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8 Critical Steps for 2-Midnight Compliance

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At a Glance

Organizations can prepare for compliance with the two-midnight rule by:

- Embedding questions from the optional certification form within electronic orders or using the manual form
- Educating their physicians
- Empowering their utilization review team

The "two-midnight rule" is creating a lot of consternation among finance leaders who are concerned that, as of Oct. 1, 2013, the regulation puts their inpatient volumes at risk. However, much of this anxiety is unwarranted. Hospitals that take the time to educate their clinicians on how to use the optional certification form—and document why they presume the patient is going to meet the two-midnight threshold—will be in good shape to comply with the new rule.

Action Steps for Hospitals

Here are eight critical action steps that providers can take to ensure their organization is ready for, and abiding by, the two-midnight rule.

Embed questions from the optional certification form within electronic orders or use the manual form.

The optional certification form—in electronic or paper format—is the most important tool for two-midnight compliance. The form can be used at the initiation of care and after the first midnight to help physicians and utilization review (UR) staff answer two key questions:

- What is the reason for admit?
- Can the physician attest that the patient needs two medically appropriate midnights to resolve the condition?

To answer the first question, physicians must expressly state their "reason for admit," which is essentially their rationale for why the patient requires an inpatient level of care. Physicians do this already, although some routinely fail to document their rationale on paper or electronically. That is why the certification tool is a gift: It "queues" the physician to provide the information needed for compliance and virtually eliminates the need to hunt through the medical record to find the elements now required to support inpatient status.

To satisfy the second question, the physician who is directing the patient's care must certify that the patient requires an inpatient level of care. When physicians are able to attest that a patient requires a two-midnight stay at the initiation of care, they may complete the form using the two-midnights presumption. However, if physicians cannot attest to the need for two midnights at the initiation of care, the hospital has two options: Send the patient home, or convert the patient to observation status. Then, after the first midnight, the hospital's utilization review (UR) team can follow up to determine whether the patient's condition requires a second medically appropriate midnight to be resolved. If so, the UR team should ask the physician to complete the certification form indicating that the patient requires a second medically appropriate midnight, thereby establishing that the patient has met the two-midnight threshold to qualify for inpatient status.

Empower UR staff to assist with compliance. UR staff should be the "owners" of the optional certification form, making sure that it is complete and accurate for each patient. However, many hospitals lack sufficient UR staff, who are often nurses, to provide this level of control. These hospitals should expand their UR teams because nurses with UR expertise can be excellent trainers for physicians on patient status.

But to be effective in this role, UR nurses must let go of guidelines they have long valued. For decades, UR nurses have remained staunchly committed to following the InterQual and Milliman care guidelines —evidence-based care guidelines that are used by care managers in making decisions regarding care delivery, including whether to approve inpatient stays, even though they were never mandated or required by Medicare. Today, the guidelines are still a great reference guide, but the physician's declaration of the two-midnight criteria trump those guidelines. Now more than ever, it is critical that UR staff shift their focus from the old care guidelines to ensuring that the certification form is complete and accurate for every patient, which creates the beginning of the inpatient patient story.

Know which procedures are riskiest, such as cath lab procedures and outpatient surgeries that "stay the night." Unfortunately, many hospitals have gotten into some bad habits, such as allowing patients to stay the night for no other reason than "sleeping." These habits must change.

Consider the cath lab, in particular. Patients may have up to six hours of recovery after a procedure; however, in many hospitals, recovery after a cath lab procedure routinely takes eight to 12 hours. These hospitals should remember that cath lab patients who are spending their first night in their routine recovery are considered outpatients, not patients under observation.

Staying the night has nothing to do with inpatient or outpatient status. For example, inpatient status requires an interventional cardiologist to attest that the patient will need two midnights to resolve the condition. Otherwise, the patient will be considered an outpatient and monitored for up to six hours of routine recovery. If, during that recovery, the patient has an unplanned event and the physician is not certain whether two midnights are needed to resolve the condition, the patient will be considered to be

under observation. After the first midnight, the patient's status can be reevaluated and the patient reclassified as an inpatient if resolving the patient's condition requires a second medically appropriate midnight, thus meeting the two-midnight benchmark provision.

Outpatient surgeries are another risky area. The later the case, the more at risk the hospital is for bad status decisions. Many physicians will order that a patient should "stay the night" after a late case. This practice puts hospitals in a tough spot because "sleeping" is not billable. No matter what time of day the procedure is, the same rule applies: A patient has up to six hours of routine recovery after a procedure. To reduce the risk associated with late cases, the UR team should take time each morning to review the outpatient surgical patients from the previous night. Then, the team can determine why patients are still in the hospital and which patients may require a status change.

Target physicians in the emergency department (ED). Focusing education on ED physicians is important because, on average, 65 percent of patients admitted to the hospital come through the ED. The ED therefore should be a trigger point for getting the patient status correct from the beginning.

In most hospitals, ED physicians do not have admitting privileges; instead, they have bridge or transition privileges, meaning they must get the attending physician to agree to the patient status they recommend. The certification form can be a valuable tool in helping to document the decisions the ED physician made after speaking with the attending physician.

The UR team can be effective in working with ED physicians to clarify patient status. ED physicians should see UR nurses as their partners in this effort. Many hospitals do not think they can afford putting "UR in the ER"—but what they really cannot afford is an increase in their denials and loss of appropriate patients.

Hire internal physician advisers to assist with education. Many hospitals are realizing the benefits of having internal physician advisers who can help support the UR staff and educate other physicians on the new two-midnight requirements. Specifically, these advisers can help a physician understand what must be included on the certification form, in the medical record, and in the discharge summary to support the physician's rationale that a patient requires two midnights in the hospital.

Ideally, physician advisers should be paid for their important role, and even small hospitals should have at least one part-time physician adviser on staff. Using volunteer physicians as advisers is less than ideal; these physicians may be less likely to call out their noncompliant peers, upon whom they rely for referrals.

It also is important that physician advisers be good listeners. By listening, a physician adviser can more effectively work with his or her peers to identify reasons for noncompliance and motivate them to change their behaviors.

Understand the implications for transfers. It is simply not possible to "split" the two midnights between two hospitals; if a patient transfers from one hospital to another, the two-midnight "clock" must be restarted in the new hospital.

Use internal audits to identify problem areas. Typically, internal audits are led by the physician adviser and UR team and may be integrated into the organization's clinical documentation improvement program. The goal of an internal auditing program is to determine whether the hospital is doing the best possible job of telling the patient's story so it can make the case for inpatient status, if appropriate. For example, if a physician attests to two midnights and the patient gets better sooner than expected and goes home after one midnight, that patient is still considered an inpatient. However, that patient's story—captured in the certification form, medical record, and discharge summary—must be incredibly strong. If not, the hospital could appear to be gaming the system. Internal audits can identify any such problem areas before external auditors do.

Learn from the probes, and then hammer the message home. Since December 2013, Medicare

administrative contractors have been conducting "probe and educate" reviews to gauge how well hospitals are prepared to follow the two-midnight rule. Most hospitals will have a probe of 10 patient records by the end of March. Immediately upon receiving their probe results, hospitals should use the findings to educate their physicians and UR team on any problem areas.

Take the Time to Tell the Patient's Story

Remember that the primary goal with respect to two-midnight compliance should be to gather as complete a patient story as possible. That patient story begins with the certification form, continues in the medical record, and then is resolved with the discharge summary. By providing more complete documentation for patients who will require at least a two-midnight stay, hospitals can set aside their worries and better protect their inpatient volumes.

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sidebar

The 2-Midnight Rule: Taking a Closer Look

The 2014 Inpatient Prospective Payment System (IPPS) final rule, published Aug. 2, 2013, established new requirements for coverage of Medicare Part A inpatient hospital claims, such as the type of documentation needed to support an admission that lasts at least two midnights. The rule also outlined actions hospitals must undertake to determine medical necessity before admitting Medicare Part A patients.

The two-midnight rule is designed to limit the use of observation status for Medicare patients, which results in higher out-of-pocket costs for Medicare beneficiaries. Researchers for the Centers for Medicare & Medicaid Services determined that 36 percent of payments for inpatient one-day stays had an improper payment rate, but this number dropped to about 13 percent for two-day and three-day stays, which suggested that 24-hour observation stays for Medicare patients have been overused.

CMS issued subregulatory guidance on Sept. 5 that further specified the steps hospitals need to take to admit a patient under Medicare's inpatient admission rules. This guidance addressed issues related to the two-midnight provisions of the IPPS final rule, including what details to include in an admission order, the timing of that order, and how to handle verbal orders.

The physician role in determining whether hospital inpatient services are "reasonable and necessary" and provided in accordance with the two-midnight requirements, which went into effect Oct. 1, 2013, includes estimating the length of hospitalization that beneficiaries will require.

The guidance also specifies the timeframe for completion and submission of the physician certification and the qualifying elements that patient records must contain. It further requires that physician orders to admit patients include specific terminology or reference services typically rendered in inpatient settings.

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