



## Comprehensive Observation Services and the 2-Midnight Rule – Part 1

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Mary Guyot

Principal

[mguyot@stroudwater.com](mailto:mguyot@stroudwater.com)

207-650-5830 (cell)



NATIONAL  
RURAL HEALTH  
RESOURCE CENTER

STROUDWATER ASSOCIATES

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# Objectives for Part 1

- **The participant will be able to:**
  - **Enumerate at least 3 key reasons for having a good understanding of Observation services**
  - **Explain key components of determining the need for Observation services**
  - **Verbalize the key components of medical necessity documentation**
  - **Implement processes to manage the 2-Midnight rule**
  - **Discuss the role of UR staff regarding meeting admission criteria**

The background of the slide is a vibrant blue sky filled with soft, white, fluffy clouds. The clouds are scattered across the frame, with some appearing more prominent than others. The overall tone is bright and clear.

## **Why The Need To Know**

# Why The Need To Know?

- ❑ Ensure compliance with Observation services
- ❑ Prevent “pay-back” to CMS through MAC and RAC’s reviews
- ❑ IP criteria is becoming more difficult to meet but those same patients may meet Observation criteria hence potential for revenue while providing needed care for the patient
- ❑ New 2MN rule must be understood by physician and staff – though it may be a reprieve, it is still important to identify the correct service needed from the get-go as much as possible to prevent high level of 1-day acute stays

# Why The Need To Know?

- ❑ Understand that Medicare does not pay for Observation services greater than 48 hours – may be a lost opportunity if the patient met medical necessity for IP services
- ❑ Observation stay increases out of pocket cost to the beneficiary – 20% since Observation is an OP service therefore important to use the service appropriately
- ❑ CMS now allow hospitals to rebill a retrospectively determined inappropriate admission as an outpatient visit under Part B. Hospitals can do so for up to one year from the point of service
- ❑ It takes a team to be on the same page – no one person alone can manage Observation services

# AHA RACTrac Why The Need To Know?

- ❑ RAC is reviewing medical records and other medical documentation to identify improper payments to providers. Improper payments include:
  - incorrect payment amounts;
  - incorrectly coded services (including Medicare Severity diagnosis-related group (MS-DRG) miscoding);
  - non-covered services (including services that are not reasonable and necessary); and
  - duplicate services
  
- ❑ Of 1,165 hospitals who participated in the AHA RACTrac in the Q1 of 2014 (see next slide):
  - 59% of hospitals indicated they experienced short-stay medical necessity denials
  - 59% of hospitals also received denials for inpatient coding, an increase of 8% from Q4 2013
  - The majority of medical necessity denials reported (66%) were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was not medically necessary
  
- ❑ RAC appeals are costly (staff time and consultant cost)

## **RACTrac Findings**

Based on RAC (Recovery Audit Contractors) Reviews



[See AHA RACTrac Initiative – what it is?](#)

<http://www.aha.org/advocacy-issues/rac/ractrac.shtml>

See Results of most recent AHA RACTrac Survey (Q1, 2014)

<http://www.aha.org/content/14/14q1ractracresults.pdf>





## **What is Outpatient Observation?**

# What is Outpatient Observation?

- ❑ Observation is a service in an OP status.
  - Status for Medicare = IP, OP and Non-Patient (such as a lab specimen)
- ❑ Observation care is a well-defined set of specific, clinically appropriate services that include:
  - Observation is an **OP service** therefore OP rules apply
  - A **hospital-based** service which represents a category or a patient status
  - **Determined by a physician's order**
  - Observation services include **“Ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patient will require further treatment as hospital IP or if they are able to be discharged from the hospital “**
  - See Medicare Benefit Policy Manual 6 20.6A and 20.6B

# What is Outpatient Observation?

- ❑ “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 tests”. - Medicare Benefit Policy Manual 6 20.6A
  
- ❑ 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 should be **made in less than 48 hours.**
  
- ❑ Hospitals may bill for patients who are placed in Observation from ED or referred to the hospital for outpatient observation services.
  - A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the emergency department (ED) visit.



**Physician Documentation Required for Observation**

**When is Observation Not Appropriate**



# Required Documentation

- ❑ A physician **order** for the patient to be **placed in Observation** with specification as to where such in ICU, telemetry bed, ED or in Med/Surg
- ❑ Order must be **dated and timed and may not be after the fact**
- ❑ The physician must also document that they explicitly **assessed patient risk** to determine that the beneficiary would benefit from observation care vs straight OP followed by a discharged from ED
- ❑ **Medical necessity documentation** for Observation services
  - Some patients are discharged and others placed in Observation – physician needs to document what made him/her decide to place in Observation vs discharging them
- ❑ **PRN documentation** by the provider based on patient's condition
- ❑ **Discharge documentation**

# Appropriate OP Observation Placement

- ❑ Per Medicare, **examples include:**
  - Patients, with a **fixed diagnosis**, who are **likely to respond quickly** to therapeutic interventions.
  - Patients with **rule-out or symptomatic** admissions who are receiving diagnostic testing and possible therapeutic interventions to determine the medical condition and need for an inpatient hospitalization such as:

Abdominal pain	Asthma	Atrial fib	Cardiac arrhythmia
Chest pain	CHF	COPD with increased dyspnea	Dehydration
Gastroenteritis	Lithium imbalance	Palpitations	Unstable angina
Observation to determine whether labor exists	Possible overdose	Nausea and vomiting	Possible infectious process

# Appropriate Observation Cases

1. Unconfirmed acute diagnosis that will require more intensive service if it is confirmed or, stated otherwise, **symptoms suggesting a diagnosis that must be ruled out** (e.g., chest pain, abdominal pain, TIA)
2. Conditions **requiring further monitoring** and evaluation to determine the appropriate diagnosis and the need for admission
3. Diagnosed cases **likely to respond to limited treatment in less than 2 midnights**
4. Brief stays **following a planned OP surgery/procedure due to complications**, that require additional monitoring and evaluation beyond what is expected in the normal course of recovery for the procedure that was performed

❑ Medicare asks:

“Could they have been treated as OP vs IP?”

Chest Pain	Lower back pain
Simple pneumonia	Renal colic
Asthma/COPD	UTI
Atrial arrhythmias	Fracture / sprain / strain of arm or leg
CHF	Syncope or decreased responsiveness
Gastroenteritis / Esophagitis	Dialysis



- ❑ **Observation may not be ordered for** a pre procedure prep, including pre-op hydration or “renal protection protocol” or for cardiac or medical clearance
- ❑ If prep or clearance cannot be done outside hospital due to patient issues (bed bound, dementia, requires supervision, etc.) consider **“outpatient in a bed”**
- ❑ If patient given **ABN** (Advance Beneficiary Notice) hospital **can bill patient for pre op services under Part B but cannot bill for room & board** – Hospital may not bill for pre-op services under part B if ABN was not provided
- ❑ Pre-op orders should **never include post-op observation**
- ❑ IP or Observation cannot be billed for if the **pre or post-op stay is the surgeon’s preference** with no documentation of medical necessity for such

# Appropriate Observation Post Surgery/Procedures

- Persistent nausea/vomiting
- Fluid/electrolyte imbalance
- Uncontrolled pain
- Dysrhythmias
- Excessive/uncontrolled bleeding
- Psychotic behavior
- Unstable level of consciousness
- Deficit in mobility/coordination
- Exceptionally long delay from anesthesia recovery

**Recovery Room nurse notes must support the patient's post-operative medical needs in their documentation**

## Claims processing manual refers to:

- ❑ A post routine recovery period and gives an example of recovery as **4 to 6 hours (guideline)**
- ❑ A patient cannot be placed in Observation **“to remain under nursing care** for a period of time to make sure the patient may be discharged safely” — **that is recovery.**
- ❑ Observation is **not for** those patients whose surgeon anticipates a **medically monitored overnight stay** for the patient
- ❑ In the case where the surgeon had ordered an overnight stay and the patient shows atypical S & S, the patient may then be placed in Observation if the **physician documents a medical problem and issues new orders** to support the present situation

# Non-Covered Observation Services

- ⊘ Services are **not reasonable or necessary for the diagnosis or treatment** of the patient
- ⊘ If the patient will require hospitalization for **2 MNs** or greater accompanied by medical necessity documentation
- ⊘ Services are provided for the **convenience of the patient, the patient's family, or a physician**, (e.g., following an uncomplicated treatment or a procedure, physician busy when patient is physically ready for discharge, patient awaiting placement in a long term care facility...
- ⊘ **Social factors** such as transportation issues, inability to provide for activities of daily living, patient convenience or homeless conditions
  - Above the social issue, the **provider must be able to document what is medically going** on which is compounded by lack of family support

## **NOT OP Observation services when;**

- ⊘ Not to **hold a stable patient while waiting for** availability of procedures or tests such as (not all inclusive)
  - **OR due to scheduling** issues (example: patient stable but will need GB surgery the following day when physician is available)
  - Not to place a patient in Observation **because they will need a test** such as an MRI and the unit is **not available until the next day**
  - Stable chest pain **awaiting for specialty consultation** to perform stress test scheduled within 1-2 days
- ⊘ **Outpatients who** require only OP blood administration, OP allergy injections, chemotherapy, IPPB, IM/IV medications or hemodialysis

## **NOT OP Observation services when;**

- ⊘ **Outpatient diagnostic services** including cardiac catheterization, electrocardiogram, glaucoma tests, myelogram, bone scan, X-rays, IVP, cystoscopy, endoscopy, aortogram, ultrasound, CAT scan, nuclear medicine scan, and physical therapy evaluation
  
- ⊘ **Standing orders for Observation following outpatient surgery**
  - **Post-op observation** may not be ordered based on risk assessment alone (history, frailty, comorbidities); there **must be an identifiable event**
  - Recovery period can be extended if surgeon is concerned about post-op risk and **use observation or inpatient admission if a complication occurs**



## **The 2-Midnight (MN) Rule**

## 2-Midnight Rule

### ❑ **CMS wants to limit the use of observation to reduce its financial burden on Medicare beneficiaries.**

Observation stays result in greater out-of-pocket expenses for beneficiaries and do not count toward the three-day eligibility requirement for Medicare skilled nursing facility (SNF) coverage.

- CMS was particularly concerned about the growth in long-stay observation cases (those greater than 48 hours) which had increased from 3% of all observation cases in 2006 to 8% in 2011.

### ❑ As **part of the Final Rule**, CMS formulated a “2-midnight presumption” and a “2-midnight benchmark” (collectively the “**2-Midnight Rule**”) **to guide admitting practitioners** and review contractors on when it is appropriate to admit a patient as a hospital inpatient.



## 2-Midnight Rule

- ❑ The **2-midnight benchmark** states that if the admitting practitioner admits a Medicare beneficiary as an inpatient with the **reasonable expectation that the beneficiary will require care that “crosses 2 midnights,”** Medicare Part A payment is “generally appropriate,” **assuming medical record documentation justifies the admission.**
  
- ❑ The final rule addresses this problem on two fronts.
  - First, **CMS revised its guidance on inpatient admissions** by stating that an admission is appropriate if the stay requires duration of at least **two midnights including OP services** such as ED and Observation prior to admission or **care at a transferring hospital prior to a transfer**
  
  - Secondly, CMS **removed some of the previous financial disincentive for inpatient admission** (such as a potential short-stay payment denial) by allowing hospitals to rebill a retrospectively determined inappropriate admission as an outpatient visit under Part B. **Hospitals can do so for up to one year from the point of service.**

## 2-Midnight Rule

- ❑ **CMS contractors are to operate under the presumption that** stays of at least two midnights are medically necessary, with the “clock” beginning when the patient starts receiving hospital services (including observation services).
- ❑ **CMS has clarified that** if a patient stays one midnight in observation and the physician expects that the patient will require at least another midnight in the hospital, the patient can be appropriately admitted despite the fact that it is a one-day inpatient stay. If a patient is admitted but ultimately doesn't stay two midnights, clear physician documentation supporting the order and expectation of two midnights will be required.

## 2-Midnight Rule

- ❑ **CMS says that the expectation of a two-midnight stay is sufficient justification for admission**, even though there may be unforeseen circumstances such as transfers or self-discharge that result in the **eventual length of stay not meeting the physician's initial expectation**.
  
- ❑ **CMS specifically states that the medical record should clearly indicate why a physician** deemed an inpatient stay necessary, supported by complex medical factors including patient history, the presence of comorbidities, the severity of signs and symptoms, current patient care requirements (medical needs), and the risk of an adverse event
  - **It does not suffice to admit them to IP if we know that the only reason they will be in for 2 MN is that there is lack of family support – must have an active medical condition**

## 2-Midnight Rule

- ❑ CMS states that in deciding whether an inpatient admission is warranted, the **physician must assess**
  - whether the beneficiary requires hospital services and
  - whether it is expected that such services will be required for 2 or more midnights.
  - the decision to admit the beneficiary as an inpatient is a complex medical decision made by the physician in consideration of various factors, including the beneficiary's age, disease processes, comorbidities, and the potential impact of sending the beneficiary home.
  
- ❑ **It is up to the physician to make the complex medical determination** of whether the beneficiary's risk of morbidity or mortality dictates the need to remain at the hospital because the risk of an adverse event would otherwise be unacceptable under reasonable standards of care, or whether the beneficiary may be discharged.

## 2-Midnight Rule

- ❑ **If, based on the physician's evaluation of complex medical factors and applicable risk**, the beneficiary may be safely and appropriately discharged, then the beneficiary should be discharged, and hospital payment is not appropriate on either an inpatient or outpatient basis.
- ❑ If the beneficiary is expected to **require medically necessary hospital services for 2 or more midnights**, then the physician should order inpatient admission and Part A payment is generally appropriate per the 2-midnight benchmark.
- ❑ **Except** in cases involving services identified by CMS as **surgical inpatient-only**, if the beneficiary is expected to require medically necessary hospital services for **less than 2 midnights**, then the beneficiary generally should remain an outpatient (**straight OP or Observation**)

## 2-Midnight Rule - Requirements

- ❑ In order for a hospital to be paid under IP Medicare Part A the following must be present:
  - **Clear admission to IP order from the provider**
  - **Qualification of the ordering provider** (see 42 CFR 412.3(b))
    - The ordering practitioner must be **licensed by the state** and have **privileges to admit** to the hospital. The ordering practitioner must be **knowledgeable about the patient's care and condition at the time of admission**
    - CMS designates **ordering practitioner** as:
      - The attending physician or PCP of record or a physician on call for them
      - Primary or covering specialist caring for the patient
      - A surgeon responsible for a major surgical procedure on the patient or surgeon on call
      - Emergency or clinic practitioner caring for the patient at the point of admission or
      - A practitioner qualified to admit and actively treating the patient at the point of admission

## 2-Midnight Rule – Physician Certification

- ❑ Content: **The physician certification includes the following information:**
  - **Authentication of the practitioner order:** The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and in the case of services not specified as inpatient-only under 42 CFR 419.22(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark. **The requirement to authenticate the practitioner order may be met by the signature or countersignature of the inpatient admission order by the certifying physician.**
  - **Reason for inpatient services:** The physician certifies the reasons for either— (i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for outlier cases under the applicable prospective payment system for inpatient services. **For example, documentation of an admitting diagnosis could fulfill this part of the certification requirement.**

## 2-Midnight Rule

- ❑ Requirements: **Physician Certification**
  - **The estimated (or actual) time** the beneficiary requires or required in the hospital: The physician certifies the **estimated time** in the hospital the beneficiary requires (**if the certification is completed prior to discharge**) or the **actual time** in the hospital (if the certification is **completed at discharge**). Estimated or actual length of stay is most commonly reflected **in the progress notes** where the practitioner discusses the assessment and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented **in the order or a separate certification or recertification form**, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.
  - **If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed**, 42 CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. **The physician may certify the need for continued inpatient admission on this basis.**



### ❑ Requirements: **Physician Certification (cont')**

- **Includes** the plans for post-hospital care, if appropriate, and as provided in 42 CFR 424.13. **(discharge plan)**
- For inpatient **CAH services only**, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within **96 hours after admission** to the CAH.
  - Time as an outpatient at the CAH does not count towards the 96 hours requirement. **The clock for the 96 hours only begins** once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour inpatient limit.

### ❑ **Requirements: Physician Certification (cont')**

- If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within **96 hours** after admission to the CAH and **something unforeseen occurs** that causes the individual to stay longer at the CAH, there would not be a problem with regards to the CAH designation as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay – **what was unforeseen must be clearly documented**

- ❑ **Inpatient Rehabilitation Facilities (IRFs)**: The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

### ❑ Requirements: Timing

- Timing: Certification **begins with the order for inpatient admission.**
- The certification must be **completed**, signed, dated and documented in the medical record **prior to discharge**,
- **except for outlier cases** which must be certified and recertified as provided in 42 CFR 424.13.
- **Under extenuating circumstances, delayed initial certification** or recertification of an outlier case may be acceptable as long as it **does not extend past discharge.**
- With regard to **the time of discharge**, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the physician as having to occur prior to discharge (e.g., “discharge after supper” or “discharge after voids”). So **discharge itself** can but does not always coincide exactly with the time that the discharge order is written, rather it **occurs when the physician’s order for discharge is effectuated.**

## 2-Midnight Rule

### ❑ Requirements: Timing (cont')

- The **order** must be furnished **at or before the time of the inpatient admission.**
- The order **can be written in advance of the formal admission (e.g., for a pre-scheduled surgery)**, but the inpatient admission does not occur until formal admission by the hospital.
- Conversely, in the unusual case in which a patient is formally **admitted as an inpatient prior to an order to admit and there is no documented verbal order**, the inpatient stay should not be considered to commence until the inpatient admission order is documented.
- **Medicare does not permit retroactive orders .**  
Authentication of the order is required prior to discharge and may be performed and documented as part of the physician certification.

### ❑ **Requirements: Authorization to sign the certificate**

- Certifications and recertifications must be signed by the 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 (or by the dentist as provided in 42 CFR 424.11).

## 2-Midnight Rule

### □ Requirements: Authorization to sign the certificate (cont')

- Medicare considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician:
  - the admitting physician of record ("attending") or a physician on call for him or her;
  - a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her;
  - a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility,
  - a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above.
  - The admitting physician of record may be an emergency department physician or hospitalist.
  - Medicare does not require the certifying physician to have inpatient admission privileges at the hospital.

### □ Requirements: Authorization to sign the certificate (cont')

- The ordering practitioner may be, but is not required to be, the physician who signs the certification. Please see section (B)(3) for a discussion of the requirements to be knowledgeable about the patient's hospital course. See section (A)(3) for the list of physicians authorized to certify a given case.
- The admission decision (order) may not be delegated to another individual who is not authorized by the state to admit patients, or has not been granted admitting privileges by the hospital's medical staff (42 CFR 412.3(b)). **However, a medical resident, a physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner** provided they are authorized under state law to admit patients and the requirements outlined below are met.

### □ Requirements: Authorization to sign the certificate (cont')

- **Residents and non-physician practitioners** authorized to make initial admission decisions- Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same. The ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by counter-signing the order prior to discharge.
  - In countersigning the order, the ordering practitioner approves and accepts responsibility for the admission decision.
  - This process may also be used for physicians (**such as emergency department physicians**) who do not have **admitting privileges** but are authorized by the hospital to issue temporary or "bridge" inpatient admission orders.
- The countersigned order satisfies the order part of the physician certification, as long as the ordering practitioner also meets the requirements for a certifying physician in section (A)(3).



## 2-Midnight Rule

- ❑ **Requirements: Authorization to sign the certificate (cont')**
  - **Verbal orders-** At some hospitals, practitioners who lack the authority to admit inpatients under state laws and hospital by-laws (such as a **registered nurse**) **may nonetheless enter the inpatient admission order as a verbal order.**
  - In these cases, the ordering practitioner directly communicates the inpatient admission order to staff as a verbal (not standing) order, and the **ordering practitioner need not separately record the order to admit.**
  - **Following discussion with and at the direction of the ordering practitioner,** a verbal order for inpatient admission may be documented by an individual who is not qualified to admit patients in his or her own right, as long as that documentation (transcription) of the order for inpatient admission is in accordance with state law including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

## 2-Midnight Rule

### ❑ Requirements: Verbal order (cont')

- In this case, the staff receiving the verbal order **must document the verbal order** in the medical record at the **time it is received**. The order **must identify the qualified "admitting practitioner"**, and **must be authenticated (countersigned) by the ordering practitioner** promptly and **prior to discharge**. (Please see (A)(2) for guidance regarding the definition of discharge time).
- A transcribed and authenticated verbal order for inpatient admission satisfies the order part of the physician certification as long as the ordering practitioner also meets the requirements for a certifying physician in section (A)(3).
  - Example: "Admit to inpatient per Dr. Smith" would be considered an acceptable method of identifying the ordering practitioner and would meet the verbal order requirement if the verbal order (1) is appropriately documented in the medical record by the individual receiving the verbal order when the order is received; and (2) is authenticated (countersigned) by Dr. Smith promptly, prior to discharge. If Dr. Smith meets the qualifications for a certifying physician, then the authentication (countersignature) of this order by Dr. Smith also meets the requirement for the order component of the certification.

### ❑ Requirements: Authorization to sign the certificate (cont')

- Commencement of inpatient status- **Inpatient status begins at the time of formal admission by the hospital pursuant to the physician order**, including an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)) that is countersigned timely, by authorized individuals, as required in this section.
- If the physician or other **practitioner responsible for countersigning an initial order or verbal order does not agree that inpatient admission was appropriate or valid** (including an unauthorized verbal order), he or she should not countersign the order and the **beneficiary is not considered to be an inpatient**. The hospital stay may be billed to Part B as a hospital outpatient encounter.

## 2-Midnight Rule

### ❑ Requirements: Format

- As specified in 42 CFR 424.11, **no specific procedures or forms are required for certification and recertification statements.**
- The provider may adopt any method that permits verification.
- The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form.
- Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification.
- If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.
  - See attached sample

## 2-Midnight Rule

- ❑ CMS reminds hospitals that while **medical review will not be focused on Part A claims spanning 2 or more midnights after formal inpatient admission under the presumption the inpatient admission was reasonable and necessary, physicians should** generally admit as inpatients beneficiaries they expect will require 2 or more midnights of hospital services, and should treat most other beneficiaries on an outpatient basis
  
- ❑ **Time spent in observation will not count** toward a patient's three-day inpatient stay requirement for SNF coverage.
  - Despite broadening the definition of an appropriate inpatient stay under the two-midnight rule, CMS will continue to exclude time spent under observation from the three-day requirement for SNF stays. **Inpatient stays do not begin until a physician writes an order** for patient admission; thus any time spent in observation preceding an admission will not count toward the length of stay requirement.

## 2-Midnight Rule

- In the final rule CMS provided that if a **Medicare Part A claim for inpatient hospital services is denied** because the inpatient admission was not reasonable and necessary, or if a hospital determines under § 482.30(d) or § 485.641 (utilization review) after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may bill Medicare for the Part B inpatient services (**furnished after the time of inpatient admission**) that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B.
  - These services must be submitted on a Part B inpatient claim
  - Likewise, the hospital cannot bill for social admission patient who did not meet criteria but if they had tests such as lab work, radiology or treatment such as PT, such can be billed on part B inpatient claim also

## 2-Midnight Rule

- CMS also provided that for beneficiaries **treated as hospital outpatients prior to an inpatient admission** who are enrolled in Medicare Part B, hospitals may continue to bill Part B for hospital outpatient services that were furnished in the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission.
  - These services must be submitted on a Part B outpatient claim.
  
- **When billing Part B following this type of Part A hospital inpatient claim denial**, hospitals cannot change a beneficiary's patient status from inpatient to outpatient. The beneficiary was formally admitted as an inpatient and there is no provision to change a beneficiary's status after he or she is discharged from the hospital. Therefore, the beneficiary is considered B outpatient claim, and is considered an inpatient for services billed on the **Part B inpatient claim**.

## 2-Midnight Rule

- ❑ For Part A claims with dates of admission on or after October 1, 2013, timely filing applies such that hospitals **must submit the Part B claims within 12 months of the date of service in order to receive payment** (78 FR 50922 through 50924)
  
- ❑ **RAC audits may occur up to three years after a patient service**, resulting in a payment denial with no recourse if a stay is determined medically unjustified
  - **Under the new Part B rebilling rules, hospitals will need to have processes in place to self-identify cases** that were inappropriately admitted so that they can rebill before the one-year filing requirement expires



## 2-Midnight Rule

### ❑ Exceptions to the 2-Midnight rule are:

- **IP only procedures** do not require an expectation of 2 midnights of care to qualify for IP payment under part A (see 42 CFR 412.3(e)(1))
- **Mechanical Ventilation** initiated during the present visit (newly initiated/non-chronic ventilation) is generally appropriate for an IP admission and Part A payment even if the provider expects the patient to only require 1 midnight of hospital care (see FAQ: 2-Midnight Patient Admission Guidance & Patient Status Reviews for Admission on or after October 1, 2013 – last updated 3/12/14)
- **Unforeseen and interrupting circumstances** such as unforeseen death, transfer to another hospital, departure against medical advice, or clinical improvement.

## 2-Midnight Rule

- ❑ **Short IP Stay (less than 2 MNs) – paid by MCare Part A**
  - **Unforeseen circumstances** (death, transfer, AMA)
  - The beneficiary received a medically necessary service on the **Inpatient-Only List** and was able to be discharged before 2 midnights passed, those claims would be appropriately inpatient for Part A payment
  - inpatient **stays spanning less than 2 midnights** will be evaluated in accordance with the 2 midnight benchmark during review, and payment **will be appropriate if the total time receiving medically necessary hospital care (including pre-admission services) spanned at least 2 midnights.**
  - Inpatient claims for patients who **unexpectedly improved** and were discharged in less than 2 midnights would be payable as long as the medical **record clearly demonstrated that the admitting physician had reasonable expectation of a 2 midnight stay** and the improvement

## 2-Midnight Rule

- **Short IP Stay (less than 2 MNs) – paid by MCare Part A**
  - There may be **rare and unusual cases where the physician did not expect a stay lasting 2 or more midnights but nonetheless believes inpatient admission was appropriate and documents such circumstance.**
    - The MACs are being instructed to deny these claims and to submit these records to CMS Central Office for further review.
    - If CMS believes that such a stay warrants an inpatient admission, CMS will provide additional subregulatory instruction and the Part A inpatient denial will be reversed during the administrative appeals process.
    - Medicare review contractors will review any claims that are subsequently submitted for payment in accordance with the most updated list of rare and unusual situations in which an inpatient admission of less than 2 midnights may be appropriate.

## 2-Midnight Rule

- ❑ **Examples of cases where the MAC or RAC reviewer may have concerns:**
  - Patients with known diagnoses entering a hospital for a specific **minor surgical procedure or other treatment** that is expected to keep them in the hospital for less than 2 midnights, would not be appropriately classified as inpatient and paid under Part A.
    - Minor therapeutic and diagnostic services as appropriately furnished outpatient on the basis of an expected short length of stay.
  - CMS does not believe that the use of **telemetry, by itself,** constitutes a rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation.
    - “We note that telemetry is neither rare nor unusual, and that it is commonly used by hospitals on outpatients (ER and observation patients) and on patients fitting the historical definition of outpatient observation (that is, patients for whom a brief period of assessment or treatment may allow the patient to avoid an inpatient hospital stay)”.

## 2-Midnight Rule

### □ Examples of cases where the MAC or RAC reviewer may have concerns (cont’):

- “We also specified in the final rule that we do not believe that the **use of an ICU, by itself**, would be a rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation.
  - In some hospitals, placement in an ICU is neither rare nor unusual, because an ICU label is applied to a wide variety of facilities providing a wide variety of services.
  - Due to the wide variety of services that can be provided in different areas of a hospital, we do not believe that a patient assignment to a specific hospital location, such as a certain unit or location, would justify an inpatient admission in the absence of a 2 midnight expectation.”

## 2-Midnight Rule

### □ MAC and RAC reviews:

- Any evidence of systematic gaming, abuse or **delays in the provision of care in an attempt to receive the 2-midnight** presumption could warrant medical review.
- In addition, CMS will not permit Recovery Auditors to review inpatient admissions of less than 2 midnights after formal inpatient admission that occur between **October 1, 2013 and September 30, 2014**
  - This is an **opportunity to put appropriate processes in place**
- MACs and Recovery Auditors **will not review any claims submitted by Critical Access Hospitals at this time**

## 2-Midnight Rule

### ❑ **MAC and RAC reviews:**

- ❑ The MACs are still required to review 10 (or 25) claims from all applicable providers within their jurisdiction to ensure compliance with CMS-1599-F.
  - Claims previously selected for review under the Probe & Educate process, but placed on a hold status in the shared systems, will continue to be reviewed by the MAC and a denial will be issued if an error is identified. If providers are found to be non-compliant with the new rule, CMS will provide education and additional corrective action, as appropriate

See CMS FAQ 10/1/13 for more Q&A re: Probe and Educate

- ❑ [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions\\_andAnswersRelatingtoPatientStatusReviewsforPosting\\_31214.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf)

## 2-Midnight Rule

### ❑ What counts in the 2MN?

- Consider time the beneficiary spent receiving outpatient services within the hospital. This will include services such as:
  - Treatments in the emergency department,
  - Observation services, and
  - Procedures provided in the operating room or other treatment area.
- From the medical review perspective, **while the time the beneficiary spent as a hospital outpatient before the beneficiary was formally admitted as an inpatient pursuant to the physician order will not be considered inpatient time**, it will be considered during the medical review process for purposes of determining whether the 2-midnight benchmark was met and, therefore, whether payment for the admission is generally appropriate under Medicare Part A.



## 2-Midnight Rule

### □ What counts in the 2MN?

- Whether the beneficiary receives services
  - in the emergency department (ED) as an outpatient prior to inpatient admission (for example, receives observation services in the emergency room) or
  - is formally admitted as an inpatient upon arrival at the hospital (for example, inpatient admission order written prior to an elective inpatient procedure or
  - a beneficiary who was an inpatient at another hospital and is transferred),
    - the starting point for the 2 midnight timeframe for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital which includes time spent at the transferring hospital

## 2-Midnight Rule

### ❑ What does not count in the 2MN?

- CMS notes that this instruction **excludes** wait times prior to the initiation of care,
  - and therefore **triaging activities** (such as vital signs before the initiation of medically necessary services responsive to the beneficiary's clinical presentation) must be excluded.
  - a beneficiary **sitting in the ED waiting room at midnight while awaiting the start of treatment** would not be considered to have passed the first midnight,
  - **but** a beneficiary receiving services in the ED at midnight would meet the first midnight of the benchmark.
- The Medicare review contractor **will count only medically necessary services responsive to the beneficiary's clinical presentation as performed by medical personnel.**

## 2-Midnight Rule

### ❑ Delays in the provision of care: CMS FAQ

- Section 1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body.
- As such, CMS' longstanding instruction has been and continues to be that **hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment.**
- Accordingly, CMS expects Medicare review contractors will exclude extensive delays in the provision of medically necessary services from the 2 midnight benchmark.

## 2-Midnight Rule

### □ CMS FAQ re: OP surgical case

- When would it be appropriate for the physician to utilize outpatient observation and when would it be appropriate to admit the beneficiary for inpatient hospital services post an OP surgery
  - If the beneficiary requires additional medically necessary hospital care beyond the usual anticipated recovery time for a minor surgical procedure, the physician should reassess the expected length of stay.
  - Generally, **if the physician cannot determine whether the beneficiary prognosis and treatment plan will now require an expected length of stay spanning 2 or more midnights, the physician should continue to treat the beneficiary as an outpatient.** If additional information gained during the outpatient stay subsequently suggests that the physician would expect the beneficiary to have a stay spanning 2 or more midnights including the time in which the beneficiary has already received hospital care, the physician may admit the beneficiary as an inpatient at that point.

### □ CMS FAQ 3/12/14 re: IP surgical case

- How will Medicare Review Contractors review cases in which a **surgical procedure is cancelled after inpatient admission**?
- MACs will issue determinations for such claims based on the general 2-Midnight benchmark instruction. In other words, if **the physician reasonably expects** the beneficiary to require a hospital stay for 2 or more midnights at the time of the **inpatient order** and formal admission, and this **expectation is documented in the medical record**, the inpatient admission is generally appropriate for Medicare Part A payment.

## 2-Midnight Rule

### ❑ Occurrence Span Code 72

- Effective December 1, 2013, Occurrence Span Code 72 was refined to allow hospitals to capture “contiguous outpatient hospital services that preceded the inpatient admission” on inpatient claims (See NUBC implementation calendar).
- Occurrence Span Code 72 is a voluntary code, but may be evaluated by CMS for medical review purposes.
- CMS reminds providers that claims for stays of less than 2 midnights after formal inpatient admission may still be subject to complex medical record review, to which Occurrence Span Code 72 may be evaluated and the 2-midnight benchmark applied.
- Information in the medical record will continue to be used to determine whether total outpatient and inpatient time met the 2-midnight benchmark.

## 2-Midnight Rule

- ❑ **CMS FAQ re: Departures against medical advice (AMA)**
  
- ❑ What if a physician writes an inpatient order based on the expectation that the beneficiary will require care spanning 2 or more midnights, but prior to the passage of 2 midnights the beneficiary **refuses any additional medical treatment and is discharged**, would this be considered an unforeseen circumstance?
  
- ❑ Under the 2 midnight benchmark, if a beneficiary refuses any additional care and is subsequently discharged, this will be considered similarly to departures against medical advice and could be **considered an appropriate inpatient admission, so long as the expectation** of the need for medically necessary hospital services spanning 2 or more midnights was reasonable at the time the inpatient order was written, and the basis for that expectation as well as the refusal of additional treatment, are documented in the medical record.

## 2-Midnight Rule

- ❑ **CMS FAQ re: will all inpatient stays of less than 2 midnights after formal inpatient admission be automatically denied?**
- ❑ **No.** Under the new guidelines we expect that the majority of short (total of zero or one midnight) Medicare hospital stays will be provided as outpatient services. Because this is based upon the physician's expectation, as opposed to a retroactive determination based on actual length of stay, we expect to see services payable under Part A in a number of instances for inpatient stays less than 2 total midnights after formal inpatient admission



## 2-Midnight Rule

### □ What is the role of UR in screening for admission criteria

- CMS states that if the beneficiary requires medically necessary hospital care that is expected to span 2 or more midnights, then inpatient admission is generally appropriate.
- If the physician expects the beneficiary's medically necessary treatment to span less than 2 midnights, it is generally appropriate to treat the beneficiary in outpatient status.
- If the physician is unable to determine at the time the beneficiary presents whether the beneficiary will require 2 or more midnights of hospital care, the physician may order observation services and reconsider providing an order for inpatient admission at a later point in time
- While utilization review (UR) committees may continue to use commercial screening tools to help evaluate the inpatient admission decision, the tools are not binding on the hospital, CMS or its review contractors.
- In reviewing stays lasting less than 2 midnights after formal inpatient admission (i.e., those stays not receiving presumption of inpatient medical necessity), Medicare review contractors will assess the reasonableness of the physician's expectation of the need for and duration of care based on complex medical factors

## 2-Midnight Rule

### □ What is the role of UR in screening for admission criteria

- Do not do away with UR for Medicare patients
  - Initiate if not in place
- Should be checking for admission order and certification
- Review for documentation to support 2 MN including the start of OP care, admission order and certification before discharge if not on admission
- Check if the admitting MM was provided and provide the discharge MM
- Retrospective review of those admitted and discharge during UR time off and discuss with business office if lacking the required documentation
- Continue review of non-Medicare patients
- Review of chart on a daily basis to ensure that they continue needing IP stay and discuss issues with the provider and manage LOS
- Re-check status of the Observation patients and discuss with provider before leaving for the day to determine discharge or admission
- CAH UR to calculate the 96 hr beginning and end

## 2 Midnight (MN) Rule

### ❑ Scenario 1:

Patient in to ED at 10:00 PM Sun night → triage then registration 10:25 to ED exam room → 12:30 AM the patient is admitted by the ED provider with expectation that the patient will be at the hospital for at least 1 more MN

Monday am, PCP agrees based on present status so patient remains at the hospital

Tuesday am the patient is discharged

Bill Medicare for an IP stay (PPS hospitals bundle in the ED and CAH bill for IP over and above the ED services based from the time the order was written for admission)

Patient would have required Mon-Tue-Wed night as IP for SB/SNF because though Sun night counted for the 2 MN, it does not count for SB/SNF discharges

## 2 Midnight (MN) Rule

### ❑ Scenario 2:

Patient in to ED at 9:00 AM Sat and placed in Observation at 11:30 AM

PCP/Hospitalist visits and examines patient on Sat at 1:00 PM

PCP believes that the patient will not require 2 MN and leaves the patient in Observation

PCP returns Sun at 8:00 AM and now believes the patient will require to stay in the hospital Sun night hence 2 MN

Writes the order and certifies the need for 2 MNs

Patient discharged on Monday

CAHs bill Medicare for Obs time from 11:30 am Sat up to the time of the new IP order and IP stay from the new order

## 2 Midnight (MN) Rule

### ❑ **Scenario 3:**

Patient in at 8:00 AM on Tuesday for a SDS, OP procedure such as scope etc, receives recovery time but does not recover as well as expected so placed in Observation at 4:00 PM

Provider returns in am on Wed. and believes the patient will require another day at least in the hospital

Provider certifies the need for 2 MN (1<sup>st</sup> MN based on Tuesday night - Observation)

### ❑ **Scenario 4:**

As above but later surgery on Tuesday and provider determines after surgery/recovery that this patient will require 2 MN stay due to new development

Hospital will bill IP if certification for 2 MN and medical necessity is documented even if it started as a SDS

## 2 Midnight (MN) Rule

### ❑ Scenario 5:

Patient in to ED at 9:00 PM Wed and put in a telemetry bed for further assessment and treatment – no order to place in Observation

PCP/Hospitalist visits and examines patient on Thurs am but does not believe she will need another MN

Patient improves and discharged later Thursday

CAHs bill Medicare for ED and other regular OP services such as lab, x-ray but not for Observation since we did not have an order for such

No IP since patient did not remain in the hospital for 2 MNs

## 2 Midnight (MN) Rule

- ❑ CMS has provided a direct email to address any specific questions that arise as a result of this rule. You can submit questions and concerns to [IPPSadmissions@cms.hhs.gov](mailto:IPPSadmissions@cms.hhs.gov).

A background image of a bright blue sky with scattered white, fluffy clouds. The clouds are more prominent in the upper left and middle sections, while the lower right is a solid, deep blue.

## **Plans for Part 2 – Friday 7/20/14**



# Agenda Topics

- ❑ Patient notification of Observation service
- ❑ Use of ABN for Observation
- ❑ Condition Code 44
- ❑ Calculating Observation hours
- ❑ Active monitoring
- ❑ Staff documentation
- ❑ Self administered drugs
- ❑ General (high level) coding and billing information
- ❑ PLEASE take this week to email questions you have – do let me know that the question is for the 7/20 webinar (questions can be based on today also)

# As always, the name of the game is team work

STROUDWATER ASSOCIATES



Mary Guyot, Principal [mguyot@stroudwater.com](mailto:mguyot@stroudwater.com)

207-650-5830 (mobile)