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Lessons Learned from the Two-Midnight Rule: Compliance Tips for Short Stay Claims Reviews

Helpful Tips to Assist Hospitals in Coming Out of the Review Process Successfully

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Over the past year, there has been a growing controversy over the impact the Two-Midnight Rule will have on hospitals and providers. Since first set forth in the fiscal year (FY) 2014 Inpatient Prospective Payment System (IPPS) final rule, the rule has been delayed twice. The Centers for Medicare & Medicaid Services (CMS) has issued numerous guidance documents to help industry interpret the convoluted rule. The American Hospital Association and other industry lobbyists have filed lawsuits against CMS to curb implementation of the rule.

Although the longevity of the actual rule is questionable, all signs point to some sort of permanent policy change when it comes to payment for short stays. Short stays made their way onto CMS's radar after hospital claims reviews consistently showed high improper inpatient payment rates due to services that, while reasonable and necessary, could have been provided on an outpatient basis. Additionally, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) has voiced interest in the subject matter by indicating that it will review hospitals' use of short stays and observation stays.

In the FY 2015 IPPS proposed rule, CMS solicited requests for ideas on how to design a short stay payment system, a means to potentially compromise with hospitals and physicians on the much protested Two-Midnight Rule. Whatever the fate of the controversial Two-Midnight Rule, it is essential that compliance professionals understand CMS's current mechanisms for determining which claims are payable for an inpatient stay under Part A and how contractors will review short stay claims.

The Two-Midnight Rule Basics

Under the Two-Midnight Rule, lengths of stays greater than two midnights after a formal inpatient hospital admission are presumed appropriate for a Part A claim, as long as the admission is reasonable and necessary. In order to escape claims denials for stays that end up being less than two midnights, physicians are required to document their expectation that a stay of at least two midnights is required based on the patient's medical status and the physician's judgment.

CMS allows physicians and reviewers to take into account the time that the patient was receiving hospital care as an outpatient for purposes of determining whether the two-midnight threshold will be met, termed the two-midnight benchmark. CMS also has clarified a number of circumstances where an inpatient stay of less than two midnights is justified for payment under Part A, as long as the physician's expectation is documented in the medical record, including for patient transfers, departures against medical advice, death of the patient, procedures qualifying as inpatient-only, and where unexpected clinical improvements occur.

Following the implementation of the FY 2014 IPPS final rule, CMS issued guidelines regarding physician order and certification requirements as a condition of payment for inpatient services, which were subsequently amended in January 2014. The guidance sets forth very specific details about the contents required to demonstrate physician certification under the Two-Midnight Rule; however, CMS also has stressed that medical necessity for an inpatient admission must also be demonstrated elsewhere in the medical record, such as in the progress notes.

Probe and Educate Reviews

CMS instituted a "transition period" following implementation of the Two-Midnight Rule placing a moratorium on medical reviews by Medicare contractors, with the exception of pre-payment probe reviews by Medicare administrative contractors (MACs), dubbed "probe and educate" reviews, to determine providers' compliance with the Two-Midnight Rule. The transition period has twice been extended, presently to March 15, 2015. The probe and educate reviews target a limited set of records, a sample of 10 claims for most hospitals and 25 claims for larger hospitals. Hospitals found to be noncompliant with the rule are offered one-on-one sessions with the involved MAC to "educate" the hospital on how to come into compliance with the rule. The MACs also have permission to conduct larger probe audits for hospitals that continue to demonstrate moderate to major concerns.

However, feedback from hospitals that have experienced claims denials under the probe and educate process reveals that the plan has not proceeded smoothly. Common examples of issues with the process include:

- MACs often come to different conclusions under similar circumstances.
- MACs are apt to miss important information when reviewing electronic medical records, which vary from hospital to hospital.
- MACs are denying claims that are supposed to be inpatient-only. This may happen when there is no admission order because the physician did not realize the procedure was inpatient-only or where a scheduler books the procedure as outpatient. Inpatient-only procedures are also subject to improper coding.

The good news is that, pursuant to the FY 2015 Outpatient Prospective Payment System (OPPS) proposed rule, the physician certification requirement for short stays may be going by the wayside. In the proposed rule, CMS seeks to require physician certification only for long-stay and outlier cases. Elimination of the certification requirement, if finalized, will be beneficial to both providers and claims reviewers.

In an effort to comply with the Two-Midnight Rule, many organizations started implementing a certification form, with an area for the physician to check a box to indicate that a patient required a stay of at least two midnights; however, this check-the-box approach may have caused some organizations to fall short when it came to documenting medical necessity. In fact, many providers likely relied fully on the checked box as all the documentation needed to demonstrate medical necessity. This strategy failed providers going through the probe and educate process, as MACs were unable to determine how medical necessity was demonstrated in the medical record. Coming out of the process, CMS seemingly recognized that providers were overly reliant on form certification.

Compliance Tips

Below are some helpful tips, based on experiences with the probe and educate process, to aid hospitals in coming out of the review process successfully. Organizations should consider incorporating these tips into a policy to provide guidelines on how to ensure that coding and documentation support short stays. While some tips are specific to compliance with the Two-Midnight Rule, others can be adopted as a general best practice to ensure that documentation properly reflects justification for short stays.

1. **Develop a cover sheet.** A cover sheet is a useful tool to aid MACs in locating necessary documentation in medical records. Documents printed from the electronic medical record (EMR) appear much different than the record viewed electronically and may be difficult for outside reviewers to locate. The cover sheet should outline where MACs can find required documentation within the printed medical record.
2. **Conduct a self-audit.** A hospital should consider implementing self-audits of its short stays to determine whether its claims were properly billed to Part A. Additionally, a hospital should review and ensure that its discharge status codes for transfers, departures against medical advice, patients electing hospice, and patient deaths are correct to avoid the likelihood of an audit.
3. **Educate physicians on inpatient-only procedures.** To avoid denial of inpatient-only procedures, hospitals should provide education for ordering physicians regarding the inpatient-only list to clarify whether certain procedures actually require an admission order.
4. **Request educational sessions with the MAC.** Hospitals should consider requesting a one-on-one educational session with their MAC, which are offered as an option to hospitals as part of the probe and educate process. These educational sessions often allow hospitals more time to address any deficiencies identified by the MACs before they conduct a follow-up audit.
5. **Ensure collaboration between case management and clinical documentation improvement (CDI).** Health systems should consider bringing together case managers, coders, utilization reviewers, and CDI nurses through regular rounding to improve diagnosis coding, length of stay management, detailed documentation, and MS-DRG assignment.

Hospitals also should consider developing a policy to address how they will prepare short stay claims for an audit, incorporating the above tips. Such a policy could provide guidelines for preparing and organizing a claim for an external audit, including instructing providers and staff on how to ensure required documentation is properly demonstrated within the record, how documents should be organized in preparation for an audit, and how staff should respond to requests for an audit.

Although the fate of the Two-Midnight Rule is unclear, short inpatient stays will be on CMS's radar for some time, as evidenced

by the FYs 2014 and 2015 IPPS rules and findings by the OIG concerning improper payments for short patient stays. Hospitals must take steps to ensure that documentation in the medical record reflects the physician's justification for a short stay, that the documentation is sufficiently organized so that a reviewer can obtain the documentation, and that they are consistently monitoring and auditing their short stay claims.

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