Implications of the “2 Midnight Rule” for Case Management Practice

Clarifying Inpatient Admission Criteria and Part A to B Rebilling

Modern Healthcare Webinar | September 25, 2013

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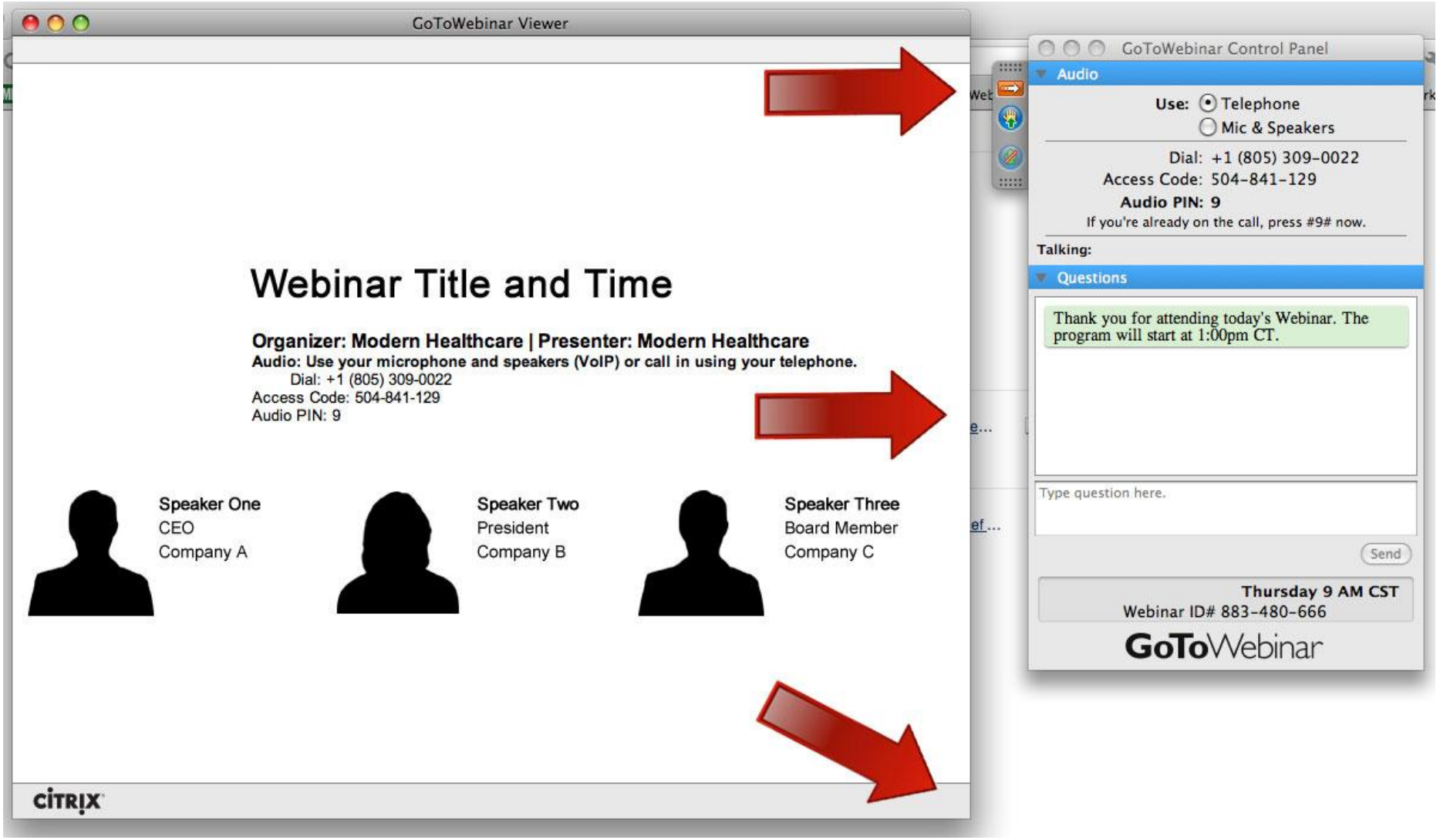
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Agenda

- Introduction
- Part A to Part B Inpatient Billing
  - Part B Inpatient Services
  - Timely Filing and Rebilling
  - Self Audits and Post Discharge Review
  - Beneficiary Impact
  - Direction to Administrative Law Judges
- Part A Inpatient Hospital Claims and Medical Necessity Review
  - The Physician Order
  - The 2-Midnight Rule
  - Certification
  - Physician Documentation
- Implications of the “2 Midnight Rule” for Case Management Practice

Introduction

Introduction

- Released August 2, 2013
- Published August 19, 2013
- Effective October 1, 2013
- Two provisions that directly affect day to day hospital operations.
  - Defining medical necessity for inpatient hospital claims
  - Part A to B rebilling
- Rationale
  - Provider requests for change
  - Increased use of observation
  - Longer length of observation stays and affect on beneficiaries

Part A to Part B Inpatient Billing

Part A to Part B Inpatient Billing

- March 13, 2013 CMS 1455 – R
  - Allowed rebilling of claims denied by a Medicare contractor for lack of medical necessity
  - Waived the one-year timely filing limit
- CMS released the final rule as part of the 2014 IPPS Final Rule, CMS-1599-F
  - Timely filing requirements and self-audits
  - Direction to ALJs
- September 19, 2013 MLN Matters® Number SE1333
  - Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims
  - Applies to admissions on or after October 1, 2013

Part B Inpatient Services

- May be billed when a Part A claim is denied by a Medicare contractor when an Inpatient admission is deemed not reasonable and necessary.
- 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.
- May bill for services except those that specifically require an outpatient status.
  - Outpatient visits, emergency department visits, and observation services

Timely Filing and Rebilling

- One-year timely filing limit reinstituted on October 1, 2013.
- Starts from the **date of service** and not the date of the denial.
- Dates of service prior to October 1, 2013, and denied after September 30, 2013.
  - Will remain under provisions of the interim rule
  - Not subject to one-year timely filing limitation
- Final rule allows for rebilling of therapy services on inpatient Part B claim.

Timely Filing and Rebilling

- For claims that fall under the interim ruling, providers have 180 days from
  - Date of dismissal notice if withdrawing appeal
  - Date of receipt of the final or binding decision if appeal has not been withdrawn
  - Issuance of initial or revised determination on the Part A claim if no appeal pending or subsequently appealed
- 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.
  - Payable as if beneficiary had originally been treated as an outpatient

Self Audits (Condition Code 44)

- The Final Rule emphasizes that the inpatient admission is based on the physician's expectation of a 2-midnight stay.
- Patients can and will recover more quickly than anticipated. The Final rules guidance is as follows:

> "such unexpected improvement may be provided and billed as inpatient care, as the regulation is framed upon a reasonable and supportable expectation, not the actual length of care, in defining when hospital care is appropriate for inpatient payment; …a beneficiary who experiences an unexpected recovery during a medically necessary stay should not be converted to an outpatient but should remain an inpatient if the 2-midnight expectation was reasonable at the time the inpatient order was written, but unexpectedly the stay did not fully transpire."

Self Audits (Condition Code 44)

- These types of cases should be thoroughly reviewed by the case management team, the UR committee and the treating physician.
- When there is sufficient documentation to support an inpatient admission, including the expectation of a two midnight stay, the case should be billed as an inpatient.
- In those cases in which an inpatient admission is deemed inappropriate and found prior to discharge, CC 44 should be utilized.
  - The entire stay is billed as an outpatient
  - Observation hours begin at the time the CC 44 is implemented

Post Discharge Review

- Claims reviewed after discharge for which the hospital determines the beneficiary should have received outpatient care rather than hospital inpatient services.
- Part A claim must be withdrawn if previously submitted.
- Must submit a provider liable / no pay claim
  - TOB 110
  - Occurrence Span Code “M1” and dates of service
- Once processed a no-pay remittance will be received.
- Resubmit an inpatient claim for payment under Part B
  - TOB 12x
  - Condition Code W2

Post Discharge Review

- Bill Part B outpatient services in the three-day window on a TOB 131.
- This should NOT be standard practice.

> "Use of Condition Code 44 or Part B inpatient billing pursuant to hospital self-audit is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols."

- The incidence of A to B rebilling is a potential quality measure.

Beneficiary Impact

- If the hospital subsequently submits a Part B inpatient claim.
  - Beneficiary is liable for Part B copayments or;
  - Inpatient Part B services and;
  - Cost of drugs that are typically self-administered
- Pursuant to a denial of a Part A inpatient admission as not reasonable and necessary.

> "the hospital is required to refund any amounts paid by the beneficiary (such as inpatient deductible and copayment amounts) for the services billed under Part A."

- Refunds may be offset by liabilities incurred associated with the Part B claim.

Beneficiary Impact

- Another issue directly affecting beneficiaries is their liability in cases in which the patient originally had a 3-day qualifying stay, was transferred to a SNF for continued Part A services, and subsequently the inpatient stay was denied as not medically necessary.

  "the status of the beneficiaries themselves does not change from inpatient to outpatient under the Part B inpatient billing policy. Therefore, even if the admission itself is determined to be not medically necessary under this policy, the beneficiary would still be considered a hospital inpatient for the duration of the stay – which, if it occurs for the appropriate duration, would comprise a 'qualifying' hospital stay for SNF benefit purposes so long as the care provided during the stay meets the broad definition of medical necessity…"

- The patient's status remains inpatient, the admission counts as a 3-day qualifying stay and there is no liability to the patient.

Direction to ALJs

- The Final Rule clarifies instruction to the Administrative Law Judge (ALJ).
- If a hospital submits an appeal of a determination that a Part A inpatient admission was not reasonable and necessary, the only issue before the adjudicator is the propriety of the Part A claim.
- The ALJ should not consider any issue regarding any potential Part B claim the provider has not yet submitted.

Part A Inpatient Hospital Claims; Medical Necessity Review

The Physician Order

Final Rule

- The Physician order must be present in the medical record.

  "For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner…"

- The order must be supported by the admission and progress notes.

  "This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A…"

- The admission order must explicitly document the admitting physician's intent to order inpatient status.

  "The order must specify the admitting practitioner's recommendation to "admit 'to inpatient,' 'as an inpatient,' 'for inpatient services,' or similar language…"

The Physician Order

Final Rule

- CMS defines who can furnish the inpatient order.

> "the order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff."

- If an order for inpatient is not written the patient will be considered an outpatient.

> "[u]nless a treating physician has written an order to admit the patient as an inpatient, the patient is considered for Medicare purposes to be a hospital outpatient, not an inpatient"

The Physician Order

CMS September 5th Memo

Content

"[c]ontains the instruction that the beneficiary should be formally admitted for hospital inpatient care. The order must specify admission for inpatient services".

Qualifications

"The order must be furnished by a physician or other practitioner ("ordering practitioner") who is: (a) **licensed** by the State to admit inpatients to hospitals, (b) granted **privileges** by the hospital **to admit** inpatients to that specific facility, and (c) **knowledgeable** about the patient's hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision".

"At some hospitals, practitioners who lack the authority to admit inpatients under either State laws or hospital by-laws may nonetheless frequently write the sets of admitting orders that define the initial inpatient care of the patient. In these cases, the ordering practitioner need not separately record the order to admit".

The Physician Order

CMS September 5th Memo

"Following discussion with and at the direction of the ordering practitioner, the order (including a verbal order) **may be documented by an individual who does not possess these qualifications** (such as a **physician assistant, resident, or registered nurse**), as long as that documentation (transcription) of the order is in accordance with State law including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations".

"In this case, the order must identify the qualified "ordering practitioner", and **must be authenticated by the ordering practitioner** (or by another practitioner with the required admitting qualifications) **prior to discharge**. A transcribed and authenticated order also satisfies the order part of the physician certification as long as the ordering practitioner also meets the requirements for a certifying physician".

Verbal Order

"[t]he inpatient order to admit may also be directly communicated to staff as a verbal (not standing) order".

The Physician Order

CMS September 5th Memo

Knowledge of the Patient

"[o]nly the following practitioners to have sufficient knowledge about the beneficiary's hospital course, medical plan of care, and current condition to serve as the ordering practitioner: the admitting physician of record ("attending") or a physician on call for him or her, **primary or covering hospitalists** caring for the patient in the hospital, the beneficiary's primary care practitioner or a physician on call for the primary care practitioner, a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her, **emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission**, and other practitioners qualified to admit inpatients and actively treating the beneficiary at the point of the inpatient admission decision".

The Physician Order

CMS September 5th Memo

Timing

"The order must be furnished at or before the time of the inpatient admission".

Specificity of the Order

"The specificity requirements outlined in the FY 2014 IPPS Final Rule are **most clearly met by the inclusion of the term "inpatient" in the admission order**. However, in the event that explicit identification of the admission as "inpatient" is not specified, the admission order may still be consistent with 42 CFR 412.3 provided that the **intent to admit** as an inpatient is clear. Orders that specify admission to an inpatient unit (e.g., "Admit to 7W", "Admit to ICU"), admission for a service that is typically provided on an inpatient basis ("Admit to Medicine"), or admission under the care of an admitting practitioner ("Admit to Dr. Smith"), and orders that do not specify beyond the word "Admit," will be considered to specify admission to an inpatient status provided that this interpretation is consistent with the remainder of the medical record".

Certification

Final Rule

Content

a. Authentication of the practitioner order: The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and in the case of services not specified as inpatient-only under 42 CFR 419.22(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark under 42 CFR 412.3);

b. Reason for inpatient services: The reasons for either— (i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for cost outlier cases under the inpatient prospective payment system (IPPS);

c. The estimated time the beneficiary requires or required in the hospital;

d. The plans for post hospital care, if appropriate, and as provided in 42 CFR 424.13.

Certification

CMS September 5th Memo

- Timing
  - Signed and documented in the medical record prior to discharge
- Authorization

"Must be **signed by the physician responsible for the case**, or **by another physician** who has **knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff** (or by the dentist as provided in 42 CFR 424.11). Medicare considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician: the **admitting physician** of record ("attending") or **a physician on call for him or her**; a **surgeon responsible** for a major surgical procedure on the beneficiary or a **surgeon on call for him or her**; a **dentist** functioning as the admitting physician of record or as the **surgeon responsible** for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the State and has been granted privileges by the facility, a **physician member of the hospital staff** (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above."

Certification

CMS September 5th Memo

- Format

"[n]o specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification".

Certification

CMS September 5th Memo

- Methodology

In the absence of specific certification forms or certification statements, CMS and its contractors will look for the following medical record elements in order to meet the initial inpatient certification requirements.

a. The **authentication requirement** for the practitioner order will be met by the s**ignature or countersignature of the inpatient admission order by the certifying physician**.

b. The requirement to certify **the reasons that hospital inpatient services are or were medically required** will be met either by the diagnosis and plan documented in the inpatient admission assessment or by the inpatient admitting diagnosis and orders.

c. The estimated time requirement will be **met by the inpatient admission order written in accordance with the 2-midnight benchmark**, supplemented by the physician notes and discharge planning instructions.

d. The post hospital care plan requirement will be met either by **physician notes or by discharge planning instructions.**

Two-Midnight Rule

- CMS had, in the past, provided guidance that states that the expectation of a hospital stay of 24 hours or greater was one of the components to be taken into consideration when evaluating a potential admission.
- CMS has stated that the decision to admit a patient as an inpatient is a complex medical decision based on many factors, including the risk of an adverse event during the period considered for hospitalization, and an assessment of the services that the beneficiary will need during the hospital stay.
- The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care.

Two-Midnight Rule

- The Final Rule, states that an inpatient admission would be generally deemed appropriate and payment made under Medicare Part A when
  - the physician expects a patient to require a stay that crosses at least 2 midnights and;
  - admits the patient to the hospital based on that expectation or;
  - if the patient is undergoing a procedure on the Inpatient-Only list. Inpatient-only procedures are appropriate for exclusion from the 2-midnight benchmark.

    "[a] physician or other qualified practitioner … should order admission if he or she expects that the beneficiary's length of stay will exceed a 2-midnight benchmark or if the beneficiary requires a procedure specified as inpatient-only under 42 CFR 419.22."

    "[t]his instruction does not override the clinical judgment of the physician" and that the appropriateness of the inpatient admission hinges on **"a reasonable and supportable expectation [of a 2-midnight stay], not the actual length of care..."**

- The IPPS Final Rule establishes two distinct, but related, medical review policies: a 2-midnight ***benchmark*** and a 2-midnight ***presumption***.

Two-Midnight Benchmark

- In an effort to summarize how the 2-midnight benchmark should be applied by medical reviewers CMS notes that
  - they will still consider the fact that the beneficiary was in the hospital for greater than 2 midnights following the onset of care when making the determination of whether the inpatient stay was reasonable and necessary.
  - For those admissions in which the basis for the physician expectation of care surpassing 2 midnights is reasonable and well-documented, reviewers may apply the 2-midnight benchmark to incorporate all time receiving care in the hospital.
- The management of hospital stays where the physician expectation is that the beneficiary will stay less than 2 midnights is not appropriate as inpatient.

  > "hospital stays expected to last less than 2 midnights are generally inappropriate for inpatient hospital admission and Part A payment absent rare and unusual circumstance to be further detailed in sub-regulatory instruction."
- Such circumstance could include death, transfer or AMA.

Two-Midnight Benchmark

- CMS is very clear that the ordering physician can consider time the patient spent receiving outpatient services (including observation services, treatment in the ED and outpatient procedures) when calculating whether the 2-midnight benchmark will be met and therefore an inpatient admission medically necessary and appropriate.

- While this outpatient time is considered for admission, it does not turn into inpatient time once the admission is written.

Two-Midnight Presumption

- The Final Rule establishes that for the purposes of contractor reviews, there is a “presumption” that

> “Under the 2-midnight presumption, inpatient hospital claims with lengths of stay greater than 2 midnights after the formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.”

Physician Documentation

- The onus falls directly on the physician to document his or her rationale for inpatient admission.

> "In their review of the medical record, Medicare review contractors will consider complex medical factors that support a **reasonable expectation** of the needed duration of the stay relative to the 2-midnight benchmark. **These include such factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event**".

- The physician must document in the medical record his or her (reasonable) expectation that the beneficiary will require a stay of 2 midnights.
- CMS reiterated on the open door forums that the physicians expectation of a 2-midnight stay must be provided and documented and supported by the history and physical, comorbidities, signs and symptoms, medical needs and risk of an adverse event.

Physician Documentation

- CMS unequivocally states that the justification for admission must be "clearly and completely" documented in the medical record.

  "the decision to admit a patient as an inpatient is a complex medical decision based on many factors, including the risk of an adverse event during the period considered for hospitalization, and an assessment of the services that the beneficiary will need during the hospital stay."

- Compliant and correct physician documentation is of paramount importance

  "the importance of physician documentation in the context of inpatient hospital claims cannot be overstated. Compliance with the Final Rule may involve the adoption of new forms (e.g., Admission Order / Certification forms), and must involve thorough documentation of the need for inpatient hospital services, the physician's expectations regarding length of stay, and rationale for the physician's opinion".

Physician Acknowledgement

- When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

  Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

- Must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient.

Implications of the "2 Midnight Rule" for Case Management Practice

October 1

"Significant changes to the criteria for Medical Necessity coverage for Part A inpatient hospital claims".

"As a condition of payment for hospital inpatient services under Medicare Part A…requires physician certification of the Medical Necessity that such services be provided on an inpatient basis."

Strategy to Standardize

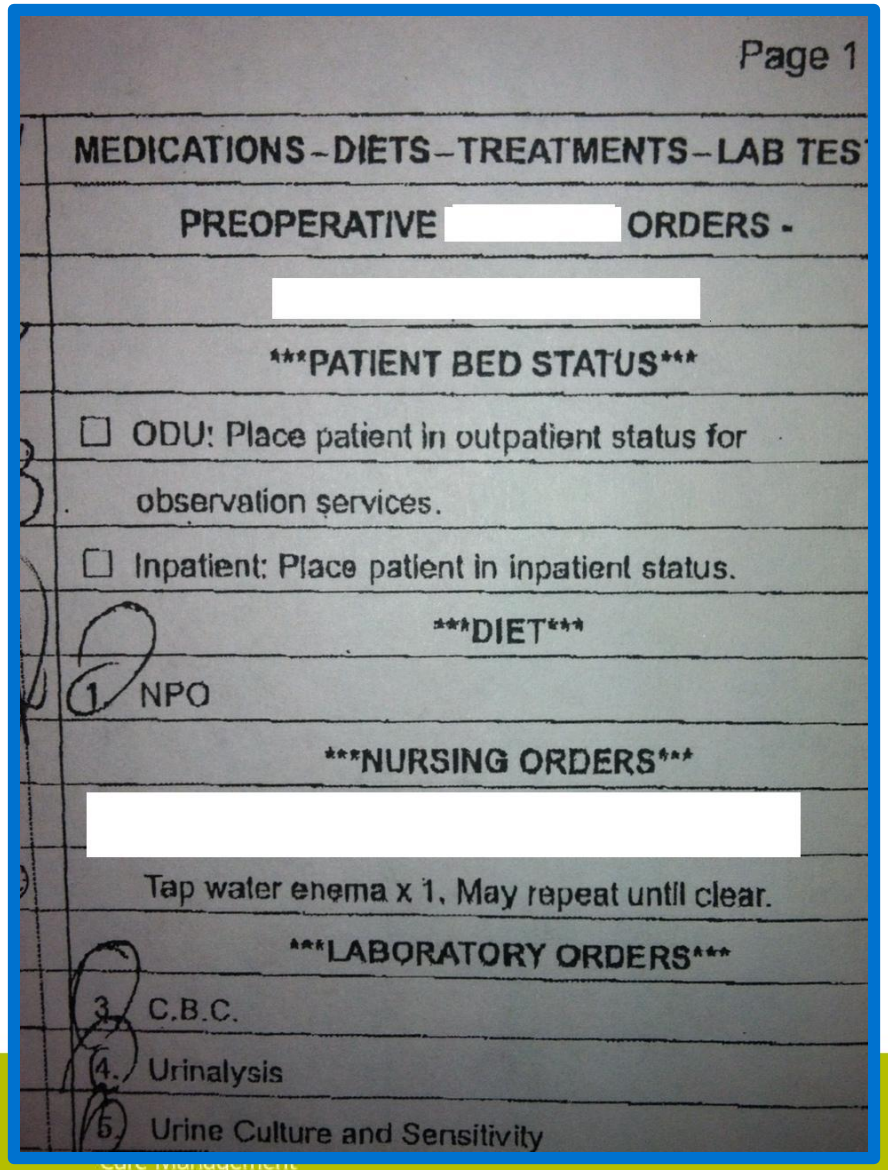
Compliance with Key Elements

Education of Stakeholders

Embedding Processes

Execution

Compliance with Key Elements



Page 1

MEDICATIONS – DIETS – TREATMENTS – LAB TES

PREOPERATIVE [redacted] ORDERS -

[redacted]

PATIENT BED STATUS

☐ ODU: Place patient in outpatient status for observation services.

☐ Inpatient: Place patient in inpatient status.

DIET

1. NPO

NURSING ORDERS

[redacted]

Tap water enema x 1. May repeat until clear.

LABORATORY ORDERS

3. C.B.C.

4. Urinalysis

5. Urine Culture and Sensitivity

- ❑ Status orders not checked?
- ❑ Orders correctly written

  "Admit to Inpatient"

  "Place in Outpatient Observation"

- ❑ Preparing Orders for CPOE

Methodology for Initial Certification

Pre-October 1

- ✓ "Admit to Inpatient" order signed or countersigned by the attending physician / ED
- ✓ Medical Necessity supported by the H&P, Orders & Progress Notes
- ✓ Effective UM process for review of medical necessity criteria
- ✓ Timely Physician Advisor case escalation

As of October 1

- ✓ "Admit to Inpatient" order signed or countersigned by the "certifying" physician
- ✓ Certify the reasons services medically required documented in the H&P, Orders and Progress Notes
- ✓ Estimated time requirement of 2 Midnight benchmark
- ✓ Post hospital care plan
- ✓ Effective UM process
- ✓ Physician Advisor

Physician Certification

The sub regulatory guidelines stated "*The provider may adopt any method that permits verification*" triggering interdisciplinary evaluation of:

- Status of CPOE to meet requirements
- Current practices for orders and medical necessity
- Risk of redundancy due to lack of clarity
- Feedback of Medical staff leadership
- Experience with RAC, MAC and other audits
- Sense of urgency for adoption

Physician Certification “Prior to Discharge”

CPOE Example

1. Integrate certification into the inpatient order for all payers
2. Create an admission certification note that must be completed to discharge

Manual Form

Bar Code

Patient Sticker

Physician's Inpatient Admission Certification Form

Expectation: Ordering provider must "expect" that the patient will require care that crosses two (2) Midnights. **If you do not** "expect" two (2) Midnights, then services should be Outpatient or Observation.

This serves as inpatient certification and must be completed by the Admitting/Attending physician at the time of hospitalization.

Level of Care: Admit to Inpatient

Inpatient Certification:

I certify that the inpatient admission services are ordered in accordance with the Medicare/payor regulations, are reasonable and necessary, and I expect inpatient services to cross over at least two midnights.

***Reason for Inpatient Admission:** (complete all fields below) **REQUIRED**

Diagnosis_____

The following are factors contributing to inpatient level of care determination:

☐ Clinical concerns requiring **two or more midnights** (Please refer to H&P and progress notes for details of medical decision making)

☐ Observation patient with clinical progression now requiring inpatient admission (Please refer to H&P and progress notes for details of medical decision making)

Anticipated Post Discharge Care: Please refer to physician notes and/or discharge planning instructions.

***Admitting/Attending Physician Signature REQUIRED**

Signature:_____ Date:_____Time:_____

Printed Name:_____

CMS REQUIRES THIS CERTIFICATION TO BE SIGNED PRIOR TO THE PATIENT'S HOSPITAL DISCHARGE

* REQUIRED

SAINT VINCENT HOSPITAL, ERIE PA 1920-NEW (9/23/2013)

Education for Stakeholders

WHO

- Medical Staff
- Nursing
- Care Coordination Services
- Emergency Department
- Compliance
- Clinical Documentation Integrity
- Medical Records
- Coding, Denial & Appeals team
- Registration, Finance
- CIO, etc…..

WHAT

- ❑ Sub regulatory Guidelines
- ❑ Implementation Strategies
- ❑ Issues / Questions

Case Management Impacts: UM

- Admission review for medical necessity within 24 hours considering the “first midnight”
- First Continued Stay review completed 24 hours later before the “second midnight”
- Decision to implement for all Payers
- Evaluated Case Management coverage
- Evaluated 7 day availability of Physician Advisor resources

Case Management Impacts

- Collaboration with Clinical Documentation Integrity
- Approaching the conversation with Physicians about documenting their thought processes for “why” ordering Inpatient services or conversions from OOS
- Working with Nursing to confirm that the Certification is completed by physician prior to discharge
- No impact on Inpatient Rehabilitation or Psychiatry
- Review and approve Utilization Management Plan which incorporates “2 Midnight Rule” requirements for an inpatient stay

Embed Processes: Anticipating the “What if…”

Stay > 2 Midnights

- “Presumption” of meeting inpatient criteria unless there is evidence of gaming the system.
- “RACs will do whatever they want to do”.

Embed Processes: Anticipating the "What if…"

Stay < 2 Midnights

- Was there an initial expectation clearly documented?
- Is it appropriate due to unexpected events?
- When do you use Condition Code 44?
- How Physician Advisor capabilities help?

Embed Processes: Anticipating the "What if…"

Inpatient is ready for discharge and the certification is not complete

- "Prevent" strategy to document certification at the time of the order if possible.
- When is it appropriate for the Physician Advisor to review the case, and complete the certification?

Execution of Strategy

"Ambiguity in the rules and many areas remain unclear"

ACMA, Public Policy Committee Survey, September 20, 2013

- How will medical necessity criteria coincide with the new 2-midnight rule?
- How will avoidable days be factored into the 2-midnight rule?
- Does the patient need to meet inpatient medical necessity criteria at the time of the inpatient order if they have already met the 2-midnight rule?
- Will case management protocol still be appropriate under the new rules?
- How does the 2-midnight rule affect outpatient surgery patients who stay overnight in the hospital for additional monitoring and care?
- If the physician initially certifies for Inpatient and then does a Condition Code 44, does the inpatient status have to be de-certified?

Execution of Strategy

- What aspects of the above provisions are still confusing and require clarification?
- Is the “2-midnight rule” a reasonable approach to reducing prolonged observation status for Medicare patients?
- What are the operational issues associated with any of the above provisions that would make it difficult to have all your processes in place by October 1, 2013?
- What should HAP be advocating for in terms of the rule? Should HAP request a delay in implementation? If so, for what period of time? For what provisions?

Execution of Strategy

"**AHA has asked for at least a 3-month delay in enforcement of the "2-midnight benchmark" provisions** which instruct admitting practitioners and Medicare review contractors that an inpatient admission is generally appropriate when the admitting practitioner has a reasonable and supportable expectation, documented in the medical record, that the patient would need to receive care at the hospital for a period spanning 2-midnights."

Hospital Association of Pennsylvania, e-mail, September 20, 2013

Did you know "too angry for discharge" and "patient refuses to leave the ER" are now Medicare approved reasons for inpatient admission?

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Q and A


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