Proposed Changes to the Two Midnight Rule and CMS Enforcement of Patient Status Reviews

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Program Agenda

• Learn about the events that led to the Two Midnight Rule
• Learn how the Two Midnight Rule works
• Learn about the proposed changes to the Two Midnight Rule
• Explore the implications of CMS’s decision to shift “patient status” reviews to QIOs
Events Preceding The Two Midnight Rule
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- Recovery Audit Contractors (RACs) concentrated reviews on short stay cases
- Medicare contractor denials of short stays as medically unnecessary focused attention on:
  - Inpatient admission criteria
  - CMS policy on billing Part B for services after Part A inpatient stay was denied
  - Increase in frequency and duration of observation services
CMS’s Policy Evolution

• FY 2013 OPPS Proposed and Final Rules
  — Solicited comments on “policy changes . . . to improve clarity and consensus . . . regarding the relationship between admission decisions and appropriate Medicare payment”

• CMS Ruling 1455-R and Final A to B Rule
  — Retroactive and prospective changes to CMS Part A to Part B rebilling policy
  — Rebilling limited to one-year after date of service

• FY 2014 IPPS Final Rule
  — Two Midnight Rule announced
Medicare Appeals Backlog

• The Medicare appeals system could not sustain the number of appeals emanating from contractor reviews (particularly RAC reviews).

• December 2013: OMHA announces that it has stopped assigning ALJ appeals.
  — Stated that ALJ assignments would likely not resume for at least 24-28 months and post-assignment hearing wait times would likely continue to exceed an additional 6 months.

• April 2015: At Senate Finance hearing, Chief ALJ Griswold states that adjudication time frames have increased to 572 days (as of February 2015), and will continue to increase.
Current Environment

• August 29, 2014 – CMS tenders global offer to settle patient status denials on appeal at 68%.

• As of June 1, 2015 – 1,900+ hospitals (300,000 claims) have settled for $1.3 billion in payments.

• Two Midnight Probe & Educate policy extended again through December 31, 2015.

• July 1, 2015 – CMS Releases 2016 OPPS Proposed Rule with proposed changes to the Two Midnight Rule and announcements regarding patient status reviews.
How Is the Two Midnight Rule Suppose to Work?
Inpatient Admission Guidance Before the Two Midnight Rule

• Benefit Policy Manual, Chap. 1, § 10.
  — Decision to admit is a “complex medical judgment” that can only be made by physician after considering several factors, such as:
    o Patient medical needs and history
    o Severity of signs and symptoms
    o Likelihood of adverse event
  — 24 hour benchmark
    o Admit if hospital care expected for 24 hours or more
The Two Midnight Benchmark

- New 42 C.F.R. § 412.3(e).
  - Inpatient admission and Part A payment is “generally inappropriate” if the physician does not expect the patient to require a stay that will “cross 2 midnights” (except for Inpatient Only)
  - Physician to look at factors such as:
    - Patient history and comorbidities
    - Severity of signs and symptoms
    - Current medical needs and risk of adverse event
  - Applies to all hospitals except IRFs
The Two Midnight Benchmark

• New 42 C.F.R. § 412.3(e), cont’d:
  — Factors that lead to two-midnight expectation must be documented in medical record
  — “Unforeseen circumstances” resulting in shorter stay will not rule out Part A payment
    o Death
    o Transfer
    o Departures against medical advice
    o Clinical improvement
    o Election of hospice
The Two Midnight Benchmark

• There are few exceptions to the benchmark:
  — Procedures on the “inpatient only” list at 42 C.F.R. § 419.22(n)
  — “Rare and unusual circumstances”
    o Only example identified by CMS: Mechanical ventilation initiated during present visit
    o CMS asked the provider community for other examples of cases that potentially might fit into this “rare and unusual” exception
  — Not rare and unusual according to CMS:
    o Admission for telemetry
    o Admission to an intensive care unit (ICU)
The Two Midnight Benchmark

• Calculation of time for physician’s expectation of two-midnight stay:
  — Clock starts when beneficiary begins receiving hospital services
  — Includes time beneficiary spends receiving outpatient services within the hospital (e.g., observation services, ED treatment)
The Two Midnight Presumption

- If inpatient stay from point of valid admission order to discharge lasts “two midnights,” the inpatient stay is presumed by Medicare medical reviewers to be medically necessary.

- If inpatient stay is less than “two-midnights,” medical reviewers will evaluate whether stay meets the Two Midnight Benchmark.
  
  — Medical record supports reasonable expectation that hospital services (including outpatient services) were needed for period greater than “two midnights” and were provided
Physician Order Requirement

• New 42 C.F.R. § 412.3:
  — Requires a physician order for Medicare Part A payment:
    o Entered in the medical record
    o Furnished at or before the time of admission
    o Signed before discharge
Physician Certification

- Initial Certification requirement for Part A payment for all inpatient stays prior to discharge:
  - Authentication of order
  - The reasons for inpatient services
  - Estimated time for required hospital stay

- In the FY 2015 OPPS Final Rule, CMS revised the requirement so that a physician certification is only required for long-stay cases — defined as 20 days or longer — or outlier cases, effective January 1, 2015. However, CMS did not change the requirement that the physician order must be authenticated prior to discharge.
Partial Enforcement Delay: Probe & Educate

• First announced in Sept. 2013, extended in January 2014

• Allows MACs to conduct Probe & Educate

• No RAC reviews of patient status for claims with dates of service in this range
Partial Enforcement Delay: Probe & Educate

• Protecting Access to Medicare Act of 2014
  — Enacted on April 1, 2014
  — Extended prohibition on patient status reviews through March 31, 2015

• Medicare Access and CHIP Reauthorization Act of 2015
  — Extended prohibition on patient status reviews through December 31, 2015
The 0.2% Two Midnight Rate Cut

• When CMS finalized the Two Midnight Rule, the agency also finalized a 0.2% reduction in inpatient rates to offset predicted shifts in utilization between inpatient and outpatient settings.

• Predicted net 40,000 additional inpatient encounters.

• Rate cut carries forward each year and has been adopted in 2014, 2015 and now 2016

• Rate cut has been challenged in federal court
Legislative Attention

- Opening Statement, Chairman Kevin Brady, House Ways & Means Health Subcommittee (May 27, 2014).

“As I have talked with stakeholders about current issues in the Medicare program, the two-midnights policy comes up over and over again. In listening to a variety of different perspectives, I have come to understand . . . [that] [t]here are misaligned incentives in CMS’ inpatient and outpatient payment systems.”
MedPAC Recommendations: 
June 2015 Report to Congress

- MedPAC covers four general areas:
  - Payment policy approaches for short hospital stays
  - The RAC program – reducing burden and increasing RAC accountability for overturned claim denials
  - A hospital short stay penalty
  - Beneficiary financial liability
What Are the Proposed Changes to the Two Midnight Rule?
Proposed Expansion of “Rare and Unusual” Exception to Two Midnight Rule

• CMS will allow for “Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the Two Midnight Benchmark, if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care despite an expected length of stay that is less than two midnights.”
Proposed Expansion of “Rare and Unusual” Exception to Two Midnight Rule

• “The following factors, among others, would be relevant to determining whether an inpatient admission where the patient stay is expected to be less than 2 midnights is nonetheless appropriate for Part A payment:
  — The severity of the signs and symptoms exhibited by the patient;
  — The medical predictability of something adverse happening to the patient; and
  — The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).”
Déjà Vu?

- Pre-Two Midnight Standard (Benefit Policy Manual, Chap. 1, § 10).
- “Factors to be considered when making the decision to admit include such things as:
  - The severity of the signs and symptoms exhibited by the patient;
  - The medical predictability of something adverse happening to the patient;
  - The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) . . . and
  - The availability of diagnostic procedures at the time when and at the location where the patient presents.”
Proposed Expansion of “Rare and Unusual” Exception – Medical Review

• Admissions will be reviewed on a case-by-case basis.
  — Admissions must be reasonable and necessary and supported by clear *documentation* in the patient’s medical record.
  — Inpatient admissions that do not span at least 1 midnight will be prioritized for medical review.

• Review criteria.
  — Medicare review contractors may continue to use commercial screening tools, although not binding.
  — CMS is “inviting public comments on whether specific medical review criteria should be adopted for inpatient hospital admissions that are not expected to span at least 2 midnights and, if so, what those criteria should be.”
Proposed Expansion of “Rare and Unusual” Exception – Medical Review

• Minor surgical procedures or short treatments.
  — CMS would expect it to “be rare and unusual for a beneficiary to require inpatient hospital admission after having a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight.”
  — CMS will monitor the number of these types of admissions and plan to prioritize these types of cases for medical review.
Medical Review
Changes:
QIOs and RACs
Medical Review Changes: QIOs and RACs

• In the Proposed Rule, CMS also announced changes regarding the review of patient status claims.

• No later than October 1, 2015, CMS intends to have Quality Improvement Organization (QIO) contractors conduct post-payment reviews of short inpatient stays rather than the Medicare Administrative Contractors (MACs).

• QIOs will educate hospitals about claims denied under the Two Midnight policy and will collaborate with hospitals to develop a quality improvement framework.

• Those hospitals that are found to have high denial rates will be referred to RACs for further audits.
What is a QIO?

- A QIO is a group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare.
- QIOs work under the direction of CMS.
- By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.
- CMS identifies the core functions of the QIO Program as:
  - Improving quality of care for beneficiaries;
  - Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
  - Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities.
Referral to RACs

• QIOs will review a sample of post-payment claims and make determination of medical appropriateness of the inpatient admission.

• “Providers found to exhibit a pattern of practices, including, but not limited to: having high denial rates and consistently failing to adhere to the 2-midnight rule (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 recovery auditors 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.
Reflections and Practical Implications
Potential Benefits of the Proposed Two Midnight Change

• Adds another way for providers to defend inpatient stays that are less than two midnights.

  — Inpatient stays that are less than two midnights may be appropriately defended as payable in the following two circumstances:

  o Where the stay meets the Two Midnight Benchmark—that is, the beneficiary receives both outpatient and inpatient services for a period of time lasting more than two midnights.

  o Where it can be demonstrated in the medical record that a physician appropriately determined the patient required inpatient services although the stay was brief and did not meet the Two Midnight Benchmark.
Potential Challenges of Proposed Two Midnight Change

• Standards for review are far from clear.
  – Time-based?
  – Severity of illness?
  – Level of care?
  – How is “rare and unusual” defined?
  – CMS does not provide any examples of cases that would fit expanded exception
CMS Guidance is Uncertain

- Level of Care.

  - August 2013: “[T]he beneficiary’s required “level of care” is not part of the guidance regarding hospital inpatient admission decisions.” 78 Fed. Reg. 50947

  - July 2015: We propose that Medicare Part A payment is appropriate if the physician determines “patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights” 80 Fed. Reg. 39350
CMS Guidance is Uncertain

• Review Criteria.
  — Screening tools are “are not binding on the hospital, CMS or its review contractors.” 80 Fed. Reg. 39351
  — “We are inviting public comments on whether specific medical review criteria should be adopted for inpatient hospital admissions that are not expected to span at least 2 midnights and, if so, what those criteria should be.” 80 Fed. Reg. 39222
Potential Challenges of Proposed Two Midnight Change

• Significant resources required to re-train and re-educate.
  — Providers have already invested substantial resources in compliance with the Two Midnight Rule
  — Difficult to operationalize a vague standard

• Physician documentation challenges.
Patient Status Reviews

- How will QIOs be trained to conduct patient status reviews?
  - MACs have been conducting patient status reviews under the Probe & Educate program

- What will QIO review look like?
  - CMS describes as “peer review”

- How will a “high error rate” for provider referral to RACs be defined?
  - Another backlog of appeals?
Potential Short Stay DRG?

• In the Proposed Rule, CMS noted that several stakeholder groups have examined short-stay payment policies, but that there is no consensus on what a short-stay payment policy should be.