



Inpatient Admission and Medical Review Criteria (“The 2 Midnight Rule”)



Updated as of 6-12-2014

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CMS-1599-F: Inpatient Admission Order and Certification

Certification

- Inpatient Certification requirements were revised in the CY 2015 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule, effective January 1, 2015
 - Under the Inpatient Prospective Payment System, physician certification only required for outlier cases and long stay cases of 20 days or more
 - The admission order will continue to be required for all inpatient admissions when a patient has been formally admitted as an inpatient of the hospital

ORDER

- Formal admission pursuant to an order
- Completed by qualified physician/practitioner
- Begins inpatient status and time

*NOTE: The 2 midnight benchmark states that the physician should account for total contiguous time in the hospital in formulating expected length of stay. This does **not** mean the order for admission may be retrospective.*

Qualifications of Ordering/Admitting Practitioner

- Must be written by a physician or practitioner:
 - Licensed by the state to admit inpatients
 - Granted privileges by the hospital to admit
 - Knowledgeable about the patient
- Not required to be certifying practitioner
- Medical residents, physician assistants, nurse practitioners, other non-physician practitioners or practitioners without admitting privileges may act as a proxy if authorized under state law AND ordering physician approves and accepts decision → countersigns

Verbal Orders

- Practitioners without admitting authority, such as nurses, may be permitted to accept and record verbal orders (VO) at their facility
- Ordering practitioner must directly communicate the order and must countersign the order as written to authenticate it
- Inpatient time starts with VO, if authenticated
- State laws, hospital policies and bylaws, rules and regulations must be met

Standing Orders and Protocols

- Order for inpatient admission may not be a standing order
- Protocol or algorithm may be used in considering inpatient admission
- Only the ordering practitioner or practitioner acting on his behalf (i.e., resident) may make and take responsibility for an admission decision

Physicians with Sufficient Knowledge to Write the Order for Inpatient Admission

- Admitting physician of record
- Physician on call
- Primary or covering hospitalist
- Primary care practitioner (PCP) (or on call for PCP)
- Surgeon responsible for major procedure
- Emergency or clinic practitioners caring for the beneficiary at the point of admission
- Others qualified to admit and actively treating
 - UR knowledge based on the record does **not** suffice

Timing and Specificity of the Order

- At or before the time of inpatient admission
 - If written in advance, inpatient admission does not occur until formal admission by the hospital
 - If formally admitted prior to order being documented, inpatient stay begins with order
- No specific language required, but it is in the best interest of the hospital that the admitting practitioner use language clearly expressing their intent to admit as an inpatient
 - Rare Circumstances it may be inferred



CMS-1599-F: The 2-Midnight Rule Presumption and Benchmark

Medical Review Presumption

- 2 or more midnights *after* formal inpatient admission begins
- Presume inpatient admission is appropriate (i.e., will not be the focus of medical review absent evidence of systematic gaming or fraud).

2-Midnight Benchmark

- Surgical procedures, diagnostic tests, and other treatments are generally **appropriate** for inpatient hospital payment under Medicare Part A when:
 - The physician expects the patient to require a stay that crosses at least 2 midnights, and
 - Admits the patient to the hospital based on that expectation

2-Midnight Benchmark

- Conversely, surgical procedures, diagnostic tests, and other treatments are generally **inappropriate** for inpatient hospital payment under Medicare Part A when:
 - The physician expects to keep the patient in the hospital for only a limited period of time that does not cross 2 midnights
- CMS anticipates such services should be submitted for Part B payment.

Unforeseen Circumstances

- Unforeseen circumstance may result in a shorter beneficiary stay than the physician's expectation (that the beneficiary would require a stay greater than 2 midnights)
 - Death
 - Transfer
 - Departure against medical advice (AMA)
 - Unforeseen recovery
 - Election of hospice care
- 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

Exceptions to the 2-Midnight Rule

- In certain cases, the physician may have an expectation of a hospital stay lasting less than 2 midnights, yet inpatient admission may be appropriate
- Includes:
 - Medically Necessary Procedures on the Inpatient-Only List;
 - Other Circumstances
 - Approved by CMS and outlined in subregulatory guidance
 - New Onset Mechanical Ventilation*
 - Additional suggestions being accepted at SuggestedExceptions@cms.hhs.gov

** NOTE: This exception does not apply to anticipated intubations related to minor surgical procedures or other treatment.*

Transfers (General)

- Pre-transfer time and care provided to the beneficiary at the initial hospital may be taken into account to determine whether the 2-midnight benchmark was met.
 - Start clock for transfers begins when the care begins in the initial hospital.
 - Excessive wait times or time spent in the hospital for non-medically necessary services must be excluded.
- Records may be requested from the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving care
 - Ensure compliance, deter gaming or abuse.
 - Claim submissions for transfer cases will be monitored and any billing aberrancy identified by CMS or the Medicare review contractors may be subject to targeted review.

Transfers (General)

- The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility.

Cancelled Surgeries

- If a surgical procedure was cancelled, the claim should be reviewed based on the general 2-Midnight benchmark instruction. Inpatient Admission and Part A payment is appropriate:
 - if the physician reasonably expected the beneficiary to require a hospital stay for 2 or more midnights (or undergo an inpatient-only procedure) at the time of the inpatient order and formal admission, and
 - this expectation is documented in the medical record.



Case Scenarios

**Note that these case scenarios are being provided for educational purposes only. Compliance with the 2-midnight rule is considered on a case-by-case basis, in accordance with the information contained in the medical record.*

Scenario #1: Initial Presentation to ED

68 year-old man presents to the ED with several day history of urinary symptoms, vague intermittent abdominal discomfort, “gassy” and “feverish” feeling over the 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

- 10:00 pm - Patient is triaged.
- 10:10 pm - Urine sample and glucometer reading obtained and patient sent to the waiting room.
- 11:00 pm - MD assesses patient, orders therapeutic/additional diagnostic modalities.
- 12:00 am - Patient with new complaint of chest pain – additional therapeutic/diagnostic modalities ordered.

10/2/2013

- 12:15 am – MD re-evaluates and determines a need for medically necessary hospital services for this patient to beyond midnight #2.
- 12:35 am – Formal order/admission provided.

10/3/2013

- 7:35 am: Patient is discharged home.

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

A 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

- 6:00 pm - Patient is evaluated by primary and sent to the hospital for further evaluation via ambulance.
- 9:00 pm - Upon arrival at the hospital the admitting practitioner confirms the suspected diagnosis and admits the beneficiary based on the expectation that the patient's care will span at least 2 midnights.

10/2/2013 -10/4/2013

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

10/5/2013

- 9:00 am - Patient is discharged home.

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

- 9:00 am - Patient arrives by ambulance to the ED. Patient is awake and alert.
- 9:03 am - Poison control/POISONINDEX consulted, which advises that patient requires telemetry monitoring; plan to intubate if necessary. Small hospital facility, telemetry monitoring is only available in the intensive care unit.
- 9:07 am - Therapeutic and diagnostic modalities have all been ordered and initiated. Patient airway intact.
- 10:00 am - MD requests transfer to ICU for telemetry monitoring. Unclear to the physician if this 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

- 10:30am - Medical concerns/ sequelae resolving; airway remained intact absent mechanical intervention.
- 12:00pm - Physician writes orders to discharge home.

Hospital should bill for outpatient services. Location of care in the hospital does not dictate patient status. The patient's expected length of stay 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

- 9:00 am – Patient begins receiving medically necessary services in the ED. She shows evidence of fluid overload, requiring intravenous diuresis and supplemental oxygen and continuous monitoring.
- 11:00 am – Intravenous 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

- 9:00 am - She remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis and supplemental oxygen.
- 5:00 pm – She continues to respond to diuretics but remains short of breath and hypoxic with ambulation, requiring additional intravenous diuresis for another 12 to 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

- 10:00 am - The patient's acute CHF exacerbation is resolved and she is discharged home.

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 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

- 10:00 pm - presents to the ED at which time the admitting provider evaluates and orders diagnostic/therapeutic modalities.

1/2/2014

- 4:00 am - Physician writes an order to admit. Patient is formally admitted with the expectation of medically necessary hospital level of care/services for 2 or more midnights.
- 9:00 am - Appropriate designee and the family discuss with the primary physician the desire for hospice care to begin for this patient immediately.
- 3:00 pm - Patient is discharged with home hospice.

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

- 11:00 pm - Beneficiary presents to the ED following fall at home. Beneficiary presents alone.
- 11:30 pm - Beneficiary arm fracture confirmed by practitioner. Pain medication provided.

11/10/13 Sunday

- 3:30 am - Beneficiary pain well controlled, stable for discharge but continues to require custodial care. No family or friends available and hospital social services are unavailable until Monday morning.
- Beneficiary held in hospital pending home care plan, no IV access, pain well controlled with oral medication.

11/11/13 Monday

- 10:00 am – Beneficiary released to home with family member. No other complications.

Outpatient services may be provided and billed to Medicare as appropriate. 26



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