

## 'Two-Midnight' Admission and Medical Review Criteria Policy

### THE ISSUE

The Centers for Medicare & Medicaid Services (CMS) finalized its "two-midnight" policy in the fiscal year (FY) 2014 inpatient prospective payment system (PPS) final rule. Under the policy, CMS generally considers hospital admissions spanning at least two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights are generally considered outpatient cases, regardless of clinical severity or a physician's judgment that an inpatient admission is medically necessary. The policy took effect Oct. 1, 2013, but enforcement has been partially delayed through Dec. 31, 2015.

The policy's time-based threshold overrides the

longstanding role of physician judgment by placing emphasis on the expected amount of time – not the level of care – as the driving factor in an admission decision. CMS continues to indicate that it believes the use of the two-midnight threshold is appropriate. However, in the outpatient PPS proposed rule for calendar year 2016, CMS proposed changes to allow certain hospital inpatient services that do not cross two midnights to be appropriate for payment under Medicare Part A if a physician determines and documents in the patient's medical record that the patient requires reasonable and necessary admission to the hospital as an inpatient. If finalized, these changes would be effective Jan. 1, 2016.

### AHA POSITION

**The AHA urges CMS to finalize its proposed changes to the two-midnight policy. In addition, we urge CMS to extend the partial enforcement delay of the two-midnight policy and postpone reviews of patient status claims by Quality Improvement Organizations until March 31, 2016. We also continue to urge CMS to fully reverse its 0.2 percent reduction associated with the two-midnight policy.**

### WHY?

- **The AHA believes that the admission decision-making process should recognize the important role of physician judgment and individual patient needs.** The AHA is pleased that CMS's proposal returns to physician judgment as the driving factors for cases that are less than two-midnights.
- **The partial enforcement delay of the two-midnight policy must be extended until March 31, 2016.** The current delay will expire on Dec. 31, 2015. However, given that the agency's proposed changes to the two-midnight policy will not be finalized until early November, hospitals will have only two months before the rule's effective date of Jan. 1 to implement the revised policy. The extension of the partial enforcement delay is necessary to allow hospitals sufficient time to implement the policy changes and to ensure that CMS has the time necessary to issue detailed guidance. Additional time will be essential for proper implementation of the new policies as well as revised admissions criteria by hospitals and CMS review contractors.

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- **Quality Improvement Organization (QIO) review also must be postponed until March 31, 2016.** CMS will begin QIO review of patient status claims beginning no later than Oct. 1. However, because the proposed changes to the two-midnight policy would not be effective until Jan. 1, 2016, it does not make sense for QIOs to audit claims from Oct. 1 to Dec. 31 under the current two midnight policy, only to switch three months later to the revised policy. In addition, as explained above, more time is necessary for both hospitals and CMS to properly implement CMS's new policies and revised admissions criteria even after its effective date of Jan. 1, 2016.
- **CMS's imposition of the 0.2 percent payment reduction is unlawful.** CMS has not provided sufficient evidence that implementation of the two-midnight policy has resulted in an increase in inpatient PPS expenditures and, therefore, the agency should fully reverse this payment reduction.

## KEY FACTS

CMS's two-midnight policy was implemented partially in response to the growing number of Medicare beneficiaries who receive observation services for more than 48 hours. However, the decision to admit a patient as an inpatient is a complex medical judgment that involves the consideration of many factors, such as the patient's medical history and medical needs, the types of facilities available to inpatients and outpatients, the hospital's bylaws and admission policies, the relative appropriateness of treatment in each setting, patient risk of an adverse event, and other factors. Hospitals strive to base admission decisions on these clinical considerations; yet, the medical judgment of the treating physician is all too often second guessed by auditors, including Recovery Audit Contractors (RACs), months or even years after the fact. Hospitals risk loss of reimbursement, monetary damages and penalties from auditors when they admit patients for short, medically necessary, inpatient stays. On the other hand, they face criticism from patients and CMS over the perceived use of observation status as a substitute for inpatient admission.

CMS and Congress have partially delayed enforcement of the two-midnight policy on many occasions, with the current partial enforcement delay set to expire on Dec. 31, 2015. During this enforcement delay, CMS will not allow RACs to conduct post-payment patient status reviews for claims with dates of admission from Oct. 1, 2013 through Dec. 31, 2015. However, during this time period, CMS is conducting prepayment "Probe and Educate" audits for

inpatient admissions claims. The agency is allowing Medicare Administrative Contractors (MACs) to assess hospital compliance with the two-midnight policy, focusing on the admission order requirements, certification requirements and two-midnight benchmark, and deny claims that they deem as out of compliance. MACs are required to conduct educational outreach efforts to hospitals with denied claims, including individualized phone calls, answering questions and providing pertinent education and reference materials.

In the outpatient PPS proposed rule for CY 2016, CMS announced changes to its patient status medical review and enforcement strategy that will go into effect no later than Oct. 1. CMS will use QIOs to conduct first-line medical reviews of the majority of patient status claims and to educate hospitals about claims denied under the two-midnight policy. CMS will allow RACs only to conduct patient status audits for those hospitals with consistently high denial rates. Specifically, those hospitals that are found by the QIO to exhibit a pattern of practices including, but not limited to, having high denial rates and consistently failing to adhere to the two-midnight policy (including having frequent inpatient hospital admissions for stays that do not span one midnight), or failing to improve their performance after QIO educational intervention, will be referred to the RACs for further payment audit. The number of claims that a RAC will be allowed to review for patient status will be based on the claim volume of the hospital and the denial rate identified by the QIO.