Two-Midnight Rule Redux

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TWO-MIDNIGHT RULE COMPLIANCE REQUIRES THAT THE CLINICAL RECORD CLEARLY EXPLAIN WHAT THE PLAN OF CARE IS AND *WHY* THE PATIENT NEEDS TO BE IN THE HOSPITAL AT LEAST TWO MIDNIGHTS.

Medicare's two-midnight rule seems relatively simple to explain, but apparently it is difficult to implement. Published two and one-half years ago, the rule sets a benchmark by which to determine whether an inpatient admission is appropriate for purposes of Medicare Part A payment (Citations: 80 *Federal Register* 70538 et seq. (Nov. 13, 2015); 42 C.F.R. Section 412.3(d).) It can be summarized as follows:

- If the physician reasonably expects the patient to need hospital care across two midnights, payment as an inpatient (Medicare Part A) is generally appropriate.
- Outpatient care prior to formal admission—while in observation status or at a transferring hospital, for example—usually may be counted toward the two-midnight rule total.
- If the care is not expected to span two midnights, the services should generally be billed as outpatient services under Medicare Part B.
- Cases designated by Medicare as "inpatient only" are exceptions and should be billed under Medicare Part A regardless of the span of care.
- If an unforeseen circumstance—such as sudden death or the need for transfer out—results in a shorter stay than the physician's reasonable expectation at the time of inpatient admission, payment may still be made under Medicare Part A.

- There may be other "rare and unusual" situations justifying Part A billing for less than two midnights, but these will be determined on a case-by-case basis by Medicare's medical reviewers.

See related tool: Checklist for Two-Midnight Rule Requirements

Having stated the rule, it appears there is still a good deal of uncertainty, according to HFMA member and frequent contributor Day Egusquiza, who has been writing and educating about the two-midnight rule ever since it was announced. "A lot of hospitals are struggling with this," she says.

Confusion Continues

"Confusion is rampant judging by some of the audits we've done," Egusquiza says. For example, she cites a small rural hospital that was not equipped to treat cardiac patients and therefore always had to transfer them to its parent facility. Even though the hospital had neither the ability nor the intent to actually treat these people, they were admitted as inpatients—apparently on the theory that they were "rare and unusual" cases—then transferred. The hospital billed the admission under Part A.

"You have to be able to provide the needed service to justify billing it as an inpatient," Egusquiza says, adding, "it's not 'rare and unusual' if you do it all the time."

Another area of confusion relates to outpatient time directly preceding the inpatient admission, especially when there was a transfer from another facility. The inpatient claim form only shows the time after the formal inpatient order and admission. But Egusquiza points out that if Occurrence Span Code 72 is used, the total, continuous outpatient care prior to inpatient admission in the hospital will count toward the two-midnight rule. This lets the Centers for Medicare & Medicaid Services (CMS) identify claims in which the beneficiary received care as an outpatient for one or more midnights and then was admitted based on the expectation that two or more midnights of hospital care were needed. "Hospitals that don't use occurrence span code 72 in this way are leaving money on the table," she says.

Egusquiza points out that CMS shares useful information like the span code 72 in many ways other than through the *Federal Register*. These include FAQs, the Medicare Learning Network (MedLearn), transmittals for the CMS Online Manual System, and other forms of sub-regulatory guidance. "The information typically gets to patient financial services personnel, but it may not be clearly communicated to utilization review staff, case managers, and social workers," she says. These folks need to know the rule so they can query physicians about their documentation. "By not having coordinated education of all the key players, hospitals are making the two-midnight rule more difficult than it needs to be."

Document, Document, Document!

Documentation is vitally important for two-midnight rule compliance, so Egusquiza's mantra is: Tell the patient's story. The clinical record must clearly explain what the plan of care is and *why* the patient needs to be in the hospital at least two midnights. "It's not enough to say, 'the patient is

really sick.' The record must explain what's going to be done across that span of time," she says.

This opinion is confirmed by consultant James Karpook, whose major focus is clinical process improvement in hospital and ambulatory care settings. "The biggest challenge, as always, is education," Karpook says. "We must teach a common understanding of the type of documentation that's required."

Karpook cites the utilization review process at Dartmouth-Hitchcock Medical Center, Lebanon, N.H., as a good model. He says Dartmouth-Hitchcock uses utilization review nurses, case managers, and social workers who have been trained in the two-midnight rule to review admission records and work with physicians to improve their documentation. And the hospital added a case management module to the electronic health record (EHR) to help with the process.

Egusquiza applauds this approach, especially the change to the EHR. "There's often a disconnect between IT and utilization review," she says. "The IT people like check-boxes in the electronic health record because they can't get metrics from free text. But you can't tell the patient's story with a check box, and auditors won't make inferences to fill in the gaps. The record must tell the patient's story from start to finish."

Karpook and Egusquiza say if the EHR can be set up to flag two-midnight rule situations and allow all necessary parties to see what's going on, communication and documentation can be greatly improved.

Many of these "lessons learned" confirm the eight critical steps Egusquiza has been preaching for more than two years.

- Embed questions from Medicare's medical necessity certification form in the EHR
- Empower utilization review/case management staff to assist with two-midnight rule compliance
- Know which procedures are riskiest, such as cath lab and outpatient surgeries that stay the night
- Give special attention to physicians in the ED
- Hire physician advisers to assist with education
- Understand the implications for transfers (in/out)
- Use internal audits to identify problem areas
- Learn from external audits, then hammer the message home.

She adds that it's important for everyone to understand that medical review tools like those published by InterQual and Milliman are *not* conclusive for documenting admission status. CMS has specifically declined to adopt such criteria. Rather, CMS believes "the two-midnight benchmark captures the individualities and clinical conditions of Medicare beneficiaries, by focusing on the physician's medical judgment in forecasting an expected plan of care and corresponding hospital duration." [Hospital Outpatient Prospective Payment System rule, *Federal Register*, vol. 80, Nov. 13, 2015.]

QIO Audits

The CMS decision last October to relieve Medicare Audit Contractors (MACs) of responsibility for initial patient status reviews has added to the

uncertainty surrounding two-midnight Rule compliance. Instead of dealing with the MACs—with whom many providers had good working relationships—hospitals are now subject to reviews by one of two Quality Improvement Organizations (QIOs). These are Livanta, for states in the Northeast and West Coast, and Keystone Peer Review Organization (KEPRO) for the Southeast and Central states.

Because the QIOs are new players in the two-midnight game, it is unclear how the reviews will work. Even CMS recognized this when they announced the change, saying: "We anticipate that it will take time for QIOs to transition and [that] they will incrementally increase their review activities to be fully operational [in early 2016]."

Egusquiza says "there's a lot we don't know about how well the QIOs are going to operate. They're getting better, but they have a lot yet to learn. What we do know is that the MACs are no longer a resource for the hospitals on this issue."

Both Karpook and Egusquiza say healthcare finance professionals should stay tuned for further developments, but in the meantime redouble your two-midnight rule education efforts.

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