically necessary services responsive to the beneficiary's clinical presentation as performed by medical personnel.

Transfers

Q2.2: How should providers calculate the 2-midnight benchmark when the beneficiary has been transferred from another hospital?

A2.2: The receiving hospital is allowed to take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, the start clock for transfers

Transfers

begins when the care begins in the initial hospital. Any excessive wait times or time spent in the hospital for non-medically necessary services shall be excluded from the physician's admission decision. (Note: for the purposes of this question, hospital is defined as acute care hospital, long-term care hospital (LTCH), critical access

Transfers

hospital (CAH), and inpatient psychiatric facility.)

Medicare review contractors may request records from the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving care to ensure compliance and deter gaming or abuse.

Transfers

Claim submissions for transfer cases will be monitored and any billing aberrancy identified by CMS or the Medicare review contractors may be subject to targeted review. The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility.

Unexpected discharge

Q3.1: If a Part A claim is selected for medical review and it is determined that the beneficiary remained in the hospital for 2 or more midnights but was expected to be discharged before 2 midnights absent a delay in the provision of care, such as when a certain test or procedure is not available on the weekend, will this claim be

Unexpected discharge

considered appropriate for payment under Medicare Part A as inpatient under the new 2 midnight benchmark?

A3.1: Section 1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of services that are reasonable and necessary for the diagnosis or treatment of illness or injury or

Unexpected discharge

to improve the functioning of a malformed body. As such, CMS' longstanding instruction has been and continues to be that hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment. Accordingly, CMS expects Medicare review contractors will exclude

Unexpected discharge

extensive delays in the provision of medically necessary services from the 2 midnight benchmark. Medicare review contractors will only count the time in which the beneficiary received medically necessary hospital services.

Who may make the order?

45 C.F.R. § 412.3(b)

“. . . 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.”

Who may make the order?

- Must be acting within scope of state license.
- Must have privileges at hospital to admit.
- Must be knowledgeable about the patient's hospital course, medical plan of care, and current condition.

Who may make the order?

"[A] medical resident, a physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner provided they are authorized under state law to admit patients and the requirements outlined below are met."

Residents, PAs, NPs, or other NPPs

- May write the inpatient admission order on the ordering practitioner's behalf IF the ordering practitioner approves and accepts responsibility for the admission decision by countersigning the order prior to discharge.

Who is “knowledgeable about the patient’s hospital course”?

- Admitting physician or on-call counterpart.
- Primary or covering hospitalist(s) caring for patient in the hospital.
- Patient’s primary care practitioner or on-call counterpart.
- Patient’s surgeon or on-call counterpart.

Who is "knowledgeable about the patient's hospital course"?

- Emergency or clinic practitioners caring for patient at the point of admission.
- Other practitioners qualified to admit patients and actively treating the patient at the point of admission.
- Does NOT include a UR physician.
  - See 42 CFR 482.30(d)(3).

What must the order say?

- 78 FR 50942: “[T]he 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.”

What must the order say?

- CMS Guidance:
  - "We do not recommend using language that may have specific meaning [*sic*.] individuals that work in the hospital (e.g. "admit to 7W") that will not be commonly understood by others."
  - Don't use "to ER," or "to Recovery," "to Short Stay Surgery" or other outpatient-like language.

Must the order be signed?

- § 412.3 doesn't say so.
- § 424.13 says the certification must be signed.
- CMS guidance says the order must be "authenticated" – see verbal orders.
- Remember that CMS says the physician must countersign an order by a "proxy."

What about verbal orders?

- Order may be communicated to staff acting within their state law scope of practice.
- Staff must document the order at the time it is received.
- “The order must be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge.”

Are standing orders okay?

- CMS says “no.”
- “While Medicare’s rules do not prohibit use of a protocol or algorithm that is part of a protocol, only the ordering practitioner . . . can make and take responsibility for the inpatient admission decision.”

Documentation

Q4.2: What factors should the physician take into consideration when making the admission decision and document in the medical record?

A4.2: For purposes of meeting the 2-midnight benchmark, in deciding whether an inpatient admission is warranted, the physician must assess whether the

Documentation

beneficiary requires hospital services and whether it is expected that such services will be required for 2 or more midnights. The decision to admit the beneficiary as an inpatient is a complex medical decision made by the physician in consideration of various factors, including the beneficiary's age, disease processes, comorbidities, and the potential impact of sending the beneficiary

Documentation

home. It is up to the physician to make the complex medical determination 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 whether the beneficiary may be discharged. If, based on the

Documentation

physician's evaluation of complex medical factors and applicable risk, the beneficiary may be safely and appropriately discharged, then the beneficiary should be discharged, and hospital payment is not appropriate on either an inpatient or outpatient basis.

What if the procedure is on the Inpatient-Only list?

CMS Final Rule:

"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."

What's the test again??

Q4.7: Are there any circumstances outside of beneficiary transfer, death, departure against medical advice, or receipt of a Medicare Inpatient-Only procedure that permit a beneficiary to be appropriately admitted as an inpatient for a stay of less than 2 midnights in the hospital?

What's the test again??

A4.7: Yes. The regulation specifies that the decision to admit should generally be based on the physician's ***reasonable*** expectation of a length of stay spanning 2 or more midnights, taking into account complex medical factors that must be documented in the medical record. Because this is based upon the physician's expectation, as opposed

What's the test again??

to a retroactive determination based on actual length of stay, unforeseen circumstances that result in a shorter stay than the physician's reasonable expectation may still result in a hospitalization that is appropriately considered inpatient. As enumerated in the final rule, CMS anticipates that **most** of these situations will arise in the context of beneficiary death, transfer, or departure

What's the test again??

against medical advice. However, CMS does recognize that on occasion there may be situations in which the beneficiary improves much more rapidly than the physician's reasonable expectation. Such instances must be clearly documented and the initial expectation of a hospital stay spanning 2 or more midnights must have been reasonable

What's the test again??

in order for this circumstance to be an acceptable inpatient admission payable under Part A.

What if the procedure is elective and scheduled?

- Use the Two Midnight Rule.

What if the surgery is cancelled after admission?

- Use the Two Midnight Rule.

Probe and Educate

- Will continue through March 31, 2015.
- As of May 12, 2014, MACs had completed most first probe reviews and were beginning to provide education.
- RACs will not review inpatients admissions with dates of admission on or prior to March 31, 2015.

Questions?

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