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The Two-Midnight Rule 2021

Five Immediate Actions for Hospitals and Compliance Officers

In November of 2020, the HHS Office of Inspector General (OIG) announced it was resuming audits of inpatient (IP) claims with short lengths of stay and added the audits to its annual work plan for 2021[1]. In addition, the Centers for Medicare and Medicaid Services (CMS) announced a three-year phase-out of the Inpatient Only List ("CMS IPOL") beginning in 2021.[2] With these two factors in mind, hospitals and compliance officers must place a renewed focus on the Two-Midnight Rule. ***It's Groundhog Day.***

With the OIG starting Two-Midnight audits again, providers are likely experiencing déjà vu. Inpatient short stays have been on the radar for hospital compliance officers and the OIG for years. Circa 2012, through the Recovery Audit (RAC) program, CMS began noticing high rates of error with respect to patient status in certain short-stay Medicare claims submitted for inpatient hospital services. CMS and the RACs indicated the inpatient care setting was medically unnecessary, and the claims should have been billed as outpatient instead.[3] At the same time, billing compliance issues were arising from patients placed in "extended observation" status, a practice which impacted patient copays as well as patients' ability to qualify for Skilled Nursing Facility (SNF) care through the SNF Three-Day IP Stay Rule.[4]

The Two-Midnight Rule

To address these issues and to clarify when hospital services should be billed as inpatient vs. outpatient, CMS introduced the Two-Midnight Rule in October of 2013, then subsequently amended it in the 2016 Outpatient Prospective Payment System (OPPS) Final Rule.[5] Under the original Two-Midnight Rule, "CMS generally considered it inappropriate to receive payment under the inpatient prospective payment system for stays not expected to span at least two midnights."[6] The only procedures excluded from the rule were patients with newly initiated mechanical ventilation and procedures appearing on the CMS IPOL (OPPS Addendum E).[7] In the FY2016 OPPS Final Rule, CMS amended the Two-Midnight Rule and clarified that, in certain circumstances, Medicare would also pay for inpatient stays that lasted less than two midnights on a case-by-case basis (see Figure 1).[8]

> *"Prior OIG audits identified millions of dollars in overpayments for inpatient claims with short lengths of stay. . . .this serves as notification that the OIG will begin auditing short stay claims again, and when appropriate, recommend overpayment collections."*[9]

Figure 1 - Summary of the Two-Midnight Rule

Payable Inpatient Hospital Claims[10]

2+ Midnights

- Inpatient hospital admissions when the admitting physician expects the patient to require hospital care that spans at least two midnights
- Medical record must support the expectation that the patient would stay at least two midnights
- Includes stays in which the physician's expectation is supported, but the actual length of stay was less than two midnights due to unforeseen circumstances (e.g., unexpected patient death, transfer, clinical improvement or departure against medical advice)

< 2 Midnights

- Inpatient Procedures on the CMS IPOL or listed as a national exception (Two-Midnight Rule does not apply)
- Newly initiated mechanical ventilation

  - OR -
- "Rare and Unusual Exceptions" where inpatient admissions may be payable under Medicare Part A on a case-by-case basis:
  - Admitting physician expects the patient to need less than two midnights of hospital care; however, only based on the judgment of the admitting physician, an IP admission is reasonable and necessary
  - Medical record documentation must support IP admission was necessary
  - Claims are subject to a medical review

The OIG Audits: What Should Compliance Officers Do?

With the OIG auditing short-stay cases again, hospitals and compliance officers need to take immediate action before the OIG knocks on their door. Five steps to take now:

1. **Perform data analysis on Medicare short-stay inpatient admissions**

   Focus on certain riskier DRGs. Frequent short-stay DRGs that have been problematic include: 313 (Chest Pain); 312 (Syncope and Collapse); 292 (Heart Failure and Shock); 392 (Esophagitis); 310 (Cardiac Arrhythmia). Consider performing length of stay (LOS) benchmarking using public data sets such as MEDPAR or SAF (and/or reviewing your PEPPER Reports) to identify DRGs where your facility may be an outlier with respect to short stays. Consider the admission source to be an indicator of risk (e.g., admits from ED, telemetry, or outpatient surgery).

2. **Perform documentation and claims reviews of Medicare short inpatient stays.**

   Review for documentation of "Two-Midnight language" in the record. In particular, confirm that the physician's documentation describes why the patient is expected to stay two or more midnights. For short stays, the documentation needs to include the rationale for patient discharge before the second midnight, or why — in the judgment of the physician — an IP admission for less than two midnights of hospital care is reasonable and medically necessary. Justification for "zero- to one-midnight" inpatient level of care might include clinical factors such as the severity of illness, the risk of an adverse outcome and the intensity of resources required to deliver care. In short, an OIG auditor will look for clear documentation to understand the physician's thinking (see Figure 2 for examples).

3. **Spread the word.**

   Given the current focus on the pandemic, it may be challenging to gain the organization's attention for anything unrelated to COVID-19. Yet it is critical to prioritize and raise awareness by informing your providers, utilization review teams, health information management coding, clinical documentation improvement (CDI) and billing staff about the resumed

OIG Audits. Re-educate providers and case managers on proper documentation requirements and ensure all appropriate parties know about the new 2021 updates to the CMS IPOL. [11]

4. **Study the new changes to the CMS Inpatient Only List.** In December of 2020, CMS announced that the CMS IPOL (OPPS Addendum E) will be phased out over a three-year period. In CY2021, approximately 300 primarily musculoskeletal-related services were removed from the CMS IPOL. Removal from the CMS IPOL will make these procedures eligible to be paid by Medicare in the hospital outpatient setting or inpatient setting when each is appropriate. That also means the list of procedures will become subject to the two-midnight rule requirements. Auditors will expect to see documentation for why an inpatient admission was required. Especially for those procedures newly removed from the CMS IPOL, providers may not be accustomed to completing thorough two-midnight documentation, so a refresher will be in order. For instance, when total knee and hip replacements were removed from the CMS IPOL in recent years, there was an uptick in related DRGs having a higher volume of short stays than in prior years. The good news is these newly removed procedures will not likely be subject to the OIG's audits, at least initially. Instead, Quality Improvement Organizations (QIOs) will be deployed to review claims and provide education to providers regarding compliance with the two-midnight rule. Claims identified by the QIO as non-compliant will not be denied with respect to the site of service under Medicare Part A. Claims and organizations will only be referred to RACs if there is an ongoing pattern of non-compliance after the QIO education took place.

5. **Review organizational policies and procedures.** Ensure policies, procedures, job aids, and training materials describing patient status determinations and promoting compliance with the two-midnight rule are compliant, implemented, and up to date.

Figure 2 - Elements of Provider Documentation

2MN Audit Checklist

- Signed physician order for inpatient admission
- Provider's documented expectations for the number of midnights
- Clinical rationale supporting the medical necessity of the inpatient admission
- Evidence that hospital care that cannot or should not be delivered as an outpatient when the risk of an adverse outcome is significant (e.g., anaphylaxis, pulmonary embolism, desensitization, diabetic ketoacidosis). [12]
- Documentation of level-of-care criteria (InterQual, MCG) applied during admission case management

About FTI Consulting Health Solutions

FTI Consulting has been involved with several of the largest short-stay settlements with the Department of Justice in the last eight years. We have worked with clients to perform reviews of the core medical record itself, including all level-of-care orders, as well as relevant case management documentation. We have also helped clients by performing detailed data mining and benchmarking analysis related to short stays. We review medical record documentation in light of relevant level-of-care guidelines and based on other clinical indicators that may override the "standard" guideline-based analysis. Our patient record reviewers are well versed in the use of both InterQual® Level of Care Criteria and MCG® (formerly known as Milliman Care Guidelines®). Additionally, we have worked closely with consulting physicians on many of these cases to further analyze and defend appropriate admissions. Our work on these engagements has been presented to the Department of Justice on multiple occasions.

We have performed admission review work as part of internal investigations; as part of a normal routine of compliance audits; under the auspices of Corporate Integrity Agreements; and in connection with pending litigation. We currently serve as the Independent Review Organization ("IRO") for a large health system under a Corporate Integrity Agreement ("CIA")

with a work plan that involves a review of zero- and one-day-stay admissions to assess the appropriateness of the admission.

Our team's knowledge of relevant risk areas and how enforcement bodies perceive these risk areas is sharpened by our work assisting clients with their defense of and response to government investigations. Our team comprises appropriately credentialed professionals with extensive experience in conducting medical necessity and appropriate reviews.

References

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