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Fact Sheet: Two-Midnight Rule

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On July 1, 2015, CMS released proposed updates to the "Two-Midnight" rule regarding when inpatient admissions are appropriate for payment under Medicare Part A. These changes would continue CMS' long-standing emphasis on the importance of a physician's medical judgment in meeting the needs of Medicare beneficiaries. These updates were included in the calendar year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) proposed rule.

Hospital Inpatient vs. Outpatient

Because of the way the Medicare statute is structured, the Medicare payment rates for inpatient and outpatient hospital stays differ.

CMS pays acute-care hospitals (with a few exceptions specified in the law) for inpatient stays under the Hospital Inpatient Prospective Payment System (IPPS) in the Medicare Part A program. CMS sets payment rates prospectively for inpatient stays based on the patient's diagnoses, procedures, and severity of illness.

In contrast, the Hospital Outpatient Prospective Payment System (OPPS) is paid under the Medicare Part B program and is a hybrid of a prospective payment system and a fee schedule, with some payments representing costs packaged into a primary service and other payments representing the cost of a particular item, service, or procedure.

Not all care provided in a hospital setting is appropriate for inpatient, Part A payment. Therefore, when a Medicare beneficiary arrives at a hospital in need of medical or surgical care, the physician or other qualified practitioner must decide whether it is appropriate to admit the beneficiary as an inpatient or treat him or her as an outpatient. These decisions also have significant implications for provider reimbursement and beneficiary cost sharing.

The Two-Midnight Rule

Background

In recent years, through the Recovery Audit program, CMS identified high rates of error for hospital services rendered in a medically-unnecessary setting (*i.e.*, inpatient rather than outpatient).

CMS also observed a higher frequency of beneficiaries being treated as hospital outpatients and receiving extended "observation" services. Hospitals and other stakeholders expressed concern about this trend, especially since days spent as a hospital outpatient do not count towards the three-day inpatient hospital stay that is required before a beneficiary is eligible for Medicare coverage of skilled nursing facility services.

To address both of these issues, hospitals and other stakeholders requested additional clarity regarding when an inpatient admission is payable under Medicare Part A. In response, in 2012, CMS solicited feedback on possible criteria that could be used to determine when inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

The Two-Midnight Rule

To provide greater clarity to hospital and physician stakeholders, and address the higher frequency of beneficiaries being treated as hospital outpatients, CMS adopted the Two-Midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admission is reasonable and payable under Medicare Part A.

In general, the Two-Midnight rule stated that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

The Two-Midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners. The Two-Midnight rule does not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service.

Following the adoption of the Two-Midnight rule, CMS received significant feedback from the stakeholder community, including concerns that the new policy was impacting physician and hospital practices.

Process for Developing Proposed Updates

Extensive Input

The proposed changes to the Two-Midnight rule reflect extensive stakeholder input, as well as important feedback from the "probe and educate" process.

Since the publication of the original Two-Midnight rule, CMS has gathered significant input from stakeholders, including hospitals, physicians, the Medicare Payment Advisory Commission (MedPAC), beneficiary advocates, and Congress

CMS has also received important information from the probe and educate process conducted by the Medicare Administrative Contractors (MACs), in which CMS contractors have worked with hospitals to clarify the parameters of Medicare payment policy with regard to inpatient and outpatient patient status.

Principles for Proposing to Update the Two Midnight Rule

As we considered changes to this rule, CMS sought to balance multiple goals, including: respecting the judgment of physicians; supporting high quality care for Medicare beneficiaries; providing clear guidelines for hospitals and doctors; and incentivizing efficient care to protect the Medicare trust funds.

Proposal in the CY 2016 OPPS Rule

In the CY 2016 OPPS proposed rule, CMS is:

- Proposing to change the standard by which inpatient admissions generally qualify for Part A payment based on feedback from hospitals and physician to reiterate and emphasize the role of physician judgment

- Announcing a change in the enforcement of the standard so that Quality Improvement Organizations (QIOs) will oversee the majority of patient status audits, with the Recovery Audit program focusing on only those hospitals with consistently high denial rates.

Changes in Review: Short Inpatient Hospital Stays

For stays expected to last less than two midnights – CMS proposes the following:

- For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient only list or otherwise listed as a national exception), an inpatient admission would be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.
- CMS is reiterating the expectation that it would be rare and unusual for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight. CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.

No change for stays over the two-midnight benchmark:

- For hospital stays that are expected to be two midnights or longer, our policy is unchanged; that is, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports that expectation that the patient would stay at least two midnights. This includes stays in which the physician's expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice.

A More Collaborative Approach to Education and Enforcement

CMS also announced changes to our approach to educating providers and enforcing the Two Midnight rule. Specifically, CMS has decided to use QIOs, rather than Medicare Administrative Contractors (MACs) or Recovery Auditors, to conduct the first line medical reviews of providers who submit claims for inpatient admissions. QIOs have a significant history of collaborating with hospitals and other stakeholders to ensure high quality care for beneficiaries.

QIO patient status reviews will focus on educating doctors and hospitals about the Part A payment policy for inpatient admissions. Recovery auditor patient status reviews will be conducted by the recovery auditors for those hospitals that have consistently high denial rates based on QIO patient status review outcomes.

This change in medical review policy compliments a number of changes CMS has already made to the Recovery Audit program, frequently referred to as recovery audit contractors (RACs). These provisions, detailed below, will be implemented upon procurement of the new recovery auditors, or sooner, if possible.

- To address hospitals' concerns that they do not have the opportunity to rebill for medically necessary Medicare Part B services by the time a medical review contractor has denied a Medicare Part A claim, CMS is changing the recovery auditor "look-back period" for patient status reviews to 6 months from the date of service in cases where a hospital submits the claim within 3 months of the date that it provides the service.
- CMS has announced limits on additional documentation requests (ADRs) that are based on a hospital's compliance with Medicare rules, incrementally applied ADR limits for providers that are new to recovery auditor reviews, and diversified ADR limits across all types of claims for a certain provider.

- CMS has also announced a requirement that recovery auditors must complete complex reviews within 30 days and that failure to do so will result in the loss of the recovery auditor's contingency fee, even if an error is found.
- Finally, CMS will require recovery auditors to wait 30 days before sending a claim to the MAC for adjustment. This 30-day period allows the provider to submit a discussion period request before the MAC makes any payment adjustments.

Next Steps

As with the entire Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule, CMS will accept comments on the Two Midnight portion of the proposed rule until August 31, 2015 and will respond to comments in a final rule to be issued on or around November 1, 2015. The proposed rule will appear in the July 8, 2015 Federal Register and can be downloaded from the Federal Register at: http://www.federalregister.gov/inspection.aspx.

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PROBE REVIEWS OF INPATIENT HOSPITAL CLAIMS

Q1: Will CMS direct the Medicare review contractors to apply the 2-midnight presumption—that is, contractors should not select Medicare Part A inpatient claims for review if the inpatient stay spanned two midnights from the time of formal admission?

A1: Yes. The 2-midnight presumption directs medical reviewers to select Part A claims for review under a presumption that the occurrence of 2 midnights after formal inpatient hospital admission pursuant to a physician order indicates an appropriate inpatient status for a reasonable and necessary Part A claim. CMS will instruct the Medicare Administrative Contractors (MACs) and Recovery Auditors that, absent evidence of systematic gaming or abuse, they are not to review claims spanning 2 or more midnights after admission for a determination of whether the inpatient hospital admission and patient status was appropriate. In addition, for a period of 6 months, CMS will not permit Recovery Auditors to review inpatient admissions of 0 or 1 midnight that begin between October 1, 2013—March 31, 2014. CMS reminds providers that a claim subject to the 2 midnight presumption may still be reviewed for issues unrelated to appropriateness of inpatient admission in accord with the 2-midnight benchmark (i.e. patient status). CMS may review claims to ensure the services provided during the inpatient stay were reasonable and necessary in the treatment of the beneficiary, to ensure accurate coding and documentation, or other reviews as dictated by CMS and/or authoritative governmental agency.

Q2: Will Medicare 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?

A2: 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.

Q3: What steps will CMS take to provide guidance and education about the inpatient rule, to ensure hospital understanding and compliance with the instructions?

A3: CMS will instruct the MACs to review a small sample of Medicare Part A inpatient hospital claims spanning 0 or 1 midnight after formal inpatient admission to determine the medical

necessity of the inpatient status in accordance with the 2 midnight benchmark. CMS will establish a specific probe sample prepayment record limit of 10 to 25 claims per hospital.

MACs will conduct probe reviews on Medicare Part A inpatient hospital claims spanning less than two midnights after formal inpatient admission with dates of admission October 1, 2013 through March 31, 2013.

- This probe sample will determine each hospital's compliance with the new inpatient regulations (CMS-1599-F) and provide important feedback to CMS for purposes of jointly developing further education and guidance.
- Because the probe reviews will be conducted on a prepayment basis, hospitals can rebill for medically reasonable and necessary Part B inpatient services provided during denied Part A inpatient hospital stays provided the denial is on the basis that the inpatient admission was not reasonable and necessary. Hospitals may rebill for Part B inpatient services in accordance with Medicare Part B payment rules and regulations.
- A sample of 10 claims will be selected for prepayment review for most hospitals, while 25 claims will be selected for prepayment review for large hospitals.
- If a MAC identifies no issues during the probe review, the MAC will cease further such reviews for that hospital for dates of admission spanning October to March 2014, unless there are significant changes in billing patterns for admissions.
- Based on the results of these initial reviews, CMS will conduct educational outreach efforts during the following 3 months. Each non-compliant claim will be denied and the reasons for denial will be sent via letter. Individualized phone calls will be made by the MAC to those providers with either moderate to significant or major concerns. During such calls, the MAC will discuss the reasons for denial, provide pertinent education and reference materials, and answer questions.
- In addition to these educational outreach efforts, for those providers that are identified as having moderate to significant concerns or major concerns, the MACs will conduct additional probe reviews on claims with dates of admission between January and March 2014. The size of these additional probe reviews will be 10 (25 for large hospitals). For those providers identified as having continuing concerns after the 6 month period, samples of 100 claims (250 for large hospitals) will be selected.
- CMS will also monitor provider billing trends for variances indicative of abuse, gaming, or systematic delays in the submission of claims, for the purpose of avoiding the MAC prepayment probe audits during this initial probe and educate period.

- The MACs will submit periodic reports to CMS for purposes of tracking the frequency and types of errors seen during these probe reviews.

During the probe and educate period of October 1, 2013 until March 31, 2014, CMS will instruct the MACs and Recovery Auditors not to review Part A claims spanning 2 or more midnights after formal inpatient admission for appropriateness of inpatient admission. CMS reminds hospitals that while medical review will not be focused on Part A claims spanning 2 or more midnights after formal inpatient admission under the presumption the inpatient admission was reasonable and necessary, physicians should make inpatient admission decisions in accordance with the 2 midnight benchmark in the final rule. That is, physicians should generally admit as inpatients beneficiaries they expect will require 2 or more midnights of hospital services, and should treat most other beneficiaries on an outpatient basis. CMS believes that, with the exception of cases involving services on the inpatient-only list, only in rare and unusual circumstances would an inpatient admission be reasonable in the absence of a reasonable expectation of a medically necessary stay spanning at least two midnights. CMS will work with the hospital industry and with MACs to determine if there are any categories of patients that represent an appropriate inpatient admission, absent an expectation of a 2 midnight stay or unforeseen and interrupting circumstances such as unforeseen death, transfer to another hospital, departure against medical advice, or clinical improvement. Any evidence of systematic gaming, abuse or delays in the provision of care in an attempt to receive the 2-midnight presumption could warrant medical review. MACs and Recovery Auditors will not review any claims submitted by Critical Access Hospitals. In addition, during this period, CMS will not permit Recovery Auditors to review inpatient admissions of less than two midnights after formal inpatient admission that occur on or after October 1.

START TIME FOR CALCULATING THE 2 MIDNIGHT BENCHMARK

Q4: 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?

A4: For purposes of determining whether the 2-midnight benchmark was met and, therefore, whether inpatient admission was generally appropriate, the 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 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 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 (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 two 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 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 in the ED at midnight would meet the first midnight of the benchmark. The review contractor will count only medically necessary services responsive to the beneficiary's clinical presentation as performed by medical personnel.

DELAYS IN THE PROVISION OF CARE

Q5: 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 considered appropriate for payment under Medicare Part A as inpatient under the new 2 midnight benchmark?

A5: 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 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 review

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

DOCUMENTING THE DECISION TO ADMIT

Q6: What documentation will review contractors expect physicians to provide to support that an expectation of a hospital stay spanning 2 or more midnights was reasonable?

A6: Review contactors' expectations for sufficient documentation will be rooted in good medical practice. Expected length of stay and the determination of the underlying need for medical or surgical care at the hospital must be supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which review contractors will expect to be documented in the physician assessment and plan of care. CMS does not anticipate that physicians will include a separate attestation of the expected length of stay, but rather that this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

Q7: What factors should the physician take into consideration when making the admission decision and document in the medical record?

A7: For purposes of meeting the 2-midnight benchmark, in deciding whether an inpatient admission is warranted, the physician must assess whether the 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 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 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. If the beneficiary is expected to require medically necessary hospital services for 2 or more

midnights, then the physician should order inpatient admission and Part A payment is generally appropriate per the 2-midnight benchmark. Except in cases involving services identified by CMS as inpatient-only, if the beneficiary is expected to require medically necessary hospital services for less than 2 midnights, then the beneficiary generally should remain an outpatient and Part A payment is generally inappropriate.

We note that in the FY 2014 IPPS final rule we stated the 2-midnight benchmark provides that hospital stays expected to last less than 2 midnights are generally inappropriate for hospital admission and Medicare Part A payment absent rare and unusual circumstances. In that rule, we stated that we would provide additional subregulatory guidance on those circumstances. We believe that we have already identified many of these rare and unusual exceptions in our Inpatient Only List. In that list, we identify those services that we have said are rarely provided to outpatients and which typically require, for reasons of quality and safety, a significantly protracted stay at the hospital. We believe that it would be rare and unusual for a stay of 0 or 1 midnights, for patients with known diagnoses entering a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 2 midnights, to be appropriately classified as inpatient and paid under Medicare Part A. This is consistent with our historical guidance in which we defined certain minor therapeutic and diagnostic services as appropriately furnished outpatient on the basis of an expected short length of stay. We also do not believe that the use of telemetry, by itself, constitutes a rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. We note that telemetry is neither rare nor unusual, and that it is commonly used by hospitals on outpatients (ER and observation patients) and on patients fitting the historical definition of outpatient observation (that is, patients for whom a brief period of assessment or treatment may allow the patient to avoid an inpatient hospital stay). We also specified in the final rule that we do not believe that the use of an ICU, by itself, would be a rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. In some hospitals, placement in an ICU is neither rare nor unusual, because an ICU label is applied to a wide variety of facilities providing a wide variety of services. Due to the wide variety of services that can be provided in different areas of a hospital, we do not believe that a patient assignment to a specific hospital location, such as a certain unit or location, would justify an inpatient admission in the absence of a 2 midnight expectation.

We recognize that there could be rare and unusual circumstances that we have not identified that justify inpatient admission absent an expectation of care spanning at least 2 midnights. As we continue to work with facilities and physicians to identify such other situations, we reiterate that we expect these situations to be rare and unusual exceptions to the general rule. If any such

additional situations are identified, we will include them in subregulatory instruction, and we will expect that in these situations the physician at the time of admission must explicitly document the reason why the specific case requires inpatient care, as opposed to hospital services in an outpatient status. We do not believe that these rare and unusual circumstances can be imputed from the medical record.

Q8: Under the new 2 midnight benchmark, how should facilities treat, and bill Medicare for beneficiaries who require potentially short-term, medical treatment in an intensive care setting?

A8: Beneficiaries treated in an intensive care unit are not an exception to the general rule that only patients requiring two or more midnights of hospital care require inpatient admission, as our 2-midnight benchmark policy is not contingent on the location of the beneficiary within the hospital. While patients requiring aggressive, intensive treatment would generally be expected to stay in the hospital for longer than 2 midnights, those patients that require a shorter period of time in the hospital should generally be furnished services that are billed on an outpatient basis. Therefore, absent rare and unusual circumstances, physicians should admit those beneficiaries whom they expect to require medically necessary hospital treatment spanning 2 or more midnights, and should generally provide care as outpatient for those beneficiaries whom they expect to require medically necessary hospital care for less than 2 midnights. If a physician believes at the time of admission that the situation is one of the rare and unusual situations where inpatient care is required despite the fact that such care is not expected to span at least two midnights, then he or she must explicitly document the reason why the specific case requires inpatient care, as opposed to hospital services in an outpatient status, for CMS review. Upon review, CMS and its contractors would retain the discretion to conclude that the documentation is not sufficient to support the medical necessity of the inpatient admission.

Q9: 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?

A9: If the beneficiary requires medically necessary hospital care that is expected to span 2 or more midnights, then inpatient 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 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 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), review contractors will assess the reasonableness of the physician's expectation of the need for and duration of care based on complex 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.

Q10: If a beneficiary is admitted for a minor surgical procedure, but then requires hospital care beyond the usual anticipated recovery time, when would it be appropriate for the physician to utilize outpatient observation and when would it would be appropriate to admit the beneficiary for inpatient hospital services?

A10: If the beneficiary requires additional medically necessary hospital care beyond the usual anticipated recovery time for a minor surgical procedure, the physician should reassess the expected length of stay. Generally, if the physician cannot determine whether the beneficiary prognosis and treatment plan will now require an expected length of stay spanning 2 or more midnights, the physician should continue to treat the beneficiary as an outpatient. If additional information gained during the outpatient stay subsequently suggests that the physician would expect the beneficiary to have a stay spanning 2 or more midnights including the time in which the beneficiary has already received hospital care, the physician may admit the beneficiary as an inpatient at that point.

Q11: 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?

A11: 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 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 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 in order for this circumstance to be an acceptable inpatient admission payable under Part A.

The more usual situation would be the one in which the physician's initial expectation of the beneficiary's length of stay is uncertain. If the physician is uncertain whether the beneficiary will be able to be discharged after 1 midnight in the hospital or whether the beneficiary will require a second midnight of care, the initial day should be spent in observation until it is clearly expected that a second midnight would be required, at which time the physician may order inpatient admission. If the physician believes that a rare and unusual circumstance exists in which an inpatient admission is warranted, but does not expect the beneficiary to require 2 or more midnights in the hospital, the physician may admit the beneficiary to inpatient status but should thoroughly document why inpatient admission and Medicare Part A payment is appropriate. CMS will work with the hospital industry and with MACs to determine if there are any categories of patients that should be added to this list of exceptions to the 2-midnight benchmark. Suggestions should be emailed to IPPSAdmissions@cms.hhs.gov with "Suggested Exceptions to the 2-Midnight Benchmark" in the subject line. During the initial probe review of inpatient admissions, the Medicare Administrative Contractor is being instructed to deny these claims and submit them to CMS' Central Office for further review. If CMS believes that such a stay warrants an inpatient admission, CMS will provide additional subregulatory instruction and the Part A inpatient denial will be reversed during the administrative appeals process.

Q12: If a physician writes an inpatient order based on the expectation that the beneficiary will require care spanning 2 or more midnights, but prior to the passage of 2 midnights the beneficiary refuses any additional medical treatment and is discharged, would this be considered an unforeseen circumstance?

A12: Under the 2 midnight benchmark, if a beneficiary refuses any additional care and is subsequently discharged, this will be considered similarly to departures against medical advice and could be considered an appropriate inpatient admission, so long as the expectation of the need for medically necessary hospital services spanning 2 or more midnights was reasonable at

the time the inpatient order was written, and the basis for that expectation as well as the refusal of additional treatment, are documented in the medical record.

Q13: Under the new guidance, will all inpatient stays of less than 2 midnights after formal inpatient admission be automatically denied?

A13: No. Under the new guidelines we expect that the majority of short (total of zero or one midnight) Medicare hospital stays will be provided as outpatient services. Because this is based upon the physician's expectation, as opposed to a retroactive determination based on actual length of stay, we expect to see services payable under Part A in a number of instances for inpatient stays less than 2 total midnights after formal inpatient admission. First, there will be cases where the physician had a reasonable expectation of a two midnight stay but there was an unforeseen circumstance that resulted in a shorter stay than the physician's reasonable expectation. As enumerated in the final rule, CMS anticipates that most of these situations will arise in the context of beneficiary death, transfer, or departure against medical advice. Second, if the beneficiary received a medically necessary service on the Inpatient-Only List and was able to be discharged before 2 midnights passed, those claims would be appropriately inpatient for Part A payment. Third, inpatient stays spanning less than 2 midnights will be evaluated in accordance with the 2 midnight benchmark during review, and payment will be appropriate if the total time receiving medically necessary hospital care (including pre-admission services) spanned at least two midnights. Inpatient claims for patients who unexpectedly improved and were discharged in less than two midnights would be payable as long as the medical record clearly demonstrated that the admitting physician had reasonable expectation of a two midnight stay and the improvement that allowed an earlier discharge was clearly unexpected. Lastly, there may be rare and unusual cases where the physician did not expect a stay lasting 2 or more midnights but nonetheless believes inpatient admission was appropriate and documents such circumstance. Although the Medicare Administrative Contractor is being instructed to deny these claims, these claims will be submitted to CMS' Central Office for further review. If CMS believes that such a stay warrants an inpatient admission, CMS will provide additional subregulatory instruction and the Part A inpatient denial will be reversed during the administrative appeals process. Hospitals should focus their attention on short (0-1 total days) stays (without death, transfer, discharge against advice, an inpatient-only service or a preceding outpatient stay over midnight) to ensure that the physician clearly expected a longer stay, the discharge was unexpected, or some other rare and unusual circumstance supports that the Part A claims represent appropriate, payable inpatient services.

SELECTION OF CLAIMS FOR REVIEW

Q14: How will review contractors identify facilities conducting 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 and the services could have been furnished in a shorter timeframe)?

A14: Review contractors will identify gaming by reviewing stays spanning 2 or more midnights after formal inpatient admission for the purpose of monitoring and responding to patterns of incorrect DRG assignments, inappropriate or systematic delays, and lack of medical necessity for services at the hospital, but not for the purpose of routinely denying Part A payment on the basis that the services should have been provided at the hospital on an outpatient basis. CMS will shift its attention to the smaller anticipated volume of 0 and 1 day short inpatient stays and then, to the extent that facilities correctly apply the 2 midnight benchmark, away from short stays to other areas with persistently high improper payment rates. CMS and its review contractors may identify such trends through data sources, such as that provided by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and Program for Evaluating Payment Patterns Electronic Report (PEPPER).

Q15: Is there a way for providers to identify any time the beneficiary spent as an outpatient prior to admission on the inpatient claim so that review contractors can readily identify that the 2-midnight benchmark was met without conducting complex review of the claim?

A15: CMS recognizes that currently, inpatient Part A claims only report the time the beneficiary spent as an inpatient (i.e., after the beneficiary is formally admitted as an inpatient pursuant to a physician order) and not the outpatient time that may have been considered by the physician when determining whether 2 or midnights of hospital care are expected. CMS is exploring means by which any outpatient time may be recorded on the Part A inpatient claim to identify Part A claims that met the 2-midnight benchmark. Stakeholders have offered suggestions such as changes to the claim date instruction; the creation of new condition codes, remittance codes or occurrence span codes; and provider input in the remarks fields. CMS will evaluate potential changes in claim information and notify providers if changes in claim submission are required. CMS reminds providers that claims for stays of less than 2 midnights after formal inpatient admission may still be subject to complex medical record review, to which the 2-midnight

benchmark will be applied. Information in the medical record will support whether total outpatient and inpatient time met the 2-midnight benchmark.