Admission and Medical Review Criteria: The “Two-Midnight” Benchmark and Presumption

Background
As part of the fiscal year 2014 Inpatient Prospective Payment System (IPPS) Final Rule (CMS-1599-F), the Centers for Medicare & Medicaid Services (CMS) made an effort to provide much needed clarification concerning hospital inpatient admission criteria (including the physician certification requirement) by instituting a “two-midnight” benchmark for providers and a “two-midnight” presumption for claims auditors. Unfortunately, the solution ignores the root of the problem, which is an unnecessary increase in Medicare Part A claim denials by Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs), specifically targeting and systematically denying “short-stay” inpatient admissions. Auditors believe these admissions are not medically necessary and services should have been provided in an alternative setting.

IHA POSITION
CMS’s attempt to solve this problem has raised more questions than it answered and has unfairly increased regulatory burdens on hospitals rather than reviewing the claims audit and review practices of Medicare contractors. IHA recommends that instead of continuing to burden hospitals and physicians with ongoing regulation and complex sub-regulatory guidance, CMS and Congress should work with the hospital community to address real solutions to reduce Medicare fraud and abuse and fundamentally reform medical review and claims audit programs.

Two-Midnight Benchmark for Payment under Medicare Part A
The final rule puts in place a time-based benchmark stating that inpatient stays that span more than two-midnights following a physician’s order for inpatient admission will be presumed generally appropriate for Medicare Part A payment and will not be selected for medical review, unless there is evidence of systematic fraud and abuse as determined by the claims auditors.

Clarifying guidance\(^1\) from CMS indicated that sufficient physician documentation is needed in the patient’s medical record certifying the physician orders the patient to be placed in the hospital inpatient care setting, and that the duration of the inpatient care is expected to span at least two-midnights (See CMS’ September 5, 2013 guidance for more information regarding elements of the physician order.). The guidance also outlines time spent in other care settings (such as time spent as an outpatient) can be counted toward the two-midnight benchmark, but time spent waiting for an inpatient bed to become available, for example, cannot count toward the benchmark.

Two-Midnight Presumption for Medicare Medical Review and Claims Audit Contractors
The 2014 IPPS final rule also includes a time-based presumption for Medicare contractors stating that Medicare contractors should presume submitted claims for hospital inpatient stays that span more than two-midnights are generally appropriate for payment.

\(^1\) CMS guidance released September 5, 2013.
Partial Enforcement Delay
On November 1, CMS released additional guidance\(^2\) stating that, generally, post-payment *patient status reviews* for claims with dates of admission from October 1, 2013 through March 31, 2014 will not be audited. This increases the original partial enforcement delay by three months. Notably, only patient status reviews will be under delay, all other audit reviews will remain in effect.

Then, on January 31, CMS made several changes and clarifications including a six-month extension of the agency’s partial enforcement delay of the two-midnight policy through September 30, 2014.

“Probe and Educate”
To assist claims auditors in correctly identifying short-stay claims spanning from 0-1 midnight, CMS indicated it will implement a “Probe and Educate” process where auditors will review hospital compliance with the two-midnight benchmark. The audits will be conducted for inpatient claims with *dates of admission* (not dates of claims submission) between October 1 and March 31, 2014 submitted by: acute care inpatient hospital facilities, long-term care hospitals and inpatient psychiatric facilities. CMS confirmed on the November 12, 2013 Special Open Door Forum that Critical Access Hospitals (CAHs) are not subject to the probe and educate audits.

The November 1 guidance stated that, for most hospitals, MACs will select 10 sample claims for pre-payment review and 25 claims for large hospitals (“large” hospital has not been clearly defined). Based on the results, MACs will then reach out to providers over the course of six months to provide education and guidance for better compliance. CMS states the outreach will include one-to-one phone calls to answer questions and provide detailed reasons for denials.

Following the initial probe audit, a secondary review period will be conducted for providers defined as having “moderate or significant to major” concerns, and MACs will perform additional reviews and education on a varying number of claims (based on hospital size and level of concern) with dates of admission between January 1, 2014 and March 31, 2014.

Related Legislative Action
**H.R. 1250/S. 1012: The Medicare Audit Improvement Act of 2013**
This bill would establish a consolidated limit for medical record requests, impose financial penalties on RACs that fail to comply with program requirements, make RAC performance evaluations publicly available and allow denied inpatient claims to be billed as outpatient claims when appropriate.

*See related Issue Brief on H.R. 1250/S. 1012.*

Resources:
- [Questions and Answers Relating to Patient Status Reviews](#)
- [Selecting Hospital Claims for Patient Status Reviews](#)
- [Reviewing Hospital Claims for Patient Status](#)

Contact:

\(^2\) CMS guidance released November 1, 2013.
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