Two Midnight Rule
What does it mean for Coders?

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Agenda

• The Two-Midnight Rule
• Supportive documentation
• Observation vs Inpatient - What to code
• MACs and RACs and what they will be reviewing
2 Midnight Rule

The 2-Midnight rule

• Surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital payment under Medicare Part A when:
  – The qualified physician expects the patient to require a stay that crosses at least 2 midnights
  – Admits the patient to the hospital based on that expectation
The 2-Midnight Rule

• Surgical procedures, diagnostic tests, and other treatments are generally **inappropriate** for inpatient hospital payment under Medicare Part A when:
  – The practitioner does not expect to keep the patient as an inpatient for more than 2 nights
  – Observation services
  – Other procedures/services or diagnostic tests

Exceptions to the 2-midnight rule

• Cases which do not span over 2 midnights may meet medical necessity for an inpatient status:
  – Inpatient-Only List
  – Other Circumstances:
    • Approved by CMS and outlined in sub-regulatory guidance
    • **New Onset Mechanical Ventilation***
    • Additional suggestions being accepted at IPPSAdmissions@cms.hhs.gov (subject line “Suggested Exception”)

*NOTE: This exception does not apply to anticipated intubations related to minor surgical procedures or other treatment.*
Unforeseen Circumstances

• These cases may not be appropriate for inpatient status:
  – Death
  – Transfer
  – Against Medical Advice
  – Unforeseen Recovery
  – Election of hospice care

• The practitioner should document any expected and any unforeseen interruptions in care.

Supportive Documentation
Documentation - Certification

– Authentication of the practitioner order
  • The treatment will reasonably span over two midnights
– Reason
– ELOS
– Plan of care
– CAHs – may be reasonably expected to be discharged or transferred to a hospital within 96 hours after admission

Documentation - Certification

– Timing:
  • Begins with the order for inpatient admission
  • Must be completed, signed, dated and documented prior to discharge (except outlier cases)
– Authentication:
  • Must be a physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital’s medical staff.
    – Doctor of medicine or osteopathy
    – A dentist in the under 42 CFR 424.13(d)
    – Podiatrist – following State law
Documentation - Admission Order

– The order must clearly state admission to inpatient at or before the time of admission.
– Must be furnished by a physician or other practitioner who is:
  • (a) licensed by the state to admit inpatients to the hospital
  • (b) granted privileges by the hospital to admit inpatient to that specific facility
  • (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission (42 CFR §482.11).

Documentation - Admission Order

• The admit order may be written under direction of the ordering practitioner:
  – Must have knowledge of the case
    • Covering physician
    • ER physician
    • Attending surgeon
  – The admit order may be a verbal order
    • Following verbal order regulations
  – Either case, the certifying physician must cosign/authenticate the order before discharge.
Documentation - Physicians

• Admit/place to the correct level of care
• If Inpatient status is medically necessary:
  • Documentation in the History and Physical/admit note for Medicare patients:
    – The patient is expected to need inpatient services for more than 2 midnights
    – A short description of why the patient needs inpatient services for at least 2 midnights

Documentation - Physicians

• Admit/place to the correct level of care
• If Observation services are medically necessary:
  – Documentation in the History and Physical/admit note for Medicare patients:
    • A short description of why the patient needs observation services.
Documentation - Physicians

• Always document:
  – Risks to the patient’s health and well-being
    • Even the clinically obvious (practitioners are required to connect the “clinical dots”)
  – Medical comorbidities
  – Connect Medical Necessity to the course of care
  – Why a patient left medical care:
    • Discharged
    • Unforeseen changes in patient health/care

Treatment Time

• Time patient started receiving care.
  – Treatment time may be added to calculate if the stay meets 2 midnights:
    • Observation services
    • Emergency Room
  – Time not allowed in the calculation
    • Excessive wait times
    • Triage
Treatment Time

• Occurrence Span Code 72, Contiguous outpatient hospital services that preceded the inpatient admission.
  – Voluntary, but encouraged by CMS
  – Used by hospitals to report the number of midnights spent in the hospital
    • Start of care until formal inpatient admission

Documentation – Things to Consider

• Sign, Date and Time – Oh My!
  – Policies to clarify the order authentication process
    • All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations (42 CFR §482.24(c)(2)).
Documentation – Things to Consider

• Skilled Nursing Homes
  – Three day rule still applies
    • Does not include all treatment
    • Must be three inpatient days

• Medical necessity:
  – Practitioner is responsible to connect the dots for medical necessity
  – Social Security Act §1862(a)(1)(A))

Inpatient vs. Observation
Inpatient versus Observation Services

• “Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.”

(Medicare Benefit Policy Manual Ch. 6, 20.6)

Inpatient versus Observation Services
- Observation

• “Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.”

(Medicare Benefit Policy Manual Ch. 6, 20.6)
Inpatient versus Observation Services - Observation

• Admit – refers to inpatient status
• Consider:
  – “place patient for Observation services”
  – “refer patient for Observation services”
• Observation time starts when documented services begin.
• Observation time ends when clinical or medical interventions have been completed, including follow-up care after release order has been documented.

Inpatient versus Observation Services - Observation

• The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
• The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.
Inpatient versus Observation Services
- Observation

• Observation must include one of the following services in addition to the observation service.
  – An emergency department visit (99281-99285)
  – A clinic visit (99201-99215)
  – Critical care (99291)
  – Billed as a direct admission to observation reported with HCPCS code G0379

• Observation services must span a minimum of 8 hours or more than one calendar day.

• Hospitals should round to the nearest hour.

Inpatient versus Observation Services
- Observation

• Do not double dip when reporting observation services!

• Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (Chapter 4 of the Medicare Claims Processing Manual section 290.2.2):
  – According to CMS “A complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring.” (Medicare FAQ #2725)

• Hospitals must delineate monitoring services from observation services
• CMS will instruct MACs to assess the hospital’s compliance with three things:
  – The admission order requirements
  – The certification requirements
  – The 2-midnight benchmark
MACs and RACS

• Admission order requirements:
  – 42 CFR 412.3 – Admission
• Certification/Plan Requirement
  – 42 CFR 424.13 – Hospitals other than Inpatient Psychiatric Facilities
  – 42 CFR 424.14 – Inpatient Psychiatric Facilities
  – 42 CFR 424.15 – Critical Access Hospitals

MACs and RACS

• The 2-midnight Benchmark
  – 0-1 Midnight: Review contractor will review to see if the beneficiary was admitted for an inpatient-only procedure or if other circumstances justify inpatient admission per CMS guidance (new onset ventilation).
  – 2 or More Midnights: Review contractor will generally find Part A payment to be appropriate.
MACs and RACS

• The 2-midnight Presumption
  – The second part of the 2-midnight benchmark.
    • How claims will be selected.
  – Not selected if the claim shows 2 or more midnights after formal inpatient admission begins
  – Contractor will presume for claim selection purposes that inpatient admission is appropriate
  – May be selected if a pattern for evidence of systematic gaming or abuse
    • Unnecessary delays in the provision of care
    • Medically unnecessary longer length of stay

CMS Case Scenarios
Scenario #1: Initial Presentation to ED

68 year-old man presents to the ED with several day history of urinary symptoms, vague intermittent abdominal discomfort, “gassy” and “feverish” feeling over the past several days, and intermittent chills and nausea without vomiting. Patient on oral medications for constipation, hypertension, cholesterol, and diabetes. Patient complains that he is not feeling like himself – no appetite, tired, “maybe a touch of the flu”. No other complaints.

10/1/2013
• 10:00 pm - Patient is triaged.
• 10:10 pm - Urine sample and glucometer reading obtained and patient sent to the waiting room.
• 11:00 pm - MD assesses patient, orders therapeutic/additional diagnostic modalities.
• 12:00 am - Patient with new complaint of chest pain – additional therapeutic/diagnostic modalities ordered.

10/2/2013
• 12:15 am - MD re-evaluates and determines a need for medically necessary hospital level of care/services for this patient to beyond midnight #2.
• 12:35 am - Formal order/admission provided.

10/3/2013
• 7:35 am - Patient is discharged home.

Scenario #1: Initial Presentation to ED

• CMS guidance:
  – Hospital may bill this claim for inpatient Part A payment. Claim will demonstrate 1 midnight of outpatient services and 1 midnight of inpatient services. This claim may be selected for medical review, but will deemed appropriate for inpatient Part A payment so long as the documentation and other requirements are met.
Scenario #2: Initial Presentation to Physician Office

An 80 year-old woman presents to her primary care physician’s office not feeling well. Past medical history is significant for chronic obstructive pulmonary disease and the patient is on multiple medications. She has experienced increasing shortness of breath for several days.

10/1/2013
• 6:00 pm - Patient is evaluated by primary and sent to the hospital for further evaluation via ambulance.
• 9:00 pm - Upon arrival at the hospital the admitting practitioner confirms the suspected diagnosis and admits the beneficiary based on the expectation that the patient’s care will span at least 2 midnights.

10/2/2013-10/4/2013
• Patient continues to receive medically necessary hospital level of care/services.

10/5/2013
• 9:00 am - Patient is discharged home.

Scenario #2: Initial Presentation to Physician Office

• CMS guidance:
  – Hospital may bill this claim for inpatient Part A payment. Claim will demonstrate 2 midnights of inpatient services. Review contractors will generally not select this claim for review as it is subject to the “presumption.”
Scenario #3: Treatment in the ICU

73 year-old male with an accidental environmental toxic exposure presents to the ED.

12/1/2013

• 9:00 am - Patient arrives by ambulance to the ED. Patient is awake and alert.
• 9:03 am - Poison control/POISONINDEX consulted, which advises that patient requires telemetry monitoring; plan to intubate if necessary. Small hospital facility, telemetry monitoring is only available in the intensive care unit.
• 9:07 am - Therapeutic and diagnostic modalities have all been ordered and initiated. Patient airway intact.
• 10:00 am - MD requests transfer to ICU for telemetry monitoring. Unclear to the physician if this patient will need medically necessary hospital level care/services for 2 or more midnights. Determination will be dependent on clinical presentation and results of diagnostic and therapeutic modalities.

12/2/2013

• 10:30am - Medical concerns/ sequelae resolving; airway remained intact absent mechanical intervention.
• 12:00pm - Physician writes orders to discharge home.

Scenario #3: Treatment in the ICU

• CMS guidance:
  – Hospital should bill for outpatient services. Location of care in the hospital does not dictate patient status. The patient’s expected length of stay was unclear upon presentation and the physician appropriately kept the patient as an outpatient because an expectation of care passing 2 midnights never developed. No other circumstance was applicable.
Scenario #4: Uncertain Length of Stay

80 year-old patient presents from home to the ED on a Saturday with clinical presentation consistent with an acute exacerbation of chronic congestive heart failure. She is short of breath and hypoxic with ambulation. The physician determines that she will require hospital care for diuresis and monitoring, however it is unclear at presentation whether she will require 1 or 2 midnights of hospital care.

12/7/2013
• 9:00 pm – Patient begins receiving medically necessary services in the ED. She shows evidence of fluid overload, requiring intravenous diuresis and supplemental oxygen and continuous monitoring.
• 11:00 pm – Intravenous diuretics are provided and an order for observation services is written with a plan to re-evaluate her within 24 hours for the need for continued hospital care or discharge to home.

12/8/2013
• 9:00 am - She remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis and supplemental oxygen.
• 5:00 pm – She continues to respond to diuretics but remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis for another 12 to 24 hours. Inpatient admission order is written based on the expectation that the patient will require at least 1 more midnight in the hospital for medically necessary hospital care.

12/9/2013
• 10:00 am - The patient’s acute CHF exacerbation is resolved and she is discharged home.

Scenario #4: Uncertain Length of Stay

• CMS guidance:
  – Hospital may bill this claim for inpatient Part A payment. Providers should treat patients as outpatients until the expectation develops that the patient will require a second midnight of hospital care. When the expectation develops, an inpatient admission order should be written by the physician.
Scenario #5: Unforeseen Circumstance  
(after formal admission)

Disabled 50 year-old man presents to ED from home with history of cancer, now with probable metastases and various complaints, including nausea and vomiting, dehydration and renal insufficiency.

1/1/2014  
• 10:00 pm - presents to the ED at which time the admitting provider evaluates and orders diagnostic/therapeutic modalities.

1/2/2014  
• 4:00 am - Physician writes an order to admit. Patient is formally admitted with the expectation of medically necessary hospital level of care/services for 2 or more midnights.  
• 9:00 am - Appropriate designee and the family discuss with the primary physician the desire for hospice care to begin for this patient immediately.  
• 3:00 pm – Patient is discharged with home hospice.

Scenario #5: Unforeseen Circumstance  
(after formal admission)

• CMS guidance:  
  – Hospital may bill this claim for inpatient Part A payment. Claim will demonstrate 1 midnight of inpatient services. This represents an unforeseen circumstance interrupting an otherwise reasonable admitting practitioner expectation for hospital care. Upon review, this would be appropriate for inpatient admission and payment so long as the physician expectation and unforeseen circumstance were supported in the medical record.
Scenario #6: Medical Necessity

78 year-old man with a past and current medical history of chronic illnesses that are well controlled with medications. Patient slips while shoveling and falls and sustains a closed wrist fracture.

11/9/2013
• 11:00 pm - Beneficiary presents to the ED following fall at home. Beneficiary presents alone.
• 11:30 pm - Beneficiary arm fracture confirmed by practitioner. Pain medication provided.

11/10/13
• 3:30 am - Beneficiary pain well controlled, stable for discharge but continues to require custodial care. No family or friends available and hospital social services are unavailable until Monday morning.
• Beneficiary held in hospital pending home care plan, no IV access, pain well controlled with oral medication.

11/11/13
• 10:00 am - Beneficiary released to home with family member. No other complications.

Scenario #6: Medical Necessity

• CMS guidance:
  – Outpatient services may be provided and billed to Medicare as appropriate.
References

- [www.cms.gov](http://www.cms.gov)
  - Medicare Learning Network
  - Internet Only Manuals
- [http://www.ecfr.gov](http://www.ecfr.gov)

Questions?

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