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# Finding Your Lost Inpatients

By J. Stuart Showalter

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Medicare is concerned about the criteria for inpatient admission; you should be too

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Despite what you might have heard, the “two midnight rule” is alive and well according to Day Egusquiza of AR Systems, Inc., but some hospitals are not using it correctly. For example, her audits often show patients who are not responding to treatment still listed in “observation” status even though their stay spanned two midnights. Those patients should be converted to “inpatient” status. If you don’t do that, you’ve “lost” an inpatient. There should never, ever be a case where you have a second billable midnight in an outpatient status, she says.

On the other hand, if a patient really does not *for clinical reasons* need to be an inpatient across two midnights, that person cannot be billed as an inpatient. “Sleeping comfortably” is not a hospital service, it’s a hotel service, Egusquiza said recently at a meeting of the Oregon HFMA chapter. That’s especially so, for example, if the reason the patient is staying over is because the family can’t pick her up until tomorrow.

## Summary of the 2MN Rule

The 2-Midnight Rule allows hospitals to account for total hospital time (including outpatient time directly preceeding the inpatient admission) when determining if an inpatient admission order should be written based on the expectation that the beneficiary will stay in the hospital for 2 or more midnights receiving medically necessary care. Because the inpatient claim only permits CMS to accurately track inpatient time after formal inpatient order and admission (i.e., utilization days/midnights), CMS would like to use Occurrence Span Code 72 to track the total, contiguous outpatient care prior to inpatient admission in the hospital. This will enable CMS to identify claims in which the beneficiary received care as an outpatient for 1 or more midnights and was subsequently admitted as an inpatient based on the expectation that the beneficiary would require 2 or more midnights of hospital care. (See MLN Matters #MM8586.)

Link: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R1334OTN.html?DLPage=1&DLFilter=8586&DLSort=1&DLSortDir=ascending>

## Tell the patient’s story from the very start

According to Egusquiza, documenting the necessity for inpatient status only requires the clinicians to *tell the patient’s story*. She says not to worry so much about InterQual criteria or Milliman’s care guidelines, neither of which does Medicare endorse. Instead, “just document the patient’s story in a way your mother would understand. Just tell why the person needs to be in the hospital *for medical reasons* for a couple of nights.”

Egusquiza has written on this before for HFMA, and she recommends that hospitals assign Utilization Review staff to the emergency department so they can be the first point of contact. UR can be the “safety net” for inpatient status, timely certification, etc., and they can help assign the patient to the right patient type from the start. Otherwise you’re just “placin’ and chasin,’” she says.

Links: <http://www.hfma.org/Content.aspx?id=21373> <http://www.hfma.org/Content.aspx?id=23613>

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