OPERATIONALIZING THE TWO MIDNIGHT RULE:
One Size Approach Does Not Fit All

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Prepared for the American Health Lawyers Association’s Fraud and Compliance Forum
held October 6, 2014

I. INTRODUCTION

For over a decade, the federal and state governments through task forces and data analysis have been seeking opportunities to identify fraud, waste and abuse in the provision of and billing for medical care. Over the past several years, commercial and governmental payors have scrutinized varying categories of inpatient hospital stays, including one day stays and short stays, to determine whether patients receiving inpatient care for short periods of time required the care provided in an inpatient setting, and were reimbursed at an inpatient rate. On August 2, 2013, the Centers for Medicaid & Medicare Services (CMS) issued a final rule, CMS-1599-F, commonly referred to as the “Two-Midnight rule” (TMR) that modified inpatient criteria and when a provider could bill for an inpatient stay. Health care providers, as well as Medicare beneficiaries, have been hotly contesting CMS’s TMR even before its release. This paper provides an overview of the current status of the TMR as well as practical considerations for compliance, patient focused care, and the prevention of lost revenue.

II. BACKGROUND

A. Legal History: Upon passage, the TMR was intended to go into effect for dates of service as of October 1, 2013. Presently, CMS can continue medical review activities under the MAC Probe & Education process through March 31, 2015, but Recovery Auditors are prohibited from conducting inpatient hospital patient status reviews on claims with admission dates of October 1, 2013 through March 31, 2015. The TMR updated fiscal year FY 2014 Medicare payment policies and rates under the

1 The author wishes to thank Anu Paulose and Sapna Shah, Esq. for their contributions to the research and preparation of this paper as well as Rodney Williams, MD, JD, Steve Friedman, and Wm. Scott Cain for their input and expertise.

Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). Appeals filed by advocacy groups and providers, questions posed during webinars and open letters and comments provided to CMS, delayed the implementation and/or enforcement of the rule by the Recovery Auditors through post-payment reviews until March 31, 2015. Prepayment reviews of claims with dates of admission from October 1, 2013 through March 31, 2015 have already commenced:

“Updates 5-12-2014
On April 1, 2014, The President signed the Protecting Access to Medicare Act of 2014. Section 111 of this law:
1. Permits CMS to continue medical review activities under the MAC Probe & Educate process through March 31, 2015, and
2. Prohibits CMS from allowing the Recovery Auditors to conduct inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through March 31, 2015.

Prior to the passage of this law:
a. CMS had planned to operate the MAC Probe and Educate process until at least September 30, 2014, and
b. CMS had prohibited the Recovery Auditors from conducting inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through September 30, 2014.

CMS will continue the Probe & Educate process through March 31, 2015, and will continue to prohibit Recovery Auditor inpatient hospital patient status reviews for dates of admission occurring between October 1, 2013 and March 31, 2015.

As of May 12, 2014, MACs have completed most first probe reviews, of 10 (or 25) claims, for providers within their jurisdiction, and are beginning to provide educational information related to the first probe period findings.”

Given the number of implementation modifications, guidance updates and lawsuits filed to address components of the TMR (including the 0.2% cut in reimbursement for Medicare beneficiary discharges), providers are encouraged to check the CMS website regularly and continue to focus on the basics: physician documentation, robust case management and internal data analysis.

B. The Nuts and Bolts of the TMR: Arguably, the TMR has only changed the appropriateness of billing for inpatient status by adding a provider certification requirement and modifying the requirement that a physician must expect a patient to need inpatient level care for two midnights instead of the prior benchmark of 24 hours.

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4 Id.

5 HOSPITAL INPATIENT ADMISSION ORDER AND CERTIFICATION, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-
patient who presents to the hospital at 2PM who, in a physician’s opinion required 36 hours of inpatient services may meet the TMR criteria. But that same patient who presents at 2 AM may not meet the TMR’s requirements. It seems arbitrary that a patient’s arrival time can determine whether or not the patient’s stay is eligible under the TMR for inpatient reimbursement. So, what exactly does the TMR require for a hospital to bill for an inpatient stay?

1. TMR Two Steps: The TMR modifies and clarifies CMS’s policy on how Medicare contractors review inpatient hospital and critical access hospital admissions for payment processes. Admissions for surgical procedures, diagnostic tests and other treatments (in addition to services designated as “inpatient-only” by CMS), “are generally appropriate for inpatient hospital admission and payment under Medicare Part A when (1) the physician expects the beneficiary to require a stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation.” A patient admission for a procedure listed on Medicare’s Inpatient-Only list, regardless of length of stay, can also be provided for and billed for as an inpatient admission. Certain events, such as qualified transfers, election to hospice services, deaths and discharge against medical advice (leaving “AMA”) are generally exceptions to the TMR.

CMS implemented this policy to respond to providers’ requests for clarification regarding when a beneficiary is appropriately treated and paid by Medicare as an inpatient and to beneficiaries’ concerns about the more frequent use of and duration of outpatient hospital stays that have impacted the beneficiaries out of pocket expenses for the hospital stay and impacted their eligibility for reimbursement for services such as inpatient rehabilitation.

2. MCG (formerly known as Milliman) or InterQual versus TMR: Hospitals already utilize various clinical criteria models and guidelines to ensure

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7 See 42 C.F.R. § 419.22(n).


9 Id.

10 [http://www.mcg.com/](http://www.mcg.com/)

they are asking the questions necessary to gather and document the patient’s condition and the information used by the physician in deciding whether to admit the patient. There are countless software tools and vendors that provide tracking tools for inpatient admission decision-making as well as provide third party review that can be used by the admitting physician to assist with cases that fall in the grey area between inpatient admission and observation. CMS provided guidance regarding the use of Milliman (now MCG) or InterQual criteria in complying with the TMR during an outreach session held on January 14, 2014. CMS participant, Melanie Combs-Dyer, CMS’s Acting Director of the Provider Compliance Group, instructed attendees that “we are anticipating that most hospitals will choose not to use InterQual or Milliman to make the decision about whether or not to write the inpatient order. Instead, we’re expecting that most hospitals are going to look to the guidance in this rule [the TMR] about the physician’s expectation of a 2-midnight or more stay in the hospital requiring that hospital-level care.” Commercially available tools, guidelines and question sets are nevertheless beneficial in assisting the admitting physician in making the decision as to whether or not to admit, but hospitals must focus on the criteria outlines in the TMR when determining whether services can be billed for as inpatient services.

3. What type of care counts towards two midnights: The final rules set forth that the timeframe used in determining the expectation of a stay surpassing two midnights begins when care in the hospital begins. The start time of outpatient observation services or services in an emergency department operating room or other treatment area at the hospital can count towards the TMR requirements in addition to time spent in inpatient status as long as the medical record documentation and physician orders clearly speak to the medical necessity, and decision making as well as the start time of the services provided. The time a beneficiary spends receiving outpatient care, prior to the entering of the formal written or verbal admission order (if the verbal admission order is subsequently authenticated, signed and dated) remains classified as outpatient time. But the hospital billing for the service and the physician making the TMR determination


Id.

Id.
may consider this period when determining if it is reasonable to expect the patient to require hospital care for more than two or more midnights.16

4. Occurrence Span Code 72: The hospital’s billing department can signal to the governmental claims processors and auditors that qualifying outpatient time is being counted towards TMR compliance by using Occurrence Span Code 72 to memorialize in the billing submission that the hospital is counting qualifying outpatient services to qualify the stay as an inpatient admission.17 Proper utilization of the Occurrence Span Code 72 is critical to ensure proper payment and reduce the likelihood of audit delays when considering cases where the TMR is met based on the counting of qualifying, and thoroughly documented outpatient care.

5. The benchmark versus the presumption: The benchmark is based on the physician’s decision making process in determining whether the beneficiary’s care and treatment will require inpatient level services for two or more midnights. It can include qualifying outpatient services. Triage time, waiting room time or any time prior to the documented start of outpatient services do not qualify as outpatient services. The auditor’s presumption begins once the patient is formally admitted, the time noted on the UB-04.18 Governmental auditors will presume that care provided in inpatient status for less than two midnights is inappropriately billed as inpatient and will then look for evidence in the chart for other qualifying time. The proper use of Code 72 will signal to the auditor that outpatient time was used towards meeting TMR criteria.

6. The written order and certification: The physician certification must authenticate the practitioner’s order by certifying that care is medically necessary in an inpatient setting and that, unless the services appear on the CMS Inpatient-Only list, the admission will also meet the TMR criteria. It must include the reasons for inpatient services and the estimated time that the beneficiary will be in the hospital. If care is provided in a critical access hospital, the physician must certify that the patient is expected to be discharged or transferred to a hospital within 96 hours. With limited exceptions, certification must be completed, signed, and dated as well as documented in the medical record prior to the patient’s discharge. Only (1) a doctor of osteopathy or doctor of medicine, (2) a dentist in limited circumstances, or (3) a doctor of podiatric medicine if the

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16 Id.
Certification is for care that can be provided under a podiatric license, may sign the physician certification. 19

Certification is closely linked to the practitioner order. The admitting inpatient order must be made by a physician or qualifying practitioner with admitting privileges to the facility and knowledge of the patient. The order must clearly state that the beneficiary should be admitted for inpatient care and that inpatient care is medically necessary. The order must be completed at or before the time of inpatient admission. Verbal inpatient admission orders must be signed, dated, and timed by the ordering practitioner or another practitioner with the required admitting qualifications. 20

7. The 0.2% across the board cut for inpatient discharges: The TMR describes the expectation that as a result of the TMR, Medicare will incur increased cost from paying for more inpatient stays. Therefore, the TMR implemented a 0.2% across the board cut for beneficiary discharges occurring on or after October 1, 2013.

C. Oops, Beneficiary Didn’t Really Meet Inpatient Criteria, Now What?:
Except in cases involving services on the CMS Inpatient-Only list and in certain rare and unusual circumstances, 21 documentation in the medical record must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance, this must also be clearly documented in the medical record.

1. The beneficiary is still in-house: If during a patient’s stay, the admitting physician, case manager or utilization review committee determines that the patient does not meet inpatient criteria, the care team can take steps to change the patient’s status from inpatient to outpatient. Providers must ensure that federal guidelines and state laws are adhered to, including Condition Code 44 criteria. In order to utilize Condition Code 44 to change the patient’s status from an inpatient stay to an outpatient stay that can be billed for as an outpatient stay, all of the


following conditions must be met: (1) the patient is still in the hospital; (2) the hospital has not yet submitted an inpatient admission claim to Medicare; (3) after a utilization review committee determined that the patient no longer meets inpatient criteria, a physician agrees with their decision; and (4) the physician documents that he or she agrees with the utilization review committee’s decision. This is preferable because the hospital can generally receive more money from billing an outpatient stay than it otherwise could by only billing for the Medicare Part B Ancillary services provided during a stay for which the hospital cannot bill for Medicare Part A services due to the patient no longer meeting inpatient criteria.

Since, for example, the patient’s financial responsibility is likely to change, some states have imposed more strict guidelines than Condition Code 44. In New York, in addition to legal requirements for patients’ rights, hospitals are required to provide oral and written notice to patients placed in observation status that contains an explanation of the financial and other implications that the patient might face. Compliant notices state (1) that the patient is not admitted to the hospital; (2) observation status might impact insurance coverage for care such as medication, medical supplies, out of pocket expenses, coverage for any care provided upon hospital discharge by a skilled nursing facility or home and community-based care; and (3) that the patient should contact his or her insurer.

2: The beneficiary has been discharged: Once a beneficiary has been discharged, if the claim is denied, or if the utilization committee determines that the stay did not meet inpatient criteria, the following rule applies:

“When an inpatient admission is found to be not reasonable and necessary, the Centers for Medicare & Medicaid Services (CMS) will allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for


25 Readers are encouraged to review their state-specific patients’ rights legal requirements.
those services that specifically require an outpatient status such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients.”26 Hospitals must maintain documentation supporting Part B services.

Additionally “A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital would be required to cancel its Part A claim prior to submitting a claim for payment of Part B inpatient services. Any coinsurance or deductible collected for the Part A claim must be refunded. Whether or not the hospital had submitted a claim to Part A for payment, Medicare requires the hospital to submit a Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. The hospital would indicate Provider Liability period on the Part A claim by including the Occurrence Span Code “M1” and the inpatient admission Dates of Service. The hospital could then submit an inpatient claim for payment under Part B on a Type of Bill (TOB) 12X for inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

For Part B inpatient services furnished by the hospital that are not paid under the Outpatient Prospective Payment System (OPPS), but rather under some other Part B payment mechanism, Part B inpatient payment would be made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), hospitals paid under the OPPS, long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals paid under

the OPPS would continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 CFR 419.20(b) would be eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. For example, beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. Timely filing restrictions will apply for Part B inpatient services. Claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid. ”

Under the TMR, the provider now has only one year to rebill for Part B services.

III. RESPONSE TO THE TMR

Medical associations, health lawyers, physicians, hospital advocacy groups and patient advocacy groups are among the organizations that aired their concerns about the impact of the TMR.

A. The Center for Medicare Advocacy (CMA):

1. Bagnall v. Sebelius: The CMA and co-counsel, the National Senior Citizen Law Center, filed a class action lawsuit against Kathleen Sebelius, the Secretary of Health and Human Services, on November 2, 2011, on behalf of seven individual plaintiffs. The lawsuit alleges that the use of observation status violates the Medicare Act, the Freedom of Information Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment to the Constitution.

27 Id.


29 See OBSERVATION STATUS & BAGNALL V. SEBELIUS, http://www.medicareadvocacy.org/medicare-info/observation-status/ (last visited Sept. 5, 2014), for materials related to this specific lawsuit. See
2. Health Subcommittee of the House Committee on Ways and Means: At the hearing held in the spring of 2014 by the Health Subcommittee of the House Committee on Ways and Means, the CMA's Senior Policy Attorney, Toby S. Edelman, presented the beneficiary perspective and discussed the impact, on a patient, of placing him or her on observation status. He explained the financial and rehabilitation coverage eligibility issues for patients placed in observation status and presented information suggesting that patients are often unaware that they have been placed in observation status since they are physically located in the hospital.

The hospital and physician witnesses supported the CMA’s testimony that millions of Medicare dollars are being spent by hospitals not on care, but to defend their decisions to admit patients when those decisions are challenged by Medicare's Recovery Auditors (formerly known as Recovery Audit Contractors, or RACs). In addition, the witnesses noted that Recovery Auditors share a percentage of the savings achieved when they successfully challenge a hospital's inpatient admission decision. Amy Deutschendorf, of Johns Hopkins University Hospital, described how millions of dollars in hospital resources are consumed by the hospital's efforts to address inpatient/outpatient stays and to respond to Recovery Auditors. Deutschendorf asserted the two-midnight rule required physicians to become "soothsayers" in attempting to predict whether patients will require two midnights in the hospital, and thus should be admitted to inpatient status, or whether patients' medically necessary stays in the hospital will be shorter. She also described a 33% increase in the hospital's observation rate since the two-midnight rule went into effect. Deutschendorf estimated that each appeal of a Recovery Auditor's decision to an Administrative Law Judge costs the hospital about $2,000. In addition, the hospital spent about four million dollars to prepare for the Recovery Audit program when it first began.

Sean Cavanaugh, Deputy Administrator and Director of CMS, stated that CMS intended the two-midnight rule to bring clarity to physicians' admission decisions. He suggested that the proportion of long outpatient stays had declined

http://www.medicareadvocacy.org/tag/observation-status/, for a summary of legal action and advocacy undertaken by the Center for Medicare Advocacy.


since the TMR became effective in October 1, 2013. Cavanaugh acknowledged that CMS was continuing work pertaining to (1) whether and how to define short inpatient stays and (2) whether there should be additional exceptions to the TMR. He further acknowledged that hospitals often classify patients as outpatients in observation rather than as inpatients in order to protect themselves from audit liability and denials and stated that CMS demonstration is testing waiver of the three-day hospital inpatient requirement. 32

B. Michigan Health and Hospital Association (MHHA): The MHHA opined that the TMR placed hospitals in an untenable position. In its comment letter to CMS dated June 20, officials at the MHHA said it has been—and remains—opposed to the two-midnight rule since its inception last summer.

"The MHA continues to believe that in cases where a physician or other qualified and licensed practitioner has determined that a patient met national guideline criteria to be admitted as a hospital inpatient, the care provided should be covered and paid by Medicare Part A," the Michigan officials wrote.

"The decision on the appropriate setting of care can best be made by the patient's physician based on the patient medical history, co-morbidities, severity of signs and symptoms, current medical need and the risk of an adverse event without regard to any 'guesses' about how long a patient will remain in the hospital. This policy has resulted in much confusion over the past year for hospital staff, patients, and their families, and can have serious financial implications." 33

C. Greater New York Hospital Association (GNYHA): New York State hospital associations such as GNYHA and Health Association of New York State (HANYS) 34 have expressed significant concerns. For example, GNYHA has taken legal action to address its issues with the TMR as well as advocated that commercial payors not adopt the TMR requirements in their managed care contracts with hospitals. In an undated statement from GNYHA, the association states that:

“GNYHA and its members continue to advocate for a suspension of the Centers for Medicare & Medicaid Services’ (CMS) two-midnight policy so CMS can work with stakeholders on addressing the policy's most damaging aspects, mainly that it preempts physician decision making. Delaying the policy would also allow sufficient time for hospitals to operationalize it. More than 165 hospital chief executive officers (CEOs) from 33 states signed an October 24 letter to CMS Administrator Marilyn Tavenner in which they asked CMS to consider suspending

32 Id.

33 Christopher Cheney, Providers Blast CMS on Two-Midnight Rule, HEALTHLEADERS MEDIA (July 1, 2014), www.healthleadersmedia.com/print/FIN-306036/Providers-Blast-CMS-on-TwoMidnight-Rule.

34 http://www.hanys.org/
implementation of the two-midnight policy to allow time to further discuss hospitals' concerns.”

“The two-midnight policy provides that services requiring a Medicare patient to stay at least two midnights in the hospital, or identified on the "inpatient-only" list, will be presumed appropriate for inpatient admission. Stays of shorter duration, with some rare exceptions, will generally be considered inappropriate. GNYHA is deeply concerned that the two-midnight policy will have significant financial and operational implications for its members and unintended consequences for Medicare beneficiaries.”

Hospital associations such as GNYHA also offer support to hospitals attempting to operationalize TMR compliant policies by providing implementation strategy suggestions, facilitating roundtables for the sharing of ideas and providing suggestions for multidisciplinary approaches to training physicians, case managers and others responsible for ensuring compliance with the TMR. Advocacy associations collaborate with governmental contractors who conduct audits and claims processing to seek clarification and provide education to hospital staff.

IV. CHALLENGES WITH THE OPERATIONALIZATION OF THE TMR

In implementing and maintaining an effective TMR compliance strategy, there are significant compliance, financial, educational, policy and other considerations that must be taken into account.

A. Financial Challenges: Patients inappropriately placed in observation or other outpatient status can result in lost revenue when inpatient status could have been supported by the TMR. Patients placed inappropriately in inpatient status can result in significant lost revenue if the error or change is not made prior to the patient’s discharge. This will result in the hospital only being able to bill for Part B ancillary services instead of qualifying outpatient care. Failure to internally monitor compliance with the TMR and criteria for observation status can result in lost revenue. Misclassification of observation cases as inpatient cases can also lead to incorrect revenue projections based on discharges that will not be paid as inpatient. The TMR prohibits rebilling of claims, including for Part B reimbursement for denied claims, greater than one year after the date of discharge. Delayed recognition of audit liability or potential internal documentation or decision making errors can have a significant financial impact as a result of the requirement that rebilling must occur within one year of the patient stay.


36 Ann Sheehy, The Recovery Audit Contractor Program and Observation Status for Hospitalized Medicare Beneficiaries, JAMA INTERNAL MEDICINE BLOG (February 4, 2014),
1. Universal Application of the TMR can cost you: Revenue loss can also occur by applying the TMR to patients covered by payors other than Medicare. For example, if a patient meets other inpatient criteria methodology created by or incorporated into a managed care contract, but not TMR criteria, failing to distinguish between the different billing rules can lead a physician to place a patient in observation status and receive the same care that the patient would have received as an inpatient but cause the hospital to forgo the inpatient rate. Physicians and case managers seeking to confirm the impact of a patient’s insurance on proper billing for the care provided can generally do so without violating Emergency Medical Treatment and Active Labor Act (EMTALA). As long as the patient’s condition has been stabilized, a provider can take reasonable steps to register the patient and obtain insurance information as long as doing so does not delay treatment of the patient. It is important to ensure that any physician determining whether the patient’s care should be appropriately provided in the inpatient or observation setting know what admission criteria their payor uses. This way the physician can apply the correct criteria, and document accordingly. The payor must never influence the quality of care provided or the treatment plan. It is also critical that providers treat patients the same regardless of payor source, whether they are Medicare, Medicaid, commercial or self pay payors.

2. But the Recovery Auditors cannot audit until March 31, 2015? Why should I prepare now?: The proscriptive, and strictly applied audit process followed by Recovery Auditors were of significant concern to advocates pushing for clarity around the TMR. Some providers might be breathing a sigh of relief due to the probable delay in awarding new Recovery Auditor contracts in RAC regions 1, 2 and 4, which will likely result in delays in the awarding of contracts in RAC regions 3 and 5 until September 2015. Instead, providers should utilize this time to tighten-up education regarding decision making and medical record documentation as well as to ensure that pertinent policies are updated to comply with the TMR. Even if by chance the TMR is further delayed or changed, documentation and CMS billing and admission status refreshers provide relevant information and in the meantime, auditors can still review claims for medical necessity.


3. Over-utilizing observation status to prevent audit liability will cost you:

The “Two Midnight Dilemma” adapted from an article by Bob Herman entitled Hospitals hope for relief from two-midnights purgatory in Modern Healthcare, citing data from the HHS Inspector General’s Office. 39

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<th>Top reasons for Medicare short stays</th>
<th>Observation pays this much less</th>
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<td>Chest pain</td>
<td>$870.00</td>
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<tr>
<td>Circulatory disorders</td>
<td>$2,312.00</td>
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<td>Coronary stent insertion</td>
<td>$2,267.00</td>
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<td>Digestive disorders</td>
<td>$2,047.00</td>
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<tr>
<td>Dizziness</td>
<td>$1,320.00</td>
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<td>Fainting</td>
<td>$1,890.00</td>
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<tr>
<td>Irregular heartbeat</td>
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<tr>
<td>Irregular heartbeat (medium severity)</td>
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<td>Loss of blood flow to the brain</td>
<td>$1,677.00</td>
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<td>Medical back problems</td>
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<td>Nutritional disorders</td>
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<td>Red blood cell disorders</td>
<td>$2,801.00</td>
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<tr>
<td>Respiratory signs and symptoms</td>
<td>$1,792.00</td>
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Notwithstanding the 0.2 % across the board cut that the TMR implements, hospitals can lose significant sums of money from conservatively assigning observation status to patients. In fact, a study conducted by the University of Wisconsin suggests that CMS was wrong in its assumption that inpatient admissions would increase:

“Applying the two-midnight rule retrospectively to all observation and inpatient encounters at the University of Wisconsin Hospital and Clinics between January 1, 2012 and February 28, 2013, physicians researchers with the University of Wisconsin School of Medicine and Public Health found that application of the two-midnight rule would actually have increased the hospital’s use of observation status. Looking only at Medicare beneficiaries treated at their hospital in the 14-month period, the physicians found that 7.4% of inpatient encounters would have been switched to outpatient if the two-midnight rule had been in effect.” 40


Therefore, the practice of placing patients in observation status to prevent audit liability for all cases that fall in the middle of the continuum between clear outpatient cases and clear inpatient cases will likely cost hospitals with a high Medicare payor mix. While the cost of defending audits should be taken into account, placing patients in observation or failing to have processes in place to aggressivelly and compliantly analyze cases that fall in the middle, can result in loss of revenue.

**B. Compliance Pitfalls:** Non-compliance with the two midnight rule can have compliance, finance, reputational and other impacts on a provider. Although the Recovery Auditors are currently precluded from auditing claims until March 31, 2015, it is likely that impacted providers, having been given additional time to implement or update policies and procedures to ensure compliance with both clinical decision making and billing, will see robust auditing.

Compliance with the two midnight rule requires hospitalists, other admitting physicians, case managers, nursing and revenue cycle staff to be educated with regard to the TMR, guided by sound admissions and observation policies and procedures as well as properly and regularly educated regarding decision making and documentation criteria. If admitting physicians including hospitalists are not adequately educated, they may fail to document outpatient service start time, timely sign off on a compliant TMR certification, or cosign an order written by a physician assistant. The physician order and physician certification must clearly outline the physician’s decision making and determination of medical necessity and compliance with the TMR. If the error is not caught in the revenue cycle or revenue integrity process, this could lead to non-compliant billing. Billing staff must be educated regarding when the provision of outpatient services counts. Clinical and revenue cycle staff must also clearly understand how to handle cases in conformance with Condition Code 44 if it is determined, after the patient has left the hospital that he or she did not meet inpatient status. With increased pressure on hospital staff and providers to comply, failure to have a TMR compliance admissions and observations policy could easily result in whistleblower action from a physician, biller, case manager or staff member. If a provider does not provide adequate notice, in compliance with federal or state law, as to the patient’s rights and/or the change in the patient’s admission status, compliance issues can arise.

**D. Patient/Family Challenges and Demands for Inpatient Status:** Even though a patient may have spent several nights in the hospital under observation status, it is still considered, and paid out an as an outpatient service at a significantly lower rate, if the patient does not meet inpatient criteria. Unfortunately, many patients are not sufficiently informed that they were outpatients or on observation status while they were in the hospital. If a patient only has Medicare Part A, and is placed “under observation,” the patient will be charged for services and medication received as an outpatient on
observation status. That is a hard “pill” to swallow. If that same patient had been admitted as an inpatient, Medicare Part A would have paid for their charges.\textsuperscript{41}

If a Medicare beneficiary is transferred to a nursing home facility from observation status at the hospital, Medicare will not cover the charges. A Medicare beneficiary must be an inpatient for three days at a hospital in order to get Medicare coverage for a nursing home facility.\textsuperscript{42} Outpatient care, even if it is a stay in the hospital for 10 days on observation status, does not count towards the 3 day inpatient stay requirement to get Medicare coverage for a nursing home facility.

Major news channels and patient advocacy groups such as the American Association of Retired Persons (AARP) are arming patients with financial, quality, customer service and other data, encouraging beneficiaries to not only know their patient rights but to demand inpatient status from physicians.\textsuperscript{43} CMA’s Self Help Packet for Medicare “Observation Status” provides the following guidance to patients:

“Typical Scenario: You are a Medicare beneficiary who is currently or has recently been hospitalized for three or more days. At the hospital you signed admission paperwork, slept in a hospital bed, underwent many tests, and saw various physician specialists. At some point during the hospitalization or while you were being discharged you were told that the discharging physician ordered follow up care in a skilled nursing facility (nursing home). You were also told that Medicare will not pay for this care because you were admitted to the hospital on observation status rather than as an inpatient.”

“Introduction: Observation status is not new. However, its use by hospitals to avoid lost revenue, scrutiny and accusations of Medicare fraud is growing. This seriously affects Medicare beneficiaries’ access to care and finances. Attempts have been made to remedy the problem legislatively. For instance, bills have been introduced in Congress to eliminate the problem. In addition, the Center for Medicare Advocacy (Center) filed a national class action lawsuit, Bagnall v. Sebelius, challenging the practice in 2011. While we wait for action on the legislation and the lawsuit, individual beneficiaries continue to be negatively affected by observation status. This packet includes information


\textsuperscript{43} MEDICARE: INPATIENT OR OUTPATIENT?, http://www.aarp.org/health/medicare-insurance/info-08-2012/medicare-inpatient-vs-outpatient-under-observation.html (last viewed Sept. 9, 2014)
about observation status and steps you might take to resolve the problems created by an observation status hospital designation. For more information about observation status, visit the Center’s webpage at: www.medicareadvocacy.org. This process is complicated and confusing. Should you have questions, call the Center for Medicare Advocacy at (860) 456-7790.”

Information from advocacy groups, such as the CMA, advises patients regarding their appeal rights and clearly outlines the financial impact of receiving observation designation instead of inpatient. Patients visiting www.medicare.gov receive similar guidance: “The decision for inpatient hospital admission is a complex medical decision based on your doctor’s judgment and your need for medically necessary hospital care. An inpatient admission is generally appropriate when you’re expected to need 2 or more midnights of medically necessary hospital care, but your doctor must order such admission and the hospital must formally admit you in order for you to become an inpatient.”

Patients are reminded that staying overnight in a hospital bed does not mean that they are inpatients. The impact of observation status versus inpatient status on rehabilitation reimbursement is also reviewed.

44 SELF HELP PACKET FOR MEDICARE “OBSERVATION STATUS,”

45 ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT? IF YOU HAVE MEDICARE – ASK!
Here are some common hospital situations and a description of how Medicare will pay. Remember, you pay deductibles, coinsurance, and copayments.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Inpatient or outpatient</th>
<th>Part A pays</th>
<th>Part B pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>You’re in the emergency department (ED) (also known as the emergency room or “ER”) and then you’re formally admitted to the hospital with a doctor’s order.</td>
<td>Outpatient until you’re formally admitted as an inpatient based on your doctor’s order. Inpatient following such admission.</td>
<td>Your inpatient hospital stay</td>
<td>Your doctor services</td>
</tr>
<tr>
<td>You visit the ED and are sent to the intensive care unit (ICU) for close monitoring. Your doctor expects you to be sent home the next morning unless your condition worsens. Your condition resolves and you’re sent home the next day.</td>
<td>Outpatient</td>
<td>Nothing</td>
<td>Your doctor services</td>
</tr>
<tr>
<td>You come to the ED with chest pain and the hospital keeps you for 2 nights. One night is spent in observation and the doctor writes an order for inpatient admission on the second day.</td>
<td>Outpatient until you’re formally admitted as an inpatient based on your doctor’s order. Inpatient following such admission.</td>
<td>Your inpatient hospital stay</td>
<td>Doctor services and hospital outpatient services (for example, ED visit, observation services, lab tests, or EKGs)</td>
</tr>
<tr>
<td>You go to a hospital for outpatient surgery, but they keep you overnight for high blood pressure. Your doctor doesn’t write an order to admit you as an inpatient. You go home the next day.</td>
<td>Outpatient</td>
<td>Nothing</td>
<td>Doctor services and hospital outpatient services (for example, surgery, lab tests, or intravenous medicines)</td>
</tr>
<tr>
<td>Your doctor writes an order for you to be admitted as an inpatient, and the hospital later tells you it’s changing your hospital status to outpatient. Your doctor must agree, and the hospital must tell you in writing – while you’re still a hospital patient before you’re discharged – that your hospital status changed.</td>
<td>Outpatient</td>
<td>Nothing</td>
<td>Doctor services and hospital outpatient services</td>
</tr>
</tbody>
</table>

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46 Id.
The end result of Medicare reimbursement methodology puts patients and physicians in conflict. Concerned about increased patient responsibility for observation care as well as the possibility of being denied coverage for rehabilitation coverage often results in patients and family members strongly advocating for the patient’s admission. News stories such as coverage of a patient by NBC entitled “How to avoid the two words that cost thousands in Medicare Bills,” convey that by speaking up, a patient or his family members can convince a provider to change a patient’s status from observation to inpatient, thus ensuring that Medicare will cover for the cost of inpatient rehabilitation. Patient and family member advocacy can benefit a patient. However, putting physicians in the precarious position of juggling the potential liability from a denied case or allegation of Medicare fraud against the negative financial impact on a patient does not provide savings or value. For the middle of the road cases that could be called inpatient or observation, the physician is often pressured by influences other than his or her best medical judgment, when choosing whether the patient meets TMR criteria.

47 Id.

48 How to Avoid the Two Words that Cost Thousands in Medicare Bills
V. BEST PRACTICES AND SUGGESTIONS FOR SUCCESS

While providers and hospital revenue cycle staff cannot foretell the future, there are some basic best practices that can position providers to be successful under the TMR.

A. Do Not Universally Apply the TMR: As demonstrated by the example of the patient who presents at the hospital at 2AM versus 2PM for care and treatment, it is possible for the presentation time to impact the result of whether a beneficiary’s care is reimbursable under the TMR. Once the patient is stabilized, triaged and registered, the criteria applied by the payor can and should be considered in determining whether the patient meets inpatient status or should be placed under observation. Determine whether the electronic medical record can link to the criteria or methodology utilized by the payor when determining whether inpatient or outpatient status is indicated. Train and educate staff regarding the varied documentation and inpatient criteria that may apply for different payors.

B. Review and Update Policies, Procedures and Forms: Whether on paper or electronic, make sure that your admissions policy, observation policy and other related policies are TMR compliant. If policies and procedures are clear, concise and current, and staff have been trained regarding any recent changes, they will have the tools necessary to be compliant. Review paper and electronic forms and templates for readability and ease of use. Poll case managers and physicians to determine whether there are obstacles to accessing and documenting pertinent information. Collaborate with electronic medical record template building staff to make needed changes.

C. Train and Educate Staff: Develop and provide meaningful training for staff whose understanding of the TMR is critical to compliance. Provide this training in a setting and approach that will be received well by staff. Use case examples with various diagnoses to illustrate the “tough calls” between observation and inpatient. It is critical to identify physician and case management champions who will participate in training, obtain the engagement and compliance of staff, and address staff who have been identified as requiring additional training to ensure compliance.

D. Review Available Data: There is a variety of internal and external data that providers can access on their own, through various hospital associations or even through databases maintained by their vendors. It is important to identify error trends by disease type, by provider, and by other meaningful criteria that hospital and physician leadership can use to address high risks for compliance and finance errors caused by incorrect criteria application, incorrect interpretation of applicable inpatient criteria or failure to adequately document or meet all components of the available criteria. Determine whether physician orders are being signed timely by physicians. Audit physician certifications to determine whether they comply with the TMR requirements. For example, were they signed and dated before the patient left the hospital? Review billing records to determine whether Occurrence Span Code 72 was appropriately used to notify Medicare contractors that qualifying outpatient time was counted toward the TMR benchmark decision by the physician. Are there more denials experienced or documentation deficiencies experienced during gaps in case management coverage? If
so, run the data to determine whether an increase in case management staffing can prevent or mitigate the loss of revenue.

Externally available data, such as RACTrac, created by the American Hospital Association (AHA), can help hospitals search for likely sources of error. The database contains information from hospitals throughout the country which allows for national and local trending and benchmarking. The RACTrac Analyzer, which contains the RAC audit experience data, can be accessed at www.aharactrac.com. Users or their vendors (with provider permission) can upload Recovery Auditor Audit claim data to the RACTrac database through their claim tracking tools and then compare their audit experience to their peer groups. Comparisons can be made by RAC region, bed size, urban or rural settings, for profit/not-for-profit/government, teaching status and critical access hospital status. Visitors can compare data between states or within a state. 49

E. Take advantage of the CMS Settlement Offer: 50 Certain types of facilities including Acute Care Hospitals and Critical Access Hospitals can take advantage of a CMS settlement offer if they act on eligible claims by October 31, 2014. The purpose of this settlement opportunity is to address the large and growing number of claims appeals. CMS will settle all qualifying claims at 68 percent of the “net paid amount” of the claim. Qualifying claims include those that meet all of the following criteria:

“1. The provider is a hospital, as defined 1886(d) or §1820(c) of the Social Security Act. Accordingly, this process is offered to Critical Access hospitals and hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS), but specifically excludes psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), cancer hospitals, and children’s hospitals. CMS will permit hospitals paid under the authority of §1815(e) and §1814(b)(3) to participate, with the understanding that payments made will be adjusted according to the relevant statutory provisions. 2. The claim was not for items/services provided to a Medicare Part C enrollee 3. The claim was denied by an entity who conducted review on behalf of CMS (e.g., Medicare Administrative Contractor (MAC), Recovery Auditor, Comprehensive Error Rate Testing Contractor (CERT), Zone Program Integrity Contractor (ZPIC))


4. The claim was denied based on inappropriate patient status (or otherwise states that the services may have been reasonable and necessary but treatment on an inpatient basis was not)
5. The first day of admission was before October 1, 2013
6. The denial was timely appealed by the hospital:
   As of the date the hospital signs and submits their first administrative agreement:
   a. The appeal decision was still pending at the MAC, Qualified Independent Contractor (QIC), Administrative Law Judge (ALJ) or Departmental Appeals Board (DAB); or
   b. The provider had not yet exhausted their appeal rights at the MAC, QIC, ALJ, or DAB levels
7. The provider did not receive payment for the services as a Part B claim
   ("rebill")

Providers can visit the CMS website to review the procedure for submitting a settlement and receiving payment, but before doing so, should consider the impact of agreeing to settlement on the provider. For example, the settlement is a lump sum pay-out at 38 cents on the dollar. Analytics should be done to determine whether it is financially beneficial to wait out the audit process or forgo appeal rights and settle for 68 cents on the dollar for claims covered by the settlement agreement. Although CMS states that it will provide payment 60 days after the execution of a fully executed settlement agreement, there are no parameters regarding when CMS must countersign the agreement.52 These and many other considerations must be carefully weighed by the provider.

IV. CONCLUSION:

Whether you believe that the TMR requires significant or minuscule changes to ensure compliance, the challenges that physicians and other hospital staff face in ensuring that admission criteria is met, properly documented, and properly billed is significant. There are no “cookie cutter” solutions and good old fashioned best compliance and finance practices will lead to success if combined with available technology, through education and regular auditing and monitoring.

51 Id.
52 CMS MAKES GLOBAL OFFER TO SETTLE ALL ACUTE CARE INPATIENT CLAIMS ON APPEAL,
   (last viewed Sept 9, 2014)