Building Clarity on the Two-Midnight Rule

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As the Centers for Medicare and Medicaid Services' (CMS') Probe and Educate Initiative draws to a close and the 2016 Outpatient Prospective Payment System (OPPS) proposed rules are released for comment, questions remain for the healthcare industry regarding expectations for selecting patient status, such as "observation" or "inpatient," and the evaluation of medical necessity.

In order to assign the patient the correct status to receive appropriate payment, it is wise to use all resources available. Education and communication throughout healthcare organizations regarding the Two-Midnight Rule will lead to accurate billing and reimbursement, as well as have a lasting effect on billing and the organization's bottom line. The key to improvement is collaboration and utilization of the resources already available to comply with the rule.

Issued by CMS, the Two-Midnight Rule went into effect on October 1, 2013. According to the rule, a Medicare patient who stays in the hospital for over "two midnights" is presumed to be an inpatient—absent rare and unusual circumstances such as death, transfer, departure against medical advice, undergoing an inpatient-only procedure, or ventilator treatment.

Hospital stays that do not meet the Two-Midnight standard are considered observation care and should be billed as outpatient claims under Medicare Part B. CMS had instructed Medicare audit contractors to look for physician orders and documentation in the medical record as to why the inpatient stay was necessary. All physician documentation should be supported by the medical factors and clinical findings within the patient record. This would include the patient's history, comorbidities, signs and symptoms of illness, patient care requirements, and risk of adverse events. CMS has made it clear that medical necessity rules have not changed.

"The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's bylaws and admissions policies, and the relative appropriateness of treatment in each setting," according to CMS' Medicare Benefit Policy Manual.

Physician documentation is fundamental in validating the decision to admit a patient. Remember the old saying, "If you didn't document it, you didn't do it." Most CMS denials are based on the lack of documentation for reasonable and medically necessary inpatient admissions. The reviewer is not familiar with the patient's past medical history and current condition—therefore the physician has to paint an accurate picture of the criteria documenting the complex medical factors of why the patient requires inpatient admission.

Suggestions for identifying factors for inpatient admission include:

- Severity of signs/symptoms
- Current medical needs
- Risk of an adverse event

- Complexity of care needed
- Comorbidities and relevant past medical history
- Acuity of patient's condition up to and at the time of inpatient admission
- Inpatient admission order signed, dated, and timed prior to discharge
- Admission order specifies "admit to inpatient," "admit as an inpatient," "admit for inpatient services," or similar language

It is highly recommended that facilities engage their physicians so that they understand and utilize appropriate clinical documentation standards. Education can be provided during rounds to address patient status issues immediately, through direct communication. For example, utilization review staff can be present in the emergency department and at the patient care units to provide timely and efficient feedback to admitting physicians while providing concurrent education on regulatory requirements.

Collaboration Brings Compliance Goals Within Reach

It is clear that creating a culture of success through collaboration will improve the opportunity to reach any goal in an organization, especially that of selecting the correct patient status. Compliance with the Two-Midnight Rule is a system-wide activity—or should be. With the objective of evaluating and assigning patient status accurately, organizations should advocate for collaboration as a top priority. Teamwork across departments builds relationships and uses existing resources efficiently, as well as inspires staff and promotes an environment ripe for creativity.

Utilizing all avenues available to evaluate and trend proper patient status assignment is vital. Designating health information management (HIM) professionals as an integral part of the universal collaboration team is an essential part of the equation for success. HIM manages the integrity of the electronic health record and utilizes analytics and systems interoperability to support the patient and healthcare as a whole. HIM can assist with status selection by providing yet another level of validation for the certification of an order and the ultimate status of the patient.

While the analysis team is evaluating the completeness of the record, coding can validate that the story being told matches the one being billed. Inpatient orders for admission and observation can be reviewed to ensure they are signed, dated, and timed. Coding specialists can alert a team member when the record or an order does not paint the full picture. Implementing more than one process to evaluate status selection and using a team-based approach could be the difference between a payday or a self-disclosure.

HIM can not only verify patient status, but can also improve the billing process. By identifying same day readmissions, coding specialists can lend a hand in evaluating "repeat admissions," as referred to by CMS:

> When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.[2]

Coding specialists have a keen awareness of what is happening to the patient based on the documentation in the record and should be catching accounts that must be combined and paid under one MS-DRG.

Orders should be monitored in registration, same day surgery, and the emergency room. Trends can be identified and benchmarked against one another and the data used in a "Lean" project or other type of continuous quality improvement measures. Although the front end is the best place to establish good documentation techniques and ultimately select the appropriate patient status, implementing a back end process to catch issues with medical

necessity can also improve status selection. By tackling this process as a team and forming a partnership amongst departments, shared power and facilitation can further enhance the status selection process.

The suggestions considered above include some of the opportunities for improvement when it comes to evaluating the documentation necessary to receive entitled payment for services provided under the Two-Midnight Rule. Clarity about the rule, using existing resources efficiently, and collaboration among departments will facilitate compliance with the regulations.

What the OPPS Proposed Rule Means for 2016

The 2016 OPPS proposed rule changes indicate all admissions must be reasonable, necessary, and supported by clear documentation in the patient's medical record. For stays expected to last less than "two midnights," CMS proposes the following.

For stays in 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.[3]

There is no change for stays over the two-midnight benchmark, as noted in the two-midnight fact sheet released by CMS. The fact sheet states:

> 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.

Notes

1. Centers for Medicare and Medicaid Services. "Medicare Benefit Policy Manual." June 27, 2014. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf.
2. Centers for Medicare and Medicaid Services. "CMS Manual System, pub. 100-04 Medicare Claims Processing, Transmittal 266." July 30, 2004. www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R266CP.pdf.
3. Centers for Medicare and Medicaid Services. "Fact Sheet: Two-Midnight Rule." July 1, 2015. www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html.

References

Centers for Medicare and Medicaid Services. “Revision of Common Working File (CWF) Editing for Same-Day, Same-Provider Acute Care Readmissions.” *MLN Matters*. July 30, 2004. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3389.pdf.

Department of Health and Human Services’ Office of Inspector General. “Review of Same-Day, Same-Provider Acute Care Readmissions in Pennsylvania During Calendar Year 1998.” August 2002. https://oig.hhs.gov/oas/reports/region3/30100011.pdf.

Shaw, Patricia et al. *Quality and Performance Improvement in Healthcare,* Third Edition. Chicago, IL: AHIMA Press, 2007.

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