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Centers for Medicare & Medicaid Services

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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