Update on Medicare’s Two-Midnight Rule

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The Two Midnight Rule

- Delayed Enforcement By CMS
- MAC Probe & Educate Audits
- Physician Certifications
- AHA Lawsuit
- New Short Stay Payment Methodology?
- Two Midnight and Medicare Advantage
- EHR Changes
- Written Admission Orders
- RAC Contracting Pause
- Physician and Staff Training
- “Rare and Unusual” Exceptions
- Two Midnight Rate Cut Lawsuits
- Delayed Enforcement By Congress
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How Did We Get Here?

• “FY 2011 marked the first year that Recovery Auditors actively reviewed short-stay inpatient hospital admission issues. Some short-stay inpatient hospital services should have been provided in the outpatient setting and they fail to demonstrate medical necessity for the inpatient setting. These admissions represent . . . a large portion of the FY 2011 overpayment collections.”

CMS FY 2011 RAC Report to Congress
RAC denials of short stays as medically unnecessary focused attention on:

- Inpatient admission criteria
- CMS policy on billing Part B for services after Part A inpatient stay was denied
- Increase in frequency and duration of observation services
• Class action lawsuit challenging CMS’s observation services policy

• AHA lawsuit challenging CMS billing policies following short stay denials
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. . . And CMS’s Reaction

• FY 2013 OPPS Rules
  — Solicited comments on “policy changes . . . to improve clarity and consensus . . . regarding the relationship between admission decisions and appropriate Medicare payment”

• CMS Ruling 1455-R and Final A to B Rule
  — Retroactive and prospective changes to CMS Part A to Part B rebilling policy

• FY 2014 IPPS Final Rule
  — Two-Midnight Admission Standard
[B]eginning in fiscal year 2010, new workloads including permanent establishment of the Recovery Audit (RA) program . . . have emerged that had not been built into the OMHA workload models. . . . As a result . . . a backlog of appeals began to form . . . . In 2013, appealed claims related to the RA program grew to over 136,000, further exacerbating the backlog of cases and resulting in a substantial increase in the adjudication time frame.

HHS Federal Register Notice, January 3, 2014
The New Inpatient Rules
Guidance Before Rule Change

• Benefit Policy Manual, Chap. 1, § 10
  — Decision to admit is a “complex medical judgment” that can only be made by physician after considering several factors, such as:
    — Patient medical needs and history
    — Severity of signs and symptoms
    — Likelihood of adverse event
  — 24 hour benchmark
    — Admit if hospital care expected for 24 hours or more
The Two-Midnight Benchmark

- New 42 C.F.R. 412.3(e)
  - Inpatient admission and Part A payment is “generally inappropriate” if physician does not expect patient to require a stay that will “cross 2 midnights” (except for “IP only”)
  - Physician to look at factors such as:
    - Patient history and comorbidities
    - Severity of signs and symptoms
    - Current medical needs and risk of adverse event
  - Applies to all hospitals except IRFs
The Two-Midnight Benchmark

• New 42 C.F.R. § 412.3(e), cont’d:
  — Factors that lead to two-midnight expectation must be documented in medical record
  — "Unforeseen circumstances" resulting in shorter stay than expected may be considered
    — Death
    — Transfer
    — Departures against medical advice
    — Clinical improvement
    — Election of hospice care in lieu of continued treatment in the hospital
The Two-Midnight Benchmark

- There are few exceptions to the benchmark:
  - Procedures on the “inpatient only” list at 42 C.F.R. § 419.22(n)
  - “rare and unusual circumstances”
    - Only example identified by CMS: Mechanical Ventilation Initiated during Present Visit
- Not rare and unusual according to CMS:
  - Admission for telemetry
  - Admission to an intensive care unit (ICU)
Two Midnight Practical Tip
“Rare and Unusual Circumstances”

• Can hospital bill if hospital thinks the “rare and unusual” exception applies?
  — CMS acknowledges the exception
  — Should also consider:
    — SuggestedExceptions@cms.hhs.gov with “Suggested Exceptions to the 2-Midnight Benchmark” in the subject line
The Two-Midnight Benchmark

- Calculation of time for physician’s expectation of two-midnight stay:
  - The clock starts when the beneficiary begins receiving hospital services
  - Includes time beneficiary spends receiving outpatient services within the hospital prior to inpatient admission (e.g., observation services, treatments in the emergency department)
The Two-Midnight Benchmark

• CMS will not count the following when determining if the two-midnight benchmark was met:
  
  — Wait times before the initiation of care, including triaging activities
  
  — Inpatient admissions to prevent inconvenience to patient family, physician or hospital

• But if patient is waiting for availability of a SNF bed, physician may certify the need for continued inpatient admission on this basis in accordance with 42 CFR §§ 424.13(c) and 424.14(e).
Two-Midnight Medical Review Policies

- Transfers
  - Reviewers will count pre-transfer time and care provided to beneficiary at the initial hospital toward the benchmark.
  - The start clock for 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 will be excluded.
Two-Midnight Medical Review Policies

• Cancelled Surgical Procedures
  — Physician expectation is what matters
  — Reasonable expectation of a 2 midnight stay at the time of the inpatient order and formal admission (documented in the medical record) → generally appropriate for Part A payment (even if the surgical procedure is cancelled)

• Delays in care:
  — Tests or procedure not available on weekend?
    — “review contractors will exclude extensive delays in provision of medically necessary services”
Two Midnight Practical Tip: Make a Good Record

• Medical reviewers may interpret “gaps of time” as:
  — Wait time, not medical care time
  — Intentional delays in care
  — For the convenience of beneficiary

• Avoid “gaps in time” and make sure record adequately documents all services
Physician Order Requirement

• New 42 C.F.R. § 412.3
  — Requires a physician order for Medicare Part A payment:
    — Entered in the medical record
    — Supported by physician admission and progress notes
    — Furnished at or before the time of admission
  — No presumptive weight for medical necessity
Physician Order Requirement

- Who can furnish an order?
  - physician or other qualified practitioner who is:
    a) authorized by the state to admit inpatients to hospitals
    b) granted privileges by the hospital to admit inpatients at that facility
    c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission
Physician Order Requirement

- A medical resident, PA, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner if he/she is:
  a) Authorized under state law to admit inpatients in the state where the hospital is located, and
  b) Permitted to do so under the hospital's bylaws or policies, and
  c) The attending must countersign the order.
Physician Order Requirement

• No specific language required on inpatient admission order.

• Use language that clearly expresses intent to admit the patient as inpatient.

• Examples include physician documentation to “admit to inpatient” or “admit to inpatient care”.
Two Midnight Practical Tip: “Missing or Defective Orders”

- Can hospital bill if there is no written order or the order is defective, e.g., not authenticated before discharge, illegible signature, etc.?
  - Recent guidance:
    - Written order is condition of payment and hospital cannot bill
    - **BUT**: “In extremely rare circumstances, the order to admit may be missing or defective . . . yet the intent … to admit the beneficiary as an inpatient can clearly be derived from the medical record…. We have provided contractors with discretion to determine that this information constructively satisfies” the written order requirement.
Physician Certification

- Changes to 42 C.F.R. § 424.13
  - Certification begins with the order for inpatient admission -- § 424.13(a)
  - Certification now required for Part A payment for *all* inpatient stays regardless of length.
Physician Certification

• No new format requirements for certifications
  — No specific forms or procedures required (may be on forms, notes, or records that an authorized individual signs, or may be made on a special separate form)
  — Basic requirement: must allow for verification, certification, and recertification
• “If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.” (CMS, January 30, 2014)
Physician Certification

• September 5, 2013 Guidance
• Updated on January 30, 2014

- Describes content requirements for certification
- Authentication of order
  - To include certification that inpatient services are reasonable and necessary and appropriately provided “in accordance with the 2-midnight benchmark”
- The reasons for inpatient services
- Estimated time for required hospital stay
- For CAHs, certification that beneficiary “may reasonably be expected to be discharged or transferred within 96 hours after admission”
Physician Certification

- September 5/January 30 Guidance, cont’d
  - Timing of certification:
    - Completed, signed, dated and documented before discharge
    - Outliers must be certified and recertified as provided in 42 CFR § 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge.
Physician Certification

• January 30 Guidance, cont’d
  – Who can sign certification?
    – Physicians “responsible for case” or who have “knowledge of the case”
      – Admitting/attending physician
      – Surgeon responsible for major procedure
    – In case of a non-physician, admitting practitioner, a physician member of hospital staff who has reviewed the case and who enters a complete certification containing all required elements
Physician Certification Update:

- CY 2015 OPPS/ASC proposed rule
  - Eliminates physician certification requirement for inpatient stays except in the case of long stays (defined as 20 days or longer) or cost outlier cases
  - Physician certification would not be required for all other inpatient stays
  - Change proposed due to “administrative requirements” certifications imposed on hospitals
- If adopted, change would apply to admissions after the effective date of the rule
- Written orders still required – but when must they be authenticated?
Two Midnight Partial Enforcement Delay
Partial Enforcement Delay

• First announced in Sept. 2013, extended in January 2014
  — Extended prior enforcement delay by six months
• Allows MACs to conduct Probe & Educate
• No RAC reviews of patient status
Partial Enforcement Delay

- Protecting Access to Medicare Act of 2014
  - Enacted on April 1, 2014
  - aka, the “SGR patch”

- Allows CMS to continue its “medical review activities” under “Probe & Educate”

- Prohibits CMS and contractors from conducting “patient status” reviews for claims with DOS from Oct. 1, 2013 through March 31, 2015

- Effectively extends partial enforcement delay by six months
4 Myths of the Enforcement Delay

1. The Two Midnight Rule is not in effect.
   - Wrong: MACs can, and will, deny claims that do not conform to the two midnight rule

2. RACs can never look at these inpatient claims.
   - Wrong: RACs can’t review for “patient status” but accurate coding and documentation are on the table

3. The enforcement delay is a free pass.
   - Wrong: Contractors will review “as dictated by CMS and/or another authoritative governmental agency.”

4. All inpatient claims greater than two midnight are safe.
   - Wrong: Contractors can still review for abuse and delay
MAC “Probe & Educate” Program
MAC “Probe & Educate”

- Announced September 2013, Extended January 30th.
- What is it?
  - MAC review of a sample of claims for admission at acute care, LTCH, and inpatient psych facilities (not CAHs)
  - To determine compliance with medical review polices in FY 2014 final rule (e.g., 2 midnight)
MAC “Probe & Educate”

- What will be reviewed?
  - Inpatient claims between Oct. 1, 2013 and September 30, 2014
  - For stays spanning 0 to 1 midnight after formal admission
  - Claims spanning 2 or more midnights will not be selected for review
MAC “Probe & Educate”

- What will happen on review?
  - 10 or 25 claims reviewed based on size
  - Claims reviewed for compliance with order, certification and 2 midnight “benchmark”
  - Non-compliant claims will be denied. Hospitals may rebill under Part B
  - Follow up action based on results of probe
MAC “Probe & Educate”

- MAC actions following probes:
  - Explanatory letter, education or further review depending on results

- Update on Probe & Educate:
  - February 24, 2014: CMS directs all MACs to re-review all Probe & Educate claims denied before Jan. 30th to ensure reviews are consistent with latest guidance
  - CMS extended 120 day appeal deadline for denials before Jan. 30, 2014
MAC “Probe & Educate”

- Providers’ experience with Probe & Educate so far:
  - Results can vary
  - Little explanation is provided in follow up explanatory letter
  - Boilerplate language is used when referencing two-midnight rule (no explanation as to why benchmark not met in opinion of reviewer)
  - Same experience with “educational” phone call provided in addition to letter
The RAC “Pause”
RAC Pause

- February 18, 2014, CMS announces temporary suspension of RAC audits as part of procurement process for next round of RAC program contracts
  - CMS will permit new RACs to review claims with DOS included within the temporary suspension period
    - Exception: “Patient status” reviews under two-midnight rule
  - February 21, 2014 -- last day RACs could send ADRs for post-payment review of claims
  - RACs must send all improper payment files to MACs for adjustment by June 1, 2014
RAC Pause

• CMS also announced new features of RAC contracts designed to alleviate audit burden
  — Delay the receipt of RAC contingency fees until after second level of appeal
  — Establish revised ADR limits that are diversified across claim types
  — Adjust ADR limits in accordance with providers’ denial rates
  — 30 Day waiting period
  — Receipt confirmation required
Two Midnight Litigation
Two Midnight IPPS
Rate Cut Litigation

• When CMS finalized the Two Midnight Rule, the Agency also finalized a 0.2% reduction in the federal rate to offset predicted shifts in utilization between inpatient and outpatient settings.
  — Predicted net 40,000 additional inpatient encounters
• Commenters opposed 0.2% reduction and cited data to support a large net decrease in inpatient encounters.
  — Athens Regional Medical Center et al. v. Sebelius, filed March 25, 2014, challenges CMS’s methodology and seeks rate cut reversal and corresponding rate increase for two midnight impact
Two Midnight IPPS Rate Cut Litigation

• Additional developments
  — FY 2015 IPPS/LTCH Proposed Rule
    — 0.2% two midnight rate cut carried forward to proposed FY 2015 rates
    — Proposed rule includes provision requesting comment on potential new payment methodology for inpatient short stays
Two Midnight AHA Litigation

• *AHA v. Sebelius*
  — Filed April 14, 2014
  — Challenges two-midnight rule itself as arbitrary and capricious
  — Challenges one-year timely filing deadline for Part A to Part B rebilling policy
  — Challenges written physician order requirement
• In separate lawsuit, AHA also challenges 0.2% rate cut
Office of Medicare Hearings and Appeals Pilot Projects

• Background
  — OMHA has indefinitely suspended assignment of ALJs to all non-beneficiary appeals
  — American Hospital Association has sued challenging the suspension
  — HHS has convened a working group to address the issue

• Recent Development
  — OMHA recently announced two pilot programs designed to reduce backlog
    — Statistical Sampling Initiative
    — Settlement Conference Facilitation Pilot
Office of Medicare Hearings and Appeals Pilot Projects

• Statistical Sampling Initiative
  — Voluntary program to use OMHA sampling expert to identify sample units for adjudication: results of hearing extrapolated to universe of claims at issue
  — Limited eligibility:
    — Appeals filed between April 1, 2013 and June 30, 2013
    — Appeals must be currently assigned to an ALJ
    — Must be a minimum of 250 claims and all claims must fall into only one of the following categories:
      — Pre-payment denials
      — Post-payment non-RAC denials
      — Post-payment RAC denials
    — Appellant can be single provider or providers and suppliers with multiple NPIs owned by single entity
    — Likely random re-assignment to ALJ for hearing
Office of Medicare Hearings and Appeals Pilot Projects

• Settlement Conference Facilitation Pilot

  — Voluntary ADR project using OMHA mediator to reach settlement of claims on appeal

  — Can result in settlement agreement with CMS resolving and dismissing appeal

  — Limited eligibility:

    — Request for hearing must be filed in 2013 and not currently assigned to ALJ

    — Amount of “each individual claim” must be less than $100,000

    — At least 20 claims must be at issue

    — Request for ADR must include all pending appeals for the same items or services

    — Applies only to claims for Medicare Part B claims
Questions