Medicare Admission Standards

In this course, we will cover:

• The Two Midnight Rule and the rule’s documentation requirements
• Medical Necessity standards
• Inpatient Order and Certification requirements for physicians
• Outpatient Observation Standards for the Two Midnight Rule
• How to determine the changes in Patient Status and how rebill Part B
• The Utilization Review process for the Two Midnight Rule
Medicare Two Midnight Rule

In an attempt to provide clarity to its inpatient admission standard, effective October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) implemented new Medicare inpatient admission standards, commonly referred to as the “Two Midnight Rule.”

Navicent Health has developed a Medicare Patient Status Policy 60-029 which outlines the current requirements of the Two Midnight Rule.
1. **Inpatient Admission Medical Necessity Standard:**
   - Inpatient admission is generally appropriate if the physician expects the patient to require medically necessary hospital services (including outpatient services) spanning two midnights or if the beneficiary requires an Inpatient Only Procedure. (42 C.F.R. § 412.3(d)).
   - CMS has also identified limited “rare and unusual exceptions” to this two midnight standard.

2. **Inpatient Order Requirements:**
   - **Inpatient (defined)** – An individual is considered an inpatient status if formally admitted as an inpatient pursuant to an order for inpatient admission by a:
     - (1) physician, or
     - (2) other qualified practitioner. (42 C.F.R. § 412.3(a)) dependent on the bylaws of the hospital.

3. **Physician Certification Requirements:**
   - Effective January 1, 2015, the physician certification requirements are only applicable to long-stay and outlier cases only.
Two Midnight Rule: Medical Necessity Standards
Two Midnight Rule

**BASIC STANDARD:** Generally speaking, the Two Midnight Rule is a *time-based standard* which provides that a hospital inpatient admission is generally considered reasonable and necessary if:

1) the physician orders inpatient admission based on his or her *expectation* that the patient will require at least two midnights of medically necessary hospital services (this expectation must be documented in the medical record), or
2) the beneficiary requires a procedure on the CMS Inpatient Only List (Addendum E to the Hospital Outpatient Prospective System Final Rule).

**ASSESSMENT FACTORS:** Physician expectations regarding the hospital services the patient will require should be based on complex medical factors, such as:

- Patient history,
- Co-morbidities,
- Severity of signs and symptoms,
- Current medical needs, and
- Risk of an adverse event.

Physician expectations should *not* be based on:

- The hour the patient arrived at the hospital,
- Whether the patient used a bed, or
- Other so called “social factors.”
Two Midnight Rule: Rare and Unusual Exceptions

CMS also provides that there may be “rare and unusual” exceptions to the Two Midnight Rule in which an inpatient admission may be appropriate even though a physician does not expect the patient to require hospital services for at least two midnights.

• “Exception” to Inpatient Admission Order Requirement is missing or defective order guidance.
• To date, the only example of a Rare and Unusual Exception to the Two Midnight Rule that CMS has provided is: Newly-Initiated Mechanical Ventilation.
Effective January 1, 2016, CMS expanded the “rare and unusual” exception to permit additional exceptions to the Two Midnight Benchmark that are determined on a case-by-case basis by the physician that is responsible for the care of the beneficiary, which is subject to CMS medical review.

- The inpatient admission must be supported by clear documentation in the patient’s medical record.

**Relevant Factors:**
- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something happening to the patient; and
- The need for diagnostic studies that appropriately are outpatient services (that is, their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).
The Two Midnight Rule: Outpatient Status

If the physician does not expect the patient to require medically necessary hospital services spanning two midnights, the services would generally be appropriate only for outpatient payment (unless the patient is admitted for a procedure on the Inpatient Only list or a rare and unusual exception is satisfied).
The Two Midnight Rule: Two Midnight Expectation

Factors that lead to the physician’s two-midnight expectation must be documented in the medical record (42 C.F.R. § 412.3(d)).

“Unforeseen circumstances” resulting in shorter stay for a patient will not necessarily result in an inappropriate inpatient admission, as long as the initial expectation was appropriate based on the information available to the physician. Examples of unforeseen circumstances may include:

- Death
- Transfer
- Departures Against Medical Advice (AMA)
- Unexpected clinical improvement
- Election of hospice
The Two Midnight Rule: Time Calculation

- Physicians are permitted to consider all the time patient has spent in the hospital receiving medically necessary hospital services as an outpatient in guiding their two midnight expectation, including for example:
  - Observation
  - Emergency Room (excluding triage and wait time)
  - Operating Room
  - Other Outpatient Treatment Areas
- If a patient is transferred from a different facility, the physician should consider time the patient spent at the prior facility receiving medically necessary hospital services.
- Clock starts when beneficiary begins receiving medically necessary hospital services.
Medical Record Documentation
Expectations

The medical record should provide sufficient documentation to:

- Support the physician’s inpatient admission decision and specifically the physician’s expectation that the beneficiary will require medically necessary hospital services spanning two midnights;
- Support continued hospitalization;
- Support the diagnosis(es);
- Describe the patient’s progress and/or complication(s); and
- Describe any unforeseen circumstances.
Two Midnight Presumption vs. Benchmark

- **Two Midnight Presumption**
  - If inpatient stay from point of valid admission order to discharge lasts “two midnights,” the inpatient stay is presumed by Medicare medical reviewers to be medically necessary.

- **Two Midnight Benchmark**
  - If inpatient stay after the inpatient admission order is *less than* “two-midnights,” medical reviewers will evaluate whether stay meets the Two Midnight Benchmark.
  - Benchmark analysis: Medical record supports the physician’s expectation that medically necessary hospital services (including outpatient services) were needed for period spanning at least “two midnights.”
Two Midnight Rule: Inpatient Admission Order and Certification Requirements
Inpatient Admission Order Requirements

• The Two Midnight Rule introduced technical order requirements and made the *inpatient order* a Condition of Payment.

• Inpatient (defined) – An individual is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an *order for inpatient admission by*:
  – A physician, or
  – Other qualified practitioner
Inpatient Admission Order Requirement: Ordering Practitioner

• The inpatient order must be furnished by a physician or other practitioner (ordering practitioner) who is:
  – licensed by the state to admit inpatients to hospitals;
  – granted privileges by the hospital to admit inpatients to that specific facility; and
  – knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission.

• **Residents can admit to the hospital, but the order is not valid unless cosigned by the attending PRIOR to discharge.**
Inpatient Admission Order Requirements Include:

- Inpatient admission order must be entered in the medical record;
- The inpatient admission order should clearly specify admission for inpatient services;
- The inpatient admission order must be furnished at or before the time of inpatient admission; and
- The inpatient admission order must be signed by a qualified practitioner prior to patient discharge.

(See 42 C.F.R. § 412.3)
Inpatient Admission Order Requirement

The admission decision may not be delegated to another individual who is not authorized by the state to admit patients, or has not been granted admitting privileges by the hospital's medical staff (42 C.F.R. 412.3(b))

- **Verbal / Telephone Orders**
  - Although verbal/telephone orders are permitted, the inpatient order must identify the qualified “ordering practitioner”, and must be countersigned by the ordering practitioner promptly and prior to patient discharge.

- **Resident Inpatient Admission Orders**
  - As permitted by state law and the medical staff bylaws, the ordering practitioner may allow residents to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by counter-signing the order prior to discharge.
A physician **certification is only required for long-stay cases** defined as 20 days or longer along with outlier cases, effective January 1, 2015.

**Physician Certification requirements:**
- Authentication of inpatient order;
- The reasons for inpatient services;
- Estimated time for required hospital stay; and
- The plans for post-hospital care, if appropriate.

The physician certification must be completed prior to patient discharge.
Overview of Two Midnight Rule: Updates to CMS Manual

- Even though the Two Midnight Rule has been in effect for more than 3 years, CMS only recently updated the Medicare Benefit Policy Manual to reflect this significant change in policy.

  - **January 2017** – Chapter 1 of the Medicare Benefit Policy Manual was updated to include brief general references to the Two Midnight Rule by CMS.
  
  - **March 2017** – Change Request 9979 was issued by CMS, which also revises Chapter 1 of the Medicare Benefit Policy Manual to include additional information regarding inpatient admission orders and certification requirements.

    - Most of the language was imported from an Order and Certification Guidance to the Chapter 1 that was previously mentioned from January of 2014. The content however was updated to reflect the current certification requirements that is now limited to long-stay and outlier cases.
Outpatient Observation Standards
Outpatient Observation Services

• If the ordering practitioner does not expect the patient to require medically necessary hospital services spanning two midnights, only outpatient services would generally be appropriate.
• CMS does not consider observation to be a patient status or geographic location in the hospital. Observation is a type of outpatient service.
• Navicent has developed a Medicare Observation Services Policy #60-028 which can be found on the intranet.
Outpatient Observation Services: Defined

• CMS defines “Observation Services” as:
  – A set of specific, clinically appropriate services, which include short term treatment and assessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. The purpose of Observation Services is to determine the need for further treatment or for inpatient admission. (Medicare Benefit Policy Manual, Ch. 6, Sec. 20.6)

• The purpose of Observation Services is to determine the need for further treatment or for inpatient admission.
Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) ACT

- Requires hospitals to provide patients receiving outpatient observation services for a time span that exceeds 24 hours with a notification explaining their status as outpatient and implication.
- Was Enacted on August 6, 2015, went into effect August 6, 2016
- Medicare Outpatient Observation Notice (MOON) form required as of March 8, 2017

Medicare Outpatient Observation Notice (MOON)

Patient Name: ___________ Patient ID: ___________ Physician: ___________

Date: ___________ Time: ___________

On ___________ at ___________, you began receiving observation services at ___________. You’re a hospital outpatient receiving observation services, also called an observation stay. You are not an inpatient.

Observation services:
- Are given to help your doctor decide if you need to be admitted as an inpatient or discharged;
- Are given in the emergency department or another area of the hospital; and
- Usually last 48 hours or less.

How being an outpatient affects what you may have to pay: Being a hospital outpatient affects the amount you may have to pay for your time in the hospital and may affect coverage of services after you leave the hospital.

Medicare Part B covers outpatient hospital services, including observation services when they are medically necessary. Generally, if you have Medicare Part B, you may pay:
- A copayment for each individual outpatient hospital service that you get; and
- 20 percent of Medicare-approved amount for most doctor services, after the Part B deductible.

Part B copayments may vary by type of service. In most cases, your copayment for a single outpatient hospital service won’t be more than your inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

If you’re enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage are determined by your plan. Check with your plan about coverage for outpatient observation services.

If you are a Qualified Medicare Beneficiary through your state Medicaid program you cannot be billed for Part A or Part B deductibles, coinsurances, and copayments.

Your costs for medications:
Generally, prescription and over-the-counter drugs, including “self-administered drugs,” given to you by the hospital in an outpatient setting (like an emergency department) aren’t covered by Part B. “Self-administered drugs” are drugs you’d normally take on your own. For safety reasons, many hospitals don’t allow patients to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs in certain circumstances. You’ll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

NOTE: Medicare Part A generally doesn’t cover outpatient hospital services, like an observation stay. However, if inpatient hospital services become necessary for you and the hospital admits you as an inpatient based on a doctor’s order, generally Medicare Part A will cover inpatient services. Generally, you’ll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you’re in a hospital. Medicare Part B covers most of your doctor services when you’re an inpatient. You may have to pay 20 percent of the Medicare-approved amount for doctor services after paying the Part B deductible.
Outpatient Observation Orders

- Observation services are covered only when provided by the order of a physician or another individual authorized by Navicent Health Medical Staff Bylaws to register patients to the hospital or to order outpatient tests.
- The order for observation services must be documented in the medical record.
- All orders for observation services must be dated, timed, and authenticated promptly and in accordance with the Medical Staff Bylaws.
Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order.

Observation time ends when all medically necessary services related to observation care are completed.

A patient receiving observation services may improve and be released, or be admitted as an inpatient.

CMS states that, in the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. (Medicare Benefit Policy Manual, Ch. 6, Sec. 20.6)

If information becomes available that supports the expectation that the patient’s stay in the hospital receiving medically necessary hospital services will span at least two midnights, including the time the patient has already spent receiving observation services or services in the emergency department, the physician should admit the patient as an inpatient.
Patient Status Changes and Rebilling for Part B
Overview of Patient Status Changes

Specific processes must be followed when changing patient status.

The processes depend on whether the patient status change is:
- Outpatient $\rightarrow$ Inpatient  or  
- Inpatient $\rightarrow$ Outpatient
Patient Status Changes: Outpatient to Inpatient

- If a patient’s status develops in such a way that the patient’s stay in the hospital receiving medically necessary hospital services will span at least two midnights, or if new information becomes available that supports that expectation, it would be appropriate under the Two Midnight Rule for the ordering practitioner to admit the patient as an inpatient.
  - Note: must satisfy inpatient admission order requirements.
- Involvement of the Utilization Review Committee is not required or necessary.
  - Note: Change from outpatient to inpatient must be made while the patient is in the hospital. Post-discharge patient status changes are not permitted.
Patient Status Changes: Inpatient to Outpatient – Code 44

If the ordering practitioner determines that (outside of unforeseen circumstances described above) an inpatient admission is improper prior to the patient’s discharge, Navicent Health and the ordering practitioner should follow the technical requirements of Condition Code 44 to change the inpatient admission to outpatient.

Involvement of the Utilization Review Committee is required.

Navicent Health has developed a Medicare Patient Status Policy #60-029 which outlines the Condition Code 44 requirements. This policy may be found on the intranet.
Patient Status Changes: Inpatient to Outpatient – Code 44

• Condition Code 44
  – Condition Code 44 permits a provider to change an inpatient admission to an outpatient claim “when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.”

• Condition Code 44 Requirements
  – The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
  – The hospital has not submitted a claim to Medicare for the inpatient admission;
  – A physician concurs with the Utilization Review Committee’s decision; and
  – The physician’s concurrence with the Utilization Review Committee’s decision is documented in the patient’s medical record.

See Medicare Claims Processing Manual, Chapter 1, § 50.3.2.
If after patient discharge, it is determined that an inpatient admission may not satisfy certain Two Midnight Rule requirements, Navicent will pursue (to the extent available) Part B rebilling.

Part B rebilling rules require, among other things, that a provider:

- Submit a nonpayment claim to reverse Part A Inpatient claims first
- Accept §1879 liability (beneficiary not liable)
- Resubmit a corrected Part B claim
- Meet the one-year timely filing deadline
There is no explicit requirement that enforce Medicare Advantage organizations to follow the Two Midnight Rule

- Some Medicare Advantage organizations have adopted policies that are consistent with the Two Midnight Rule while others rely on screening criteria or other approaches

It is vital for providers to confirm they understand each Medicare Advantage organization’s policy for patient status determinations
Navicent Health has established a utilization management process to facilitate compliance with patient status requirements. Navicent Health has documented its processes regarding utilization management in the Utilization Plan with oversight by the Clinical Stewardship Committee.
If you have any questions regarding inpatient admission and observation services, please contact:

- **Patient Access**  
  – 478-633-2639
- **Case Management**  
  – 478-633-1205
- **Corporate Compliance**  
  – 478-633-1223
Click the link below and complete the Medicare Admission Standards Post-test:

http://w3.mcccg.org/iota/test-medicare-admission-standards.asp

When the test is successfully completed, you will be prompted to enter information to record your results.