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RACs to Back Off Longer Stays as 'Two-Midnight' Standard Survives in IPPS Rule

Starting Oct. 1, recovery audit contractors (RACs) generally won't scrutinize inpatient stays that last two midnights or more. RACs and other Medicare auditors will focus on shorter stays because CMS generally will assume admissions that cross two midnights are medically necessary unless they're delayed on purpose, according to the 2014 final inpatient prospective payment system (IPPS) regulation announced Aug. 2. That shifts the medical-necessity emphasis to time spent in the hospital and puts a premium on documentation and utilization review, experts say.

Although the two-midnight clock doesn't start ticking until physicians sign an inpatient order, CMS says hospitals and auditors may count outpatient hours, such as observation, when evaluating the medical necessity of the inpatient admission. And the regulation distinguishes between a two-midnight "presumption" and "benchmark," with the former addressing audits and the latter related to clinical judgment.

This new rule changes the landscape of medical reviews. "If the patient is in the hospital for two midnights, RACs wouldn't be looking at that issue at all," George Mills, director of the CMS Provider Compliance Group, said at an Aug. 6 open door forum on the IPPS. "That issue has been taken off the table for RACs….In the future, reviews of inpatient claims should be substantially reduced because of this new rule, and they will be moving on to other areas."

In an "interrelated" provision, CMS formalized Part B rebilling for Part A claims denied based on the lack of medical necessity for the setting. "The policies were designed to work together to reduce the frequency of extended observation care when it may be inappropriately furnished and provide payment to hospitals for the reasonable and necessary services they provide to inpatients," CMS says (see rebilling story, p. 4).

The two-midnight standard "fundamentally changes how we will look at everything," says Jeffrey Farber, M.D., chief medical officer at Mount Sinai Care and associate professor at Mount Sinai Medical Center in New York City. "The major change is the new rule eliminates the old, clear distinction between outpatient and inpatient services. That's out the door, and all levels of care on the hospital premises are equivalent. Everything takes a back seat to time and the physician's expectation of time spent in the hospital."

In the regulation, CMS said the new policy isn't that radical and provides flexibility. It represents "only a change in the inpatient admissions benchmark from an hourly expectation (24 hours) to a daily (2-midnights) expectation" and doesn't "restrict the physician to a specific pattern of care." When inpatients suddenly improve and can be discharged before two midnights, Medicare reviewers "will not presume that the inpatient hospital status was reasonable and necessary for payment purposes, but may instead evaluate the claim pursuant to the 2-midnight benchmark." That includes looking at the physician order; physician certification (e.g., the reason for continued hospitalization, the estimated time the patient will need to be in the hospital and plans for post-discharge care); and documentation that the admission is reasonable and necessary. At the same time, CMS acknowledged the magnitude of the two-midnight rule. "We understand this is a pretty significant change in medical review," Jennifer Dupee, a nurse consultant in the CMS Provider Compliance Group, said at the Aug. 6 open-door forum.

CMS says physicians can include time in outpatient services, including observation, emergency room visits and outpatient procedures. "The decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpatient service," the rule notes. But this concession is not unqualified. While the outpatient hours aren't inpatient time, CMS says they "may be considered by physicians in determining whether a patient should be admitted as an inpatient, and during the medical review process for the limited purpose of determining whether the 2-midnight benchmark was met and therefore payment is generally appropriate under Part A."

The regulation implements two medical-review policies: the two-midnight threshold and two-midnight benchmark. The presumption refers to CMS guaranteeing payment for stays that transcend two midnights after the inpatient order, with Medicare auditors tackling one-

day stays. The benchmark is a goal post for physicians making clinical decisions.

Farber sees physicians as the buffer between the presumption and the benchmark. "The presumption is CMS saying they will not try to audit cases that have two-midnight stays, but benchmarks are used by clinicians," he says. "The benchmark is for clinicians making these decisions." Suppose a patient has chronic obstructive pulmonary disease (COPD) exacerbation that requires IV steroids and antibiotics. The physician believes an admission is prudent and will last two midnights. "If the patient winds up not needing both nights, that's still OK. The judgment is documented, and the clinical reasons for two midnights are documented, so that should hold up under scrutiny," Farber says. Auditors may still put the claim under the microscope for MS-DRG coding and complications and comorbidities or major CCs, but that's another story.

Ralph Wuebker, M.D., chief medical officer for Executive Health Resources in Newtown Square, Pa., interprets the presumption vs. benchmark in a similar way. The presumption is for auditors looking backward while the benchmark is for physicians to determine patient status looking forward. He also sees this as raising the stakes for documentation. "Are you practicing according to the standard of care? That's where I think CMS is going — that focus on documentation," Wuebker says. If a patient comes in for chest pain but doesn't get a stress test until the third day, perhaps because of scheduling problems, "those should not be situations to keep the patients in the hospital longer. They can get infections or fall or have complications," he says. "If you can just improve the efficiency of the case, it will be a big step."

Intensity of Service Is 'Irrelevant'

In light of the two-midnight presumption and benchmark, hospital utilization review committees "will have to figure out an action plan on educating physicians to think differently," Farber says. It's a new world when the medical necessity of an admission doesn't ride on location — ICU, a step-down unit or a med-surg floor, Farber says. "They are saying the whole range of clinical services and the provision of acuity is sort of irrelevant," he says. What matters in terms of admission is how long a patient is expected to stay in the hospital.

While orders can make or break an admission, Medicare auditors won't judge medical necessity on orders alone. "No presumptive weight" will be accorded physician orders or certifications; they will be assessed in the context of the whole medical record. But in a departure from the proposed IPPS regulation, CMS acknowledges that in some circumstances, the ordering and treating physician may be different people (e.g., emergency room physician, hospitalists and residents). Either way, orders must be signed by qualified, licensed practitioners who have hospital admitting privileges and know about the patient's condition and plan of care.

CMS also says that admissions may be appropriate when patients are transferred, leave against medical advice or die before staying for two midnights.

The two-midnight rule probably isn't a cost-cutting measure, Farber says. CMS actuaries expect it to cause 400,000 more inpatient admissions while converting 360,000 short stays to observation. But Jeffrey Epstein, senior medical director for quality, case management and resource utilization at Stamford Hospital in Connecticut, is convinced the two-midnight rule is all about the desire to fill Medicare coffers. "Why not be honest? It is all about money because whether it is inpatient or outpatient, it is all the same," he says. Some hospitals may be financially devastated. "Let's say you have $200 million per year in Medicare revenue. If they take back 1%, that is $2 million," Epstein says. "A hospital may only be making a $2 million profit, so that's it. If they are only making $1 million, they may be in the red."

Epstein agrees the "old rules" about observation and inpatient admission made sense. What's changed is that RACs and MACs apply different rules to Medicare claims. "We threw a strike, and they called a ball," he contends.

There will be elaboration on the two-midnight rule, with CMS planning one or two more open-door forums. It's also updating Medicare manuals accordingly and developing educational materials. Dupee encourages providers to e-mail any questions to ippsadmissions@cms.hhs.gov.

Contact Farber at Jeffrey.farber@mssm.edu, Wuebker at rwuebker@ehrdocs.com and Epstein at jepstein1@stamhealth.org. View the final rule, which will be published in the Aug. 19 *Federal Register*, at http://tinyurl.com/m53qko4. ✧