

Auditing the Two-Midnight Rule: Midnight Madness or Moonlight Serenade

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Objectives:

- ✓ Why worry about the Two Midnight Rule?
 - Why so difficult?
- ✓ Understanding the CMS requirements for a valid hospital inpatient admission order.
 - 2016 Amendment to Two Midnight Rule.
- ✓ Identifying the difference between an Emergency Department (ED) order and an admission order.
- ✓ Identifying compliance risks and auditing techniques associated with the Two-Midnight Rule.
 - What to audit?
- ✓ Potential Solutions to Two Midnight practices.

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About Sharp HealthCare

- **Not-for-profit serving 3 million residents of San Diego County**
- **Sharp has grown from one hospital in 1955 to an integrated care delivery system**
 - Affiliated, aligned, and integrated medical groups
 - Fully integrated information technology systems and infrastructure
 - Centralized system support services
 - Senior management has an excellent track record of marked financial and operational improvement, with an average of 15 years of service at Sharp
- **Largest health care system in San Diego with highest market share**
 - 4 acute care hospitals, 3 specialty hospitals, 3 affiliated med groups and health plan,
 - Market share leader and only health system that increased market share each of the past twelve years
- **Largest private employer in San Diego**
 - 17,000 employees, 2,600 affiliated physicians, 2,300 volunteers



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Two Midnight Rule

Why Worry About the Two Midnight Rule?



- 2015's Top 10 Health Law Issues
- Top 5 Hot Issues Medicare Litigation
- Once again, the 2016 OIG Work Plan; there is a focus on short stay, inpatient admissions.
- QIOs are not the only contracted entities that will review short stay claims
 - RACs
 - MACs
 - CERTs
- Annual Risk Assessment
 - Number 1 at our organization past two years

Two Midnight Rule

Why Worry About the Two Midnight Rule?

- A moving target**
 - To date, CMS has issued regulations and sub-regulatory guidance regarding Two Midnight Rule more than 43 times*
 - Complex rules/definitions
- Complex rules/definitions**
 - CMS has continuously refined the Two-Midnight Rule
 - Constant changes have complicated compliance efforts for providers
- Hot Issue**
 - Auditors will be looking for documentation for MD's expectation of two-midnights
 - Cultural Shift-we don't typically document to LOS
 - Difficult Issue- "A cultural change..."



2016 Two Midnight Amendment:

Where are we today?

Amended regulation redrafted 42 CFR 412.3(d)

- Expectation of two midnights, unless shorter stay because of unforeseen circumstances
 - Unexpected death
 - Transfer – hospice
 - Clinical Improvement, or
 - AMA
- Inpatient-only procedures
- NEW: Case-by-case bases – no expectation of two midnights, but admission MAY be appropriate based on admitting physician's clinical judgment and medical record support for the determination
 - Payable on case-by-case basis based on admitting physician's judgment
 - Documentation must support necessity of inpatient admission

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2016 Two-Midnight Amendment

General requirement for Two-Midnight expectation

- Physicians should order inpatient care if they reasonably expect the patient to require medically necessary **hospital care** spanning at least two midnights.
 - Key is the expected need for **hospital care** – not “inpatient” care for two midnights.
 - (Formerly, inpatient care).
 - Hospital Care & Medical Necessity: MD must say “why” they need it.
 - What drives it: what is clearly in the head of the physician.
 - Note: SNF, nursing facility, and assisted living are not hospital levels of care and are not counted in the Two-midnight expectation.
 - Patients needing these levels of care are not appropriate for inpatient admission.



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2016 Two-Midnight Rule Amendment



Outpatient care prior to the inpatient order

- Physicians may consider time the patient spends receiving outpatient care (e.g., in observation or emergency department) prior to admission.
 - Exclude: “Wait time”, “triaging activities”
 - Exclude: “Delays in care”.
 - NEW: Discusses “inconvenience” to the patient
 - Normally not counted in Two-Midnight expectation, however...
 - New language: “Factors that may result in an inconvenience to a beneficiary, family, physician or hospital do not, by themselves, justify Part A payment. When such factors affect the beneficiary’s health, QIOs will consider them.”

2016 Two-Midnight Amendment



Transfers

- Physicians may consider time the patient spent at another hospital prior to transfer.
- The clock starts with initiation of medically necessary care at the initial hospital.
 - Clarification: Initial presenting hospital does not count anticipated time after transfer to another hospital.
 - Note: Still an exception for unforeseen transfers if there is original expectation of two midnights.
 - However: Patients receiving a stabilizing inpatient-only procedure must be admitted **before** transfers.

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2016 Two-Midnight Rule Amendment

Additional case-by-case basis exception



- CMS emphasized
 - Case-by-case nature of the exception.
 - Modification of "rare and unusual" exception.
 - Currently includes newly initiated mechanical ventilation.
 - Decision must be reasonable and necessary and supported by clear documentation in the medical record.
 - CMS provided some guidance.

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2016 Two-Midnight Amendment

Rare and Unusual Exception

- CMS states that the following factors, (among others), would be relevant to determining whether a patient requires inpatient admission under the expanded "rare and unusual" exception:
 - The severity of the signs and symptoms exhibited by the patient,
 - The medical predictability of something adverse 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).



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Clarification of Revised Exception Policy

What it tells us:

- An anticipated stay of less than two midnights can in certain circumstances be an INPATIENT.
- It is only physician judgment backed up by robust documentation that can make this happen.

What it does not tell us:

- What specific diagnosis could lead a physician's judgment to at least consider an inpatient level of care.
- What specific circumstances other than severity of illness and "risk of an adverse outcome" could guide a physician to consider a 1-midnight inpatient level of care.

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Points to Consider for (Short Stay) Inpatient

- Consider intensity/consumption of resources even if practitioner fully expects less than a 2-midnight stay.
- Hospital care that can't or shouldn't be delivered as an outpatient and at risk of an adverse outcome is significant.
 - Anaphylaxis
 - Pulmonary embolism
 - Desensitization
 - Diabetic Ketoacidosis (DKA)
 - Documentation!
 - Auditors want to know your thinking, and want it clearly documented.



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Documenting Two-Midnight Expectation

- Do you have to document – in writing – the two-midnight expectation?
 - Required? Recommended?
 - (Not required, but highly recommended. Nothing lost by stating it, more importantly stating why. Carried through in treatment and clearly expressed.)
 - Critical:
 - Why do you expect two midnights? How was this documented?
 - Was that carried through to treatment of the patient?

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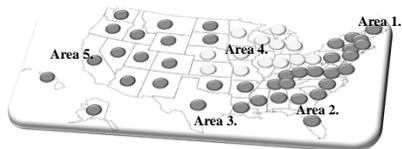
Quality Improvement Organizations (QIOs) Reviews

QIOs Conduct Inpatient Status Reviews

- Effective October 1, 2015, QIOs conduct initial medical reviews of short stay inpatient admission claims.
 - ✓ QIOs affiliated with CMS will begin reviewing short inpatient hospital stay claims effective January 1, 2016 (QIO for California: Livanta).
 - ✓ Each year, QIOs will audit only 50 records from each large hospital and 20 from medium and smaller hospitals (a tally that previously was in the hundreds).
- For dates of admission before December 31, 2015: Reviews based on the Original Two-Midnight Policy (2013).
- For dates of admission on or after January 1, 2016: Reviews based on Revised Two-Midnight Policy (2015).

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QIO Jurisdiction Map & Audit Program



- QIO for Regions 1 and 5 is LIVANTA
 - Livantia website has posted FAQs and other information for providers regarding the program. <http://liva.com/areas5.com/twomidnight.html>
- QIO for Regions 2, 3, and 4 is KEPRO
 - KEPRO website has transcripts, slides and other information for providers regarding their program. <http://www.keproqio.com/twomidnight/>

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Inpatient Status Reviews



QIOs Refer to MACs (for payment adjustments) and RACs (for further review), as appropriate.

- The new annual limits won't prevent QIOs from referring cases of "persistent non-compliance" to the Recovery Auditors (RA) for more aggressive enforcement.
- RA referrals based on patterns of practice, including:
 - High rates of claims denials after medical review
 - Failure to improve after QIO assistance
- Audit result sent to denied beneficiary, that their stay will be changed.

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Summary: Two Midnight Rule: The CY 2016 Final Rule, CMS has....

- Changed the standard by which inpatient admissions generally qualify for Part A payment – based on feedback from hospitals and physician to reiterate and emphasize the role of physician judgment.
- Announced a change in the enforcement of the standard so that QIOs will oversee the majority of patient status audits, with the Recover Audit (RA) program focusing on only those hospitals with consistently high denial rates.

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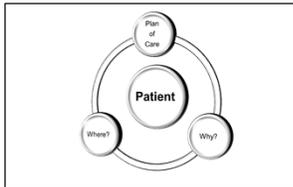
Basis for Updating the Two-Midnight Rule

- CMS sought to balance multiple goals, including:
 - Respecting the judgment of physicians;
 - Supporting high quality care for Medicare beneficiaries;
 - Providing clearer guidelines for hospitals and doctors; and
 - *Maximizing efficient care to protect the Medicare Trust Funds*



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QIOs Looking for? Effective Documentation



- Plan of care that directly correlates with assessment, every order should be easily and explicitly correlated back to a documented sign or symptom, provisional diagnosis or definitive diagnosis. Plan should tell **"Where the patient is going....and why."**

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QIOs Looking for? Concise Documentation



CMS Review Process

- Medical reviewer's clinical judgment would involve the synthesis of all submitted medical record information (for example, progress notes, diagnostic findings, medications, nursing notes, and other supporting documentation) to make a medical review determination on whether the clinical requirements in the relevant policy have been met.

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QIOs Looking for? Key Components

For Medicare payment purposes, both the decision to keep the patient at the hospital and the expectation of needed duration of the stay must be supported by documentation in the medical record based on such key factors as:



- Beneficiary medical history and comorbidities,
- The severity of signs and symptoms,
- Current medical needs, and
- The risk of an adverse event during hospitalization.

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What Can We Expect?

Education?

□ ???????

Denials By Type

- Documentation does not support services medically reasonable/necessary
- Insufficient documentation
- Order missing
- Order unsigned
- Certification not present
- No documentation of two midnight expectation

Probe and Educate Medical Reviews

Top Reasons For Denial

- Documentation did not support two midnight expectation (did not support physician certification of inpatient order) (50%-55%)
- No Records Received (29%-16%)
- Documentation did not support unforeseen circumstances interrupting stay (4% -3%)
- No inpatient admission order (3%-15%)
- Admission order not validated/signed (3%-11%)

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What Can We Expect? Inpatient Status Reviews

QIOs Review Process

- QIOs will conduct reviews twice a calendar year using a provider sample from claims paid within the past six months.
- QIOs will request medical records from provider type (per Lavanta , provider must produce records within 30 days of request).
 - Failure to produce reopening of initial determination and denial
- QIOs are responsible for:
 - Conducting claim review (per Lavanta, within 30 days of receipt of record)
 - Providing written correspondence regarding denials, conducting one-on-one provider education and generating provider results letters (per CMS, provider outreach must be completed within 90 days of completion of review).

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What to Audit? Inpatient Orders

Physician Orders for Inpatient Services

- Where to Look
 - Emergency Services Report
 - ✓ ED Note
 - ◇ Clinical Decision Making
 - ◇ Diagnostic Impression
 - ◇ Disposition Plan
 - ◇ Discussion and Assessment
 - ◇ Plan
 - History & Physical
 - Admit Note
 - Progress Note
 - Consultation Note
- Where to Focus
 - Targets
 - ✓ Short LOS (Falls, TIA's, Syncope, Chest Pain)
 - ✓ Off Hours
 - ✓ Weekend Cases



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What to Audit? Inpatient Orders

Physician Orders for Inpatient Services

- Valid inpatient order requires
 - Clear order for inpatient services
 - Order by qualified ordering practitioner OR proxy
 - Signed by qualifying ordering practitioner **before patient's discharge**



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What to Audit? Inpatient Orders-Language

Physician Orders for Inpatient Services - Language

- Language of the order
 - Should include "inpatient" (e.g., admit to inpatient, admit as inpatient, admit for inpatient services) OR
 - If term "inpatient" is not used, documentation must clearly express intent to admit the patient to inpatient in a manner commonly understood by reviewers/auditors.
 - Order for ER, observation, recovery, day surgery, short-stay surgery are considered outpatient orders.
 - Ambiguous orders must be clarified with the ordering practitioner prior to billing (ideally before discharge).

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What to Audit? Inpatient Orders-Timing

Physician Orders for Inpatient Services - Timing

- Must be at or before the time of admission
 - o If the order is before admission (e.g. pre-surgery orders), admission occurs upon "formal admission" by the hospital
 - ✓ Is this when the patient presents at the hospital? When they are registered?
 - ✓ If the patient is already at the hospital, order should be retroactive
 - o Must be signed **before the patient's discharge**



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What to Audit? Inpatient Orders-Ordering Practitioner

Physician Orders for Inpatient Services

- "Ordering practitioner"
 - o Makes the medical necessity determination/admission decision
 - o Licensed by the state and granted privileges by the hospital to admit patients
 - o Has knowledge of the patient's hospital course, medical plan of care, and current condition at time of admission
 - o May or may not be same as certifying practitioner

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What to Audit? Inpatient Orders-Ordering Practitioner

Physician Orders for Inpatient – Ordering Practitioner

- CMS considers the following practitioners to have sufficient knowledge of the patient.
 - o The admitting/attending physician of record, or a physician on call for them.
 - o "Primary or covering hospitalists" caring for the patient.
 - o The patient's primary care practitioner, or a physician on call for them.
 - o A surgeon responsible for a major surgical procedure on the patient, or a surgeon on call for them.
 - o Emergency or clinic department physicians.
 - o Other practitioners qualified to admit patients, and who are caring for the patient at the point (time) of the admission decision.

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What to Audit? Inpatient Orders-Ordering Practitioner

Physician Orders for Inpatient – Initial Order

- ❑ What if “ordering practitioner” isn’t available?
 - ✓ “Proxy” practitioner can enter “initial order”
- ❑ Who is a “proxy” practitioner?
 - ✓ Must meet the knowledge requirement.
 - ✓ Physician and non-physician practitioners not authorized by hospital bylaws to admit patients
 - ❖ E.g., emergency physician bridge orders.
 - ✓ Residents working in their residency program, licensed under state law to admit patients and allowed by hospital bylaws to write initial admission orders.



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What to Audit? Inpatient Orders-Ordering Practitioner

Physician Orders for Inpatient – Initial Order

- ❑ “Initial order” is only valid if ordering practitioner countersigns the order before the patient’s discharge.
 - By countersigning, the ordering practitioner approves and accepts responsibility for the admission.
- ❑ Impact of countersigning the initial order
 - If the initial order is countersigned before discharge, the time of the initial order is the time of admission.
 - If the initial order is not countersigned before the discharge, the patient is not considered an inpatient and should be billed as Medicare Part B, unless there was another valid inpatient order.

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Audit Findings:

- What the auditors found!
- What we found!
- What you want to find!
 - Admit Med/Surg, Dr. R., anticipate greater than 2 midnight stay secondary to the age of this patient, the multiple infectious etiologies, and evaluation of her critical injuries. She is currently a full code, however, discussed with the patient and family and do not want significant interventions to include tube feedings should there be no recovery.
 - Admit to progressive care unit, Dr. L., anticipate greater than 2 midnight stay secondary to the acute new onset of congestive heart failure, warranting the need for further evaluation of its etiology, and the need to be aggressively treated.

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Livanta Findings:

- Initial Redetermination Review Results Letter (IRRRL)
 - In accordance with criteria set forth 2014 IPPS CMS Final Rule 1599-F
- Approved
 - We agree with the classification of the admission
- Denied
 - Case Summary/Denial Rationale (2 to 3 sentences)
- Initial Overall Results
 - Claims Reviewed, Claims Denied, Claims Requested and Excluded
 - Claims Error Rate (ICER) %
 - Concern Category Rating
 - **Minor** - Less than or equal to 10%, the Initial Redetermination Results Letter will become final unless one opts to exercise the opportunity to discuss the denied claims in writing.
 - **Moderate** - Livanta offers to educate the provider about the denied claims via this IRRRL and also offers the option of either a written opportunity for discussion or 1:1 telephonic education (must receive written materials and/or request for 1:1 telephonic education within 20 days after letter.)
 - **Major** - Livanta will educate the provider about the denied claims via IRRRL and will contact the provider to schedule 1:1 telephonic provider education, results of each claim reviewed. (Allowed to

Livanta Findings - Key Points

- Samples are chosen from "universe of CMS" claims
- Apparently a Two Step Review Process
 - 1. Nurse Reviewer
 - 2. Denials reviewed by Medical Director
 - The Medical Director is reviewing the entire medical record
- Referred frequently to CMS' desires
 - One Day LOS should be rare
 - Want to avoid "single day" inpatient stays
 - "Whole goal" avoid one day admissions
- Acknowledged that Two Midnight Rule has many parts to it
 - Two Midnight rule is not just treatment, but anticipation of Two Midnight Rule
 - No magic language - "Hard to pinpoint" exact language. Looking for LOS and severity of illness
 - Telemetry and ICU - CMS doesn't consider unique or unusual
 - Big danger in "copy and pasting" from 1st Midnight Stay to second (Poor continuation of care documentation-nationally)

Sharp Findings:

Case 1
 Livanta Agreed with Admission
 *One Day Admission (14 Hours) 47 Year Old Female

CHIEF COMPLAINT - Nosebleed (ED MD)
 ✓ HPI-Hx of multiple myeloma (colon cancer with lesions, metastatic to liver) started chemo 4 days ago...clot came up, by arrival seems to almost be resolved. No fever, no chills.
 ✓ PE-No active distress, clinically not in any discomfort.
 ✓ ED Course-Epistaxis seemed to have stopped, but at this time, the patient will require hospitalization and platelet transfusion.
 ✓ Med. Decision Making-Patient is quite jaundiced with very high total bilirubin. This will require further workup in the hospital.
 ✓ Disposition: Admit
 ✓ Condition: Guarded

HISTORY AND PHYSICAL (Attending):
 ✓ Primary Diagnoses: 1. Severe thrombocytopenia, platelets 8 with epistaxis. 2. Liver failure. Total bilirubin 25.8, INR 1.8 with recently diagnosed metastatic colon cancer with liver metastasis.
 ✓ Assessment & Plan: 1. Spontaneous epistaxis secondary to severe thrombocytopenia, platelets of 8 down from 89. 2. Liver failure. Patient's bilirubin has tripled in the last three weeks. 3. Metastatic colon cancer with liver metastasis. 4. Hyponatremia, etc.

CONSULTATION (Hospitalist):
 ✓ Reason For Consultation: End-stage metastatic cancer.
 ✓ HPI: Pt. recently developed a highly aggressive adenocarcinoma metastatic to the liver. She presented in fulminant liver failure.
 ✓ Impression and Plan: Pt. is clearly failing palliative chemotherapy and her condition is worsening rapidly with critically low platelet counts, coagulopathy, and a bilirubin of 25.8.

DISCHARGE SUMMARY (Hospitalist): 36

Sharp Findings:

Case 2

Livanta Agreed with Admission
*One Day Admission (XX Hours) 68 Year Old Female

CHIEF COMPLAINT - Shortness of Breath (ED MD) (GO TO RN- Triage NN)

- ✓ HPI: Worsening gradual onset of chest heaviness sensation that is nonpleuritic, no radiation of her chest discomfort. No numbness or weakness. No abdominal pain, no cough, no hemoptysis, no diarrhea or dysuria or hematuria.
- ✓ ED Course and Medical Decision Making: Pt. was given nitroglycerin, aspirin, and diuresis with Lasix. I do feel she warrants inpatient admission. She does appear to have pulmonary edema as well, however, it is unusual that she has a normal BNP at this time. I consulted with the hospitalist, who kindly agreed to admit the patient. DX: Acute CHF exacerbation. Acute pulmonary edema.

DISPOSITION: Inpatient admission under the care of Dr. N.

HISTORY AND PHYSICAL (Attending-Dr. N.) (Not much help...)

- ✓ CC: Edema
- ✓ HPI: In ED, she had blood work, which shows actually normal ProBNP, but she has severe edema and her chest x-ray suggests some engorgement of pulmonary vessels. She was given IV Lasix and she was actually diuresing pretty well with it.
- ✓ IMPRESSION: Hx of CHF, but her ProBNP is normal. Maybe she just has severe edema from poor pulmonary venous insufficiency in her legs. Nevertheless, the patient is insistent on having this diagnosis but we do not have any records from previous ECG.

PLAN:

- ✓ Admit for IV Lasix, which seem to be effective here in the ER. We will obtain an ECG to assess the cardiac function.

DISCHARGE SUMMARY (Internist)

- ✓ HPI: Pt. has had CHF, who developed increasing pulmonary edema, chest congestion, shortness of breath, dyspnea on exertion.

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Sharp Findings:

Case 3

Livanta Denied Admission
*One Day Admission (XX Hours) 72 Year Old Male (Sunday Morning 2:15 AM 5-8-15)

CHIEF COMPLAINT - Fall, found down. (ED MD) (GO TO RN- Triage NN)

- ✓ HPI: Significant alcohol use in the past, who sustained an unwitnessed fall in his bathroom. EMS was called. Patient presents complaining of no pain.

ASSESSMENT:

- 1. Status post fall. 2. Intoxication with alcohol presumed. 3. History of hypertension. 4. Left scalp and arm abrasion. 5. Possible extremity fracture. 6. Possible blunt torso trauma given pleural effusion. 7. L1 compression fracture.

PLAN:

- ✓ 1. CT head. 2. CT C-spine. 3. CT chest 4. Thoracic and lumbar reformat. 5. Plain films of left elbow and left shoulder. 6. Spine precautions. 7. MRI L-spine. (NOTHING)

CONSULTATION:

- ✓ 72 year old gentleman slipped in the bathroom. No loss of consciousness. Pt. does have a laceration in the left convexity frontal region. CT scan of the brain is normal. CT scan of the lumbar spine demonstrates an L1 compression fracture of mild proportion with the posterior margin of L1 remained intact...At present time, only bracing is suggested. Pt. is ambulating with his brace quite nicely with little pain and I do not feel that kyphoplasty is required in this particular case. Pt. can ambulate p.r.n. with his brace on.
- ✓ ** Nothing else.....

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Par Livanta: ADMISSION DID NOT MEET 2 MIDNIGHT BECAUSE PT. HAD NO ACUTE NEUROLOGICAL DEFICITS OR INJURIES

Sharp Findings:

Case 4

Livanta Denied Admission
*One Day Admission (XX Hours) 82 Year Old Female (Thursday Night 20:56 PM 5-14-15)

CHIEF COMPLAINT - Altered mental status. (ED MD) (GO TO RN- Triage NN)

- ✓ HPI: The pt. was apparently picked up at the border in Mexico after EMS had driven her there for a 10/10 headache and altered mental status. It is unclear when the pt. was last at her baseline mental status as we have no corroborating witnesses her family.

ED COURSE AND DX STUDIES:

- ✓ An ECG was done and it showed a normal sinus rhythm with normal intervals, normal axis, no acute ST evaluation or T-wave inversions suggestive of ischemia. Initially based on the patient's severe headache and altered mental status, a stroke code was called. She was sent immediately to CT scan, and the interpretation was no acute intracranial abnormalities with no evidence of acute hemorrhage.
- ✓ After review, it actually seems that she had a very similar hospital presentation back in February where she presented with acute encephalopathy, confusion, and aphasia, and it was unclear what the symptoms were from. She had an MRI at that time, which was negative.

MEDICAL DECISION MAKING:

- ✓ Severe headache and altered mental status. Initial concern was the patient had an intracranial hemorrhage, given her elevated BP, however, this did not appear to be the case based on negative CT scan. She was afebrile with a normal WB cell count, so I think an infectious etiology is very unlikely, but the patient will be admitted for further observation.

DISPOSITION: Admission to the hospital.

CONDITION: Stable **CONTRARY TO DS

- ✓ H&P: CC, Trouble Speaking
- ✓ HPI: History of recurrent TIA, as well as hyperlipidemia. Brought into ED by ambulance from Mexico with complaints of aphasia.

PLAN:

- Pt. has been recommended for admission to Internal Med. She has been admitted to the PCU due to her worry for elevated BP and the possibility of recurrent TIA versus stroke. The patient will remain on telemetry monitoring to ensure there is no evidence of arrhythmia that could have contributed to her symptoms. (WEAK: ??)

FINAL REPORT: (Attending) DX: Will require a lengthy stay of admission at hospital > 39 more than 48 hours at this point in time we'll obtain MRI of the brain/MRA of the brain carotids echo have been done already and will not be repeated.

Problematic Clinical Situations (What you'll find)

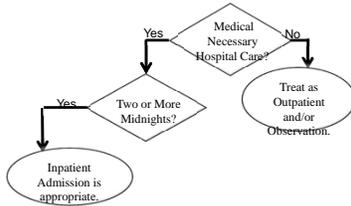
- ✓ Inadequate historical detail to understand symptoms of unknown significance in patients with underlying diseases.
- ✓ Unstated or unclear impressions and treatment plans.
- ✓ Admissions for management based on clinical guidelines and algorithms then not following those guidelines.
- ✓ Variations in descriptions of patient condition by different physicians without explanation or reason.
- ✓ Disconnects (and disagreements) between admitting and attending physician and between attending physician and specialist physicians.

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✓ ~~Use case circumstances versus incorrect admission diagnosis and treatment plan~~

Training Tools

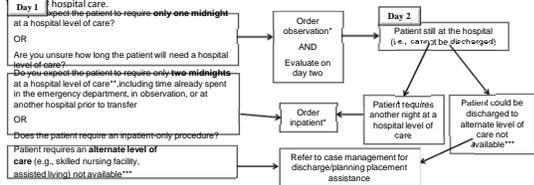
- **Ask two questions:**
 1. Does my patient require medically necessary hospital care?
 2. Do I expect that care to span two or more midnights?
 - If yes to *both* – Inpatient admission is generally appropriate
 - If no to either – Treat as outpatient with or without observation
- **Document key elements:**
 - o Properly executed inpatient order via Medicare Order Form or CPOE.
 - o For inpatient: medical record documentation that describes the patient's condition, treatment plan, risk of being treated in an alternative setting.
 - o For outpatient: diagnosis and outpatient treatment plan.



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Medicare Patient Status Decision Tree

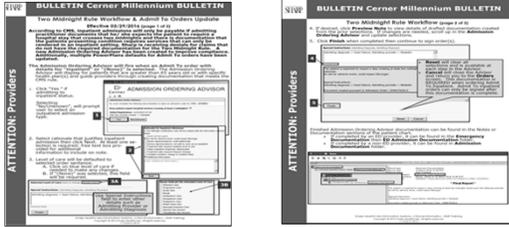
- Inpatient admission is appropriate for a Medicare patient requiring two midnights at a hospital level of care.
- A patient who could be cared for at an alternate level of care (e.g., skilled nursing facility, assisted living) is not considered to require hospital care.
- A patient at the facility waiting for a procedure/test or who decides to remain when he or she could be discharged is not considered at a hospital level of care.



*Utilization review/physician advice may review and make recommendations to ensure documentation meets the medical necessity of the patient status ordered.
**Newly initiated mechanical ventilation is an exception to the requirement for a 2-midnight stay.
***Patient may remain in the hospital due to a lack of placement.

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Example: Bulletin Corner Millennium



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Corrective Action Plans Where Do the Patients Come From?

- ER & Inpatient surgery.
- Attack these places with a pro-patient status focus, not placing and chasing.
- Develop internal flow to attack.
 - ER – How much Utilization Review (UR) coverage? 24/7 or utilizes ER lead RNs or house supervisors. No patient is given a bed without patient status “blessed” integrated CDI program will help with cross training.
 - Inpatient surgery – All daily inpatient schedules are reviewed by UR to review outpatient being scheduled as an outpatient.
 - Direct – House supervisors and/or UR clarify PRIOR to placement.
 - Involve the internal UR leaders and PA for patterns.
 - Senior Leadership will have to be prepared to push thru the regulation with any problematic providers.

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Steps for Better Compliance: Two-Midnight Rule

- Clarification of order form – consistently start and clarify the patient’s story.
- UR in the ER – always involved in prior placement.
- Hospitalist – always see the pat rapidly/less than 2 hours from referral to inpatient.
- Integrated CDI program – one on going audit, one voice for ed.
- Dedicated beds for OBS – OBS hasn’t changed at all. UR assigned to closely monitor every OBS that exceeds the first midnight.
- Groom an internal physician advisor – Ongoing education, Utilization Review support/intervention = effective change
- Actively involve nursing – as the eyes of the patient story 24/7
- Actively involve surgery – scheduling to ‘spot’ any common outpatient surgeries being scheduled as inpatient
- Strengthen the UR Committee.
- Strengthen the UR’s role, separate from Case Management. Front end.
- EMR: Alert to the MD, patient stay < two midnights

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Steps for Better Compliance



- Embed questions from the optional certification form with the electronic orders or use the manual form
- Empower UR staff to assist with compliance
- Know which procedures are riskiest, such as Cath lab procedures and outpatient surgeries that "stay the night"
- Target physicians in the ED
- Hire internal physician advisors to assist with education.
- Understand the implications for transfers
- Use internal audits to identify problem areas
- Learn from the past (the probes) and hammer the message home

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Two-Midnight Rule Summarized

Inpatient Determination:

- Patient requires medically necessary hospital services.
- Physician has reasonable expectation of two or more midnight total hospital stay.
- If less than two-midnight expectation or uncertain it's not inpatient.
 - May still be appropriate if expectation was documented and reasonable, however,
 - ✓ Patient left AMA
 - ✓ Patient expired
 - ✓ Patient newly elected hospice care
 - ✓ Patient is transferred to another acute care hospital
 - ✓ Patient unexpectedly improved
 - ❖ Physician clearly documents that unforeseen improvement

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Two-Midnight Rule Summarized - (Continued)

Inpatient Order:

- Must be signed, dated and timed prior to discharge by a clinician with admitting privileges.
 - Ability to write this order is governed by CMS regulations, state law as well as hospital bylaws.
 - As a result, inpatient orders written by interns, residents, or non-physician clinicians MAY require authentication.
- Must be signed, dated and timed prior to the start of surgery by a physician with admitting privileges for surgical cases on the Inpatient-Only List.
 - If not signed before surgery, may be signed after surgery prior to discharge if compliant with the three-day window.
- Must have documentation consistent with Two-Midnight expectation.
 - Avoid Conflicting terms
 - ✓ Use of inpatient and observation in same order
 - ✓ IP order with a plan to discharge next day

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Education:

Physician Documentation Tips

- An order for inpatient admission must be accompanied by documentation of a reasonable expectation of a Two-Midnight stay.
- The admission or progress note for each day in the hospital, as well as DS, should include one or two sentences with rationale/medical necessity supporting the most likely diagnosis (e.g., angina given...; bowel obstruction due to...; CHF based on...).
- If possible, avoid listing symptoms as the patient's diagnosis (e.g., chest pain, N/V/D short of breath).
- Prior to the patient's discharge the attending physician must sign the inpatient order.

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Education:

Inpatient Versus Observation Ordering Guidelines

- If the MD believes the patient will be discharged same day or the day following hospitalization, consider ordering outpatient or observation.
- If you believe the patient will not be ready for discharge the day after hospitalization, consider ordering inpatient.
- Orders for inpatient cases should include the word "inpatient" to be a valid inpatient order.
- Observation and outpatient cases should include the phrase "refer for observation services" or "outpatient status."
 - ✓ Avoid using "admit" and "observation or outpatient" in the same order. CMS considers this to be contradictory.
 - ✓ Avoid using phrases such as "admit to 6S" or admit to Dr. Smith" in orders.

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Education:

Guidelines for Surgical Cases



- Cases on the CMS inpatient-only list should always be ordered as inpatient.
- Same-day discharge (no overnight stay) is always outpatient.
- A 1-midnight or overnight stay is an outpatient.
- A 2-midnight stay is inpatient, unless the second night is not medically necessary (e.g., placement issue, transportation issue).
 - ✓ Consider ordering inpatient for high-risk patients.
 - ✓ Consider ordering outpatient for low-risk patients.

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Questions:



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