Lee Memorial Health System

Two Midnight Rule for Inpatient Admission

Presented by: Lee Memorial Health System Corporate Compliance Department
Medical Necessity for Admission

Physician decision: Treat in hospital vs. home

• “Decision to admit a patient as an inpatient is a complex medical decision based on many factors:”
  • Risk of an adverse event during the period considered for hospitalization
  • Assessment of services needed during hospital stay”

The crux of the decision is the choice to keep the beneficiary in hospital to receive services or reduce risk, or discharge home because they may be safely treated through outpatient services (IPPS Final Rule CMS – 1599-Federal Register, p. 50945)
Medical Necessity Must be Documented

- Physician’s order for inpatient admission should be based on a clinical expectation that care will surpass 2 midnights.

- Significant clinical considerations must be clearly and completely documented in the medical record.
Physician Documentation Supportive of Inpatient Admission

Complex Medical Factors

• Medical reasons for inpatient hospitalization
• Failed outpatient treatment \((\text{What was tried and did not work})\)
• History and co-morbidities
• Severity of signs and symptoms
• Current medical needs
• Risk of an adverse event
Medicare Inpatient Two Midnight Rule

Summary: 2014 IPPS Final Rule

- Physician certification required for all inpatient admissions starting Oct. 1, 2013
- Authentication of inpatient order (the order signed by the physician) must be done before discharge
- The reason(s) for inpatient services (medical reasons that inpatient care is needed)
- The decision to admit as inpatient must be based on physician expectation that stay will span two midnights
Medicare Inpatient Two Midnight Rule

Summary: 2014 IPPS Final Rule (cont’d)

• If patient spent 1 night in observation and you document a medical reason that they need to stay another midnight, it is appropriate to admit as inpatient before the second midnight.
  • The first midnight counts toward the two midnight benchmark, but it is still an outpatient day and does not count toward the three inpatient midnights needed to qualify for SNF.

Physician certification and signed admission order **must** be completed before discharge.
Medicare Inpatient Two Midnight Rule

Summary: 2014 IPPS Final Rule (cont’d)

- Projected plans for post-hospital care (if appropriate) should be documented upon admission.
- Surgeries on the Medicare Inpatient Only List are exempt from the two midnight benchmark regardless of length of stay (LOS).
- Stays for social or scheduling issues (delay in care) do not show a medical reason to be in the hospital.
- Without a reasonable expectation of two midnight stay, even ICU admissions should be outpatient observation.
Unforeseen Circumstances

- Unforeseen circumstance may result in a shorter stay than the physician’s initial expectation of a stay greater than 2 midnights:
  - Death
  - Transfer
  - Departure against medical advice (AMA)
  - Unforeseen recovery
  - Election of hospice benefit

- Such claims may be considered appropriate for hospital inpatient payment.

- The physician’s expectation and any unforeseen interruptions in care must be documented in the medical record.
Start Clock

Two midnight benchmark “clock” starts:

• When hospital care begins
  • Observation care
  • Emergency Department, Operating Room, other treatment area services

• The start of care after registration and initial triaging activities (i.e. vital signs)

Remember:

• Total time in hospital may be taken into consideration when the physician is making an admission decision (i.e. expectation of hospital care for 2 or more midnights)

But:

• The inpatient admission does not begin until the inpatient order and formal admission occur.
Observation or Inpatient Admission?

- **Observation is appropriate**
  - Can the pt's condition be evaluated / treated w/in 24 hrs and/or is rapid improvement of pt's condition anticipated w/in 24 hrs?
  - Yes
  - Observation is appropriate
  - No
  - Inpatient admission is appropriate

- **Alternate level of care is appropriate (outpt, home health, extended care facility)**
  - Does the pt's condition require treatment / further evaluation that can ONLY be provided in a hospital setting (i.e. inpatient or observation)?
  - Yes
  - Alternate level of care is appropriate
  - No
  - Additional time is needed to determine if inpatient admission is medically necessary; observation is appropriate.

**Unsure**
I certify that current hospital inpatient services are reasonable and necessary, and appropriately provided as inpatient services in accordance with the 2-midnight benchmark under 42 CFR 412.3 (a).

Order Information
- Order Date/Time: 10/9/2013 1:46 AM
- Release Date/Time: None
- Start Date/Time: 10/9/2013 1:47 AM

Order Details
- Frequency: ONCE
- Duration: 1 occurrence
- Priority: ROUTINE

This order was placed using: GENERAL MEDICINE ADMISSION ORDERS (NOT FOR TELEMETRY)
Anticipated midnights
Medical Necessity
Diagnosis
Case Scenarios

Compliance with the Two Midnight Rule is considered on a case-by-case basis, in accordance with the information contained in the medical record.
68 year-old man presents to the ED with several day history of urinary symptoms, vague intermittent abdominal discomfort, “gassy” and “feverish” feeling over past several days, and intermittent chills and nausea without vomiting. Patient on oral medications for constipation, hypertension, cholesterol, and diabetes. Patient complains that he is not feeling like himself – no appetite, tired, “maybe a touch of the flu”. No other complaints.

10/1/2013
• 2200 – Patient triaged
• 2210 – Urine sample and glucometer reading obtained and pt. sent to waiting room
• 2300 - MD assesses patient, orders therapeutic / additional diagnostic modalities

10/2/2013
• 0015 – MD re-evaluates and determines a need for medically necessary hospital level of care/services for this patient beyond midnight #2
• 0035 – Formal admission order provided

10/3/2013
• 0735 – Patient is discharged home.
Scenario #1: Initial Presentation to ED

Discussion:

- Hospital may bill this claim for inpatient Part A payment.

- Claim will demonstrate 1 midnight of outpatient services and 1 midnight of inpatient services.

- This claim may be selected for medical review, but will be deemed appropriate for inpatient Part A payment so long as the documentation and other requirements are met.
Scenario #2: Initial Presentation to Physician Office

80 year-old woman presents to her primary care physician’s office not feeling well. Past medical history is significant for chronic obstructive pulmonary disease and the patient is on multiple medications. She has experienced increasing shortness of breath for several days.

10/1/2013
• 1800 – Patient is evaluated by primary and sent to the hospital for further evaluation via ambulance.
• 2100 - Upon arrival at the hospital the admitting practitioner confirms the suspected diagnosis and admits the patient based on the expectation that care will span at least 2 midnights.

• Patient continues to receive medically necessary hospital level of care / services.

10/5/2013
• 0900 – Patient is discharged home.
Scenario #2: Initial Presentation to Physician Office

Discussion:

• Hospital may bill this claim for inpatient Part A payment.

• Claim will demonstrate 2 midnights of inpatient services.

• Review contractors will generally not select this claim for review as it is subject to the “presumption”.
Scenario #3: Treatment in the ICU

73 year-old male with an accidental environmental toxic exposure presents to the ED.

12/1/2013
- **0900** – Patient arrives by ambulance to the ED. Awake and alert.  
- **0903** - Poison control / POISONINDEX consulted, and advised telemetry monitoring; plan intubation if necessary. Small hospital facility, telemetry monitoring only available in ICU.  
- **0907** – Therapeutic and diagnostic modalities have all been ordered and initiated. Airway intact.  
- **1000** - MD requests transfer to ICU for telemetry. Unclear to physician if patient will need medically necessary hospital level care/services for 2 or more midnights. Determination will be dependent on clinical presentation and results of diagnostic and therapeutic modalities.

12/2/2013
- **1030** – Medical concerns / sequelae resolving. Airway remained intact absent mechanical intervention.  
- **1200** - Physician writes orders to discharge home.
Scenario #3: Treatment in the ICU

**Discussion:**

- Hospital should bill for outpatient services.
- Location of care in the hospital does not dictate patient status.
- The patient’s expected LOS was unclear upon presentation and the physician appropriately kept the patient as an outpatient because an expectation of care passing 2 midnights never developed.
- No other circumstance was applicable.
Scenario #4: Uncertain Length of Stay

80 year-old patient presents from home to the ED on a Saturday with clinical presentation consistent with an acute exacerbation of chronic congestive heart failure. She is short of breath and hypoxic with ambulation. The physician determines that she will require hospital care for diuresis and monitoring, however it is unclear at presentation whether she will require 1 or 2 midnights of hospital care.

12/7/2013
• 2100 - Patient begins receiving medically necessary services in the ED. She shows evidence of fluid overload, requiring IV diuresis and supplemental oxygen, and continuous monitoring.
• 2300 - IV diuretics are provided and an order for observation services is written with a plan to re-evaluate her within 24 hours for the need for continued hospital care or discharge to home.

12/8/2013
• 0900 - Remains short of breath and hypoxic with ambulation, requiring additional IV diuresis and supplemental oxygen.
• 1700 - Continues to respond to diuretics but remains short of breath and hypoxic with ambulation, requiring additional IV diuresis for another 12 – 24 hours. Inpatient admission order is written based on the expectation that the patient will require at least 1 more midnight in the hospital for medically necessary hospital care.

12/9/2013
• 1000 - The patient’s acute CHF exacerbation is resolved and she is discharged home.
Scenario #4: Uncertain Length of Stay

**Discussion:**

- Hospital may bill this claim for inpatient Part A payment.

- Providers should treat patients as outpatients until the expectation develops that the patient will require a second midnight of hospital care.

- When the expectation develops, an inpatient admission order should be written by the physician.
Scenario #5: Unforeseen Circumstance After Formal Admission

Disabled 50 year-old man presents to the ED from home with history of cancer, now with probable metastases and various complaints, including nausea and vomiting, dehydration and renal insufficiency.

1/1/2014
• 2200 - Presents to the ED at which time the admitting provider evaluates and orders diagnostic / therapeutic modalities.

1/2/2014
• 0400 - Physician writes an order to admit. Patient is formally admitted with expectation of medically necessary hospital level of care / services for 2 or more midnights.
• 0900 - Appropriate designee and the family discuss with the primary physician the desire for hospice care to begin for this patient immediately.
• 1500 - Discharged with home hospice services.
Scenario #5: Unforeseen Circumstance After Formal Admission

**Discussion:**
- Hospital may bill this claim for inpatient Part A payment.
- Claim will demonstrate 1 midnight of inpatient services.
- This represents an unforeseen circumstance interrupting an otherwise reasonable admitting practitioner expectation for hospital care.
- Upon review, this would be appropriate for inpatient admission and payment so long as the physician expectation and unforeseen circumstance were supported in the medical record.
Scenario #6: Medical Necessity

78 year-old man with a past and current medical history of chronic illnesses that are well controlled with medications. Patient slips while shoveling and falls and sustains a closed wrist fracture.

11/9/2013 Saturday
• 2300 – Presents to ED following a fall at home. Patient presents alone.
• 2330 – Arm fracture confirmed by practitioner. Pain medication given.

11/10/2013 Sunday
• 0330 - Pain well controlled, stable for discharge but continues to require custodial care. No family or friends available and hospital social services not available until Monday. Patient held in hospital pending home care plan, no IV access, pain controlled with oral medication.

11/11/2013 Monday
• 1000 – Patient released to home with family member. No other complications.
Scenario #6: Medical Necessity

Discussion:

• Outpatient services may be provided and billed to Medicare as appropriate.
References


References


Questions?

We are Caring People, Caring for People.