PUBLICATION

2-Midnight Rule Updates [Ober|Kaler]

2016

- **CMS Adopts Change to Benchmark and Shift in Enforcement**
- **CMS Explains Reasoning Behind 0.2% Payment Reduction**

CMS has published discussions of the 2-midnight rule in two recent Federal Register publications. In the final 2016 IPPS rule published in the November 13, 2015 Federal Register [PDF], CMS adopted a change to the 2-midnight benchmark that it had included in the 2016 IPPS proposed rule this summer and further discussed a shift in enforcement of the rule that it announced in that same IPPS proposed rule. For a discussion of these provisions in the IPPS proposed rule, please see our earlier article. In addition, in a December 1, 2015 Federal Register [PDF], CMS published an explanation of its earlier calculation that resulted in a 0.2% payment reduction as a result of the adoption of the 2-midnight rule. Both of these Federal Register publications are discussed below.

Change to Benchmark and Shift in Enforcement (11/13/15 Fed. Reg.)

- **Change in Benchmark**

Under the 2-midnight rule benchmark, when a patient enters a hospital for a surgical procedure, a diagnostic test, or any other treatment and the physician expects the beneficiary will require medically necessary hospital services for two or more midnights (including inpatient and pre-admission outpatient time) and orders admission based upon that expectation, the services are generally appropriate for inpatient payment under Medicare Part A.

CMS established two exceptions to the general rule that there must be an expectation of a two midnight stay to allow an inpatient admission: procedures on the OPPS inpatient only list and certain "rare and unusual" circumstances which, in the reasonable medical judgment of the admitting physician or practitioner, are not likely to meet the two-midnight benchmark but which nevertheless warrant payment under Part A. The only specifically-identified service qualifying under the rare and unusual circumstances exception up to this point has been an admission for newly-initiated mechanical ventilation.

In the November 13 Final Rule, CMS clarified its rare and unusual exceptions policy to allow inpatient payment on a narrow, case-by-case basis for certain inpatient admissions that do not satisfy the 2-midnight rule benchmark. Specifically, an inpatient admission would be appropriate where the documentation in the medical record supports the physician's determination that the patient requires inpatient hospital care despite an expected length of stay less than 2 midnights. The supporting documentation must be based on factors such as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs and the risk of an adverse event during hospitalization.

Such cases will not, however, fall within the protection of the 2-midnight presumption, under which stays of 2 midnights or greater are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, absent evidenced of systematic gaming, abuse or delays in care.

- **Shift in Enforcement**

Effective September 1, 2015, Beneficiary and Family Centered Care Quality Improvement Organizations (QIOs) are responsible for all initial reviews of post-payment claims for the medical appropriateness of inpatient admissions. The QIOs are responsible for related provider education. Providers that exhibit a pattern of practices, including, but not limited to, having high denial rates and consistently failing to adhere to the 2-mdnight rule (including having frequent inpatient hospital admissions for stays that do not span one midnight), or failing to improve their performance after QIO education, will be referred by the QIOs to the Recovery Auditors for further medical review. The number of claims that will be permitted to be reviewed by the Recovery Auditor will be based on the claim volume of the hospital and the denial rate identified by the QIO. QIOs must use information from the patient's medical record and may use evidence-based guidelines and other relevant clinical decision support materials in their reviews. CMS asserted that it would address related technical medical review questions on its website by December 31, 2015, but no such guidance was available at the time this article was written.

Rational for the 0.2% Payment Reduction Related to the 2-Midnight Rule (12/1/15 Fed. Reg.)

This fall the United States District Court for the District of Columbia ruled that CMS did not adequately explain the reasoning for its 0.2% reimbursement reduction related to implementation of the 2-midnight rule. *Shands Jacksonville Med. Ctr. v. Burwell*, D.D.C., No. 1:14-cv-00263 (Sept. 2, 2015). Specifically, the court ruled that CMS failed to disclose key aspects of its methodology and critical assumptions used by CMS's actuaries in its proposed rule. The court agreed with the plaintiffs and concluded that by omitting the important information, CMS had deprived the public and the plaintiffs of a meaningful opportunity to comment, and that such action violated the Administrative Procedure Act. The court remanded the matter to CMS to develop and publish additional justifications for the payment reduction. Please see our earlier article for a discussion of this case.

CMS's December 1, 2015 Federal Register publication is the agency's explanation of its reasoning behind the 0.2% payment reduction, as ordered by the court in *Shands*. The payment reduction recognized that some cases that were previously outpatient cases would become inpatient cases and vice versa. CMS anticipated that the result would be an estimated $220 million in additional reimbursement for inpatient stays. Hospitals and hospital trade groups are currently analyzing CMS's explanation. **Comments are due by February 2, 2016**, which CMS says it will respond to in a final notice to be published by March 18, 2016. Hospitals with concerns or complaints regarding CMS's explanation should consider filing comments either independently or in conjunction with their hospital trade associations.