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On July 1, 2015, the Centers for Medicare and Medicaid Services (CMS) announced proposed changes to the controversial Two-Midnight Rule. This payment rule clarifies the circumstances under which Medicare will consider a given hospital stay to be an inpatient service (and therefore reimbursable at a higher rate

under Medicare Part A), versus an outpatient service (and therefore reimbursable at a lower rate under Part B).

Before the rule, physicians generally were allowed to exercise professional judgment regarding the appropriate treatment setting, subject to Medicare's retrospective medical review. The Two-Midnight Rule largely replaced medical judgment with regulatory benchmarks for inpatient versus outpatient admissions. The proposed changes would at least partially restore case-by-case medical discretion.

Origins Of The Two-Midnight Rule

The history of the Two-Midnight Rule is relatively brief but tortured. CMS first announced the rule on August 2, 2013, as part of the Fiscal Year (FY) 2014 Inpatient Prospective Payment System annual update. After multiple delays to address stakeholder confusion, the rule took effect on October 1, 2013.

The Two-Midnight Rule established certain presumptions regarding short-stay inpatient hospitalizations. Namely, inpatient stays that the admitting physician reasonably expected would span at least two midnights were presumptively "reasonable and necessary" inpatient services and, therefore, payable under Medicare Part A. Conversely, Part A payment was presumptively inappropriate for hospital stays not expected to span at least two midnights. According to the rule, those short-stay admissions instead should be billed as Medicare Part B outpatient services.

The Two-Midnight Rule was precipitated by a number of factors. One was a trend of aggressive Recovery Audit Contractor (RAC) claims reviews, identifying a high error rate for medically unnecessary Part A inpatient services that should have been submitted by the provider as lower reimbursement Part B outpatient services. The RAC Program is a component of the federal government's crackdown on health care fraud. RACs are essentially private bounty hunters, authorized to ferret out improper payments. They are paid on a contingency basis, typically receiving 9 percent to12.5 percent of any amounts recovered.

Short-stay hospitalizations became a favorite RAC target. But given the regulatory uncertainty and complex medical judgment involved in determining the appropriateness of an inpatient versus an outpatient stay, RAC audits also spawned high rates of provider appeals. The number of pending appeals overwhelmed the Office of Medicare Hearings and Appeals, leading to CMS' offer to settle hospitals' claims for partial payment—68 cents on the dollar—of net allowable amounts.

Meanwhile, cautious providers changed their practices and began admitting high numbers of patients for extended outpatient “observation” services under Part B, rather than inpatient services under Part A. From the patient’s perspective, the technical designation might be imperceptible; she might be admitted to a regular hospital room and stay for one or more nights. From the billing department’s perspective, however, the designation is highly important. Through that strategy, hospitals could keep patients overnight but avoid being snared by RAC audits. However, patients who were never admitted as inpatients became ineligible for Medicare payment for post-acute care skilled nursing facility services — an outcome that caused considerable difficulty for patients needing these services who now had to pay for it themselves. (According to Medicare rules, skilled nursing care is allowable only after at least a three-day inpatient hospital stay.)

Thus entered the Two-Midnight Rule, which says, in short, that any hospital stay not expected to span two midnights will be paid as an outpatient service under Part B. But health care providers complained that the Two-Midnight benchmark was a blunt instrument that undermined physicians’ professional judgment and injected new uncertainty. RACs continued to target short-stay admissions, now armed with a bright-line rule to plug into their data-mining software, leading to more denials and more appeals.

Fallout Of The Two-Midnight Rule

CMS made several attempts to provide clarification, including hosting Open Door forums and national provider calls, and posting Frequently Asked Questions to its website. In January 2014, CMS acknowledged the possibility of “rare and unusual” circumstances for which inpatient admission may be medically necessary even if the physician does not expect the patient to require two nights of hospitalization. The guidance gave only one specific example: newly initiated mechanical ventilation. CMS invited the provider community to bring to its attention other “rare and unusual” circumstances. But until recently, CMS had not expanded on the one categorical exception.

CMS also launched an “Inpatient Probe and Educate” program. The program allowed providers to work with CMS and Medicare Administrative Contractors to settle claims related to the Two-Midnight Rule through a two-step process. The first step identified all the providers’ claims for reimbursement that the Medicare Administrative Contractor agreed were correct. In the second step, the parties negotiated and settled the subset of claims about which there was disagreement.

CMS also issued a moratorium on RAC reviews of inpatient admissions for dates beginning October 1, 2013 (the date that the Two-Midnight Rule first took effect),

through September 30, 2015. That moratorium was recently extended through December 31, 2015. As of June 11, 2015, the Probe and Educate process had resulted in settlements with more than 1,900 hospitals, involving approximately 300,000 claims and provider payments of approximately $1.3 billion.

Proposed Changes To The Rule: Case-By-Case Assessment Of Shorter Stays

Despite those efforts, confusion and controversy persisted. Accordingly, CMS recently proposed incremental changes to the Two-Midnight Rule. The proposed rule maintains the presumption of appropriateness regarding hospital stays expected to last two midnights or longer. It also maintains the presumption of inappropriateness of inpatient admissions expected to last only a few hours and not spanning at least one midnight. CMS will continue to monitor those very short admissions closely and prioritize them for medical review, although that responsibility was assigned to a different type of private contractor, as discussed below.

The most significant change in the proposed rule is the restoration of case-by-case assessment for cases expected to require less than two midnights of inpatient hospital care. Instead of presuming such admissions are inappropriate, the proposed rule calls for physicians to carefully document the medical necessity of the short stay. Such admissions are still subject to medical review, as all claims submitted to Medicare may be. Medical reviewers are instructed to look for documentation of factors including: signs and symptoms of medical severity; medical predictability of adverse consequences; and, need for diagnostic studies that are more appropriately performed in the outpatient setting.

Another notable change in the proposed rule is shifting medical review authority from Medicare Administrative Contractors and RACs to Medicare's Quality Improvement Organizations — private contractors charged with monitoring the quality of care provided to Medicare beneficiaries. Quality Improvement Organizations historically have not been involved in enforcement and have more collaborative relationships with providers. The proposed rule states that reassignment of inpatient admissions to Quality Improvement Organizations will take effect October 1, 2015, even if the other modifications to the Two-Midnight Rule are not implemented. RACs will remain authorized to review hospitals with consistently high rates of denials from Quality Improvement Organizations.

CMS' proposed change may be understood as expanding the limited "rare and unusual" exception from a categorical rule to a more flexible standard, at least with respect to

admissions longer than a few hours and shorter than two midnights. The old rule identified a single medical treatment appropriate for short-stay inpatient admission whereas the proposed new rule is based on physician judgment and documentation. At least within a subset of hospital admissions claims, the agency effectively has restored the pre-FY 2014 policy of recognizing that admissions decisions are the product of complex medical judgment. CMS is accepting comments to the proposed rules until August 31, 2015, and will respond to comments in a final rule scheduled for release in November 2015.

TAGS: CMS, MEDICARE PART A, MEDICARE PART B, QUALITY IMPROVEMENT, TWO MIDNIGHT RULE