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Two-Midnight and Observation Rule:
What you and your patients need to know about inpatient hospitalizations

The Two-Midnight Rule, which technically went into effect on Oct. 1, 2013, unleashed a storm of controversy. For hospitals and large healthcare systems, the rule can severely affect reimbursement. The rule also adds to the documentation burden of physicians while hitting unsuspecting patients in the wallet for services they assume were covered.

Now, after strenuous pushback, the Centers for Medicare and Medicaid Services (CMS) is reportedly exploring an alternative payment method for short-term inpatient stays.

The policy sets out a procedure for admitting physicians to predict how long a patient will need to be admitted. Inpatient stays of two midnights or more are generally covered under Medicare Part A.

The federal CMS has twice delayed the deadline for Recovery Auditing Contractors (RACs) to begin reviewing compliance with the rule. The new deadline is March 31, 2015. However, Medicare Administrator Contractors (MACs) can continue auditing a limited number of short-stay claims.

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But if a stay does not span at least two midnights, the patient is assigned to observation status, even if the patient spends the night in the hospital. Under this category, services are reimbursed under Part B, regardless of the hour the patient came to the hospital or if the patient used a bed.

Patients may sleep in hospital beds and have tests taken on-site but they are not classified as inpatients. Patients who come to the ER with chest pains or fainting spells often end up as outpatients under observation. These observation stays also are being used by hospitals as a tool to avoid RAC visits and readmission penalties for sending patients home too early. RACs and MACs who review admissions can dispute any decision after the fact. Inpatient acute care hospitals, long-term care hospitals, and critical access hospitals are all subject to the Two-Midnight Rule.

Complexity, confusion and stress

The two-midnight policy creates financial burdens for patients, who, as outpatients under observation, are hit with 20% copays plus the cost of self-administered drugs. Observation stays are not counted toward Medicare's three-day eligibility requirement for skilled nursing facility coverage. When informed of their out-of-pocket obligations, angry patients have walked out of hospitals, forgoing diagnostic studies and medications, according to some reports. These unintended consequences pose safety and quality concerns.

Where a patient spends one midnight in observation, and the physician thinks the patient needs at least another midnight in the hospital, but as an inpatient, Medicare will allow the patient to be admitted despite the fact it is a one-night inpatient stay, according to Advisory.com. When a patient is admitted as an inpatient, but ends up not staying two midnights, Medicare requires documentation supporting the order and initial expectation that two midnights were necessary.

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PCMS NEWS

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Understanding Your Employment Contract
Date: Wednesday, November 5
Time: 6:00 - 8:00 PM

Why Getting Paid Is More Difficult and How To Protect The Bottom Line
Date: Friday, November 14
Time: 10:00 AM - 2:30 PM; lunch included

Social Media: the HIPAA Risks
Date: Wednesday, November 19
Time: 6:30 - 8:00 PM

Maintenance of Certification
"Is MOC Needed and Appropriately Constructed for Success?"
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Calling it quits at 75? Not on your life.

by Anthony M. Padula, MD

Assuming you haven't already reached 75, Dr. Ezekiel Emanuel suggests you call it quits at that age. Shuffle off your mortal coil, as Shakespeare put it.

Dr. Emanuel, vice president of medical ethics and health policy at Penn, contends in a self-written obituary in *Atlantic*, that he doesn't want to live beyond 75. And Zeke, as he prefers to be called, might be in good company: He's outzeked, so to speak, by no less a luminary than Benjamin Rush, physician and signer of the US Constitution, who said that 'few clergymen, physicians, or lawyers living beyond 60 do any good to the world; these men do not die half fast enough.'

One wonders if Dr. Ezekiel will feel the same way at 74½ as he does now at 58. But he believes that 75 defines a clear point in time for him—2032. Assuming that he hasn't changed his mind, he claims that he will eschew most medical interventions: no screening for prostate cancer, no colonoscopies, no bypass surgery and "if I develop cancer I will refuse treatment," he says.

Similarly, he will forgo cardiac stress tests, flu shots, and he favors a 'do not resuscitate' order that will preclude any ventilators, dialysis, surgery, antibiotics or any other medication except those for palliative care.

True, the United States Preventive Services Task Force has found that the benefits of prevention are not worth the risks and hassles of testing, surgeries and medications. It also suggested that after 75 it may not be beneficial for a person without heart disease to start taking statins.

Now is this grandstanding or what? Dr. Ezekiel likes to stir things up a bit. His propensity for non-equivocation is perhaps exemplified by the subtitle of his book: "How The Affordable Care Act will improve our terribly complex, blatantly unjust, outrageously expensive, grossly inefficient, error-prone system." But isn't he forgetting the Hippocratic oath that calls for applying for the benefit of the sick all means that are required, and to prevent disease wherever possible?

How do I, as a septuagenarian physician in full harness as a medical director in a health insurance company, react to all this?

Well, I think about Winston Churchill who, in his 80s, wrote the magisterial 'A History of the English-Speaking Peoples.' I think of Supreme Court justices Oliver Wendell Holmes and Louis Brandeis who were creating law well into their 80s; in the arts, George Bernard Shaw, and Goethe were penning lucid works well into their octogenarian years; and artists Michelangelo and Titian worked prolifically until nearly 90.

Dr. Emanuel, vice president of medical ethics and health policy at Penn, contends in a self-written obituary in Atlantic, that he doesn't want to live beyond 75 .... But if, as has been suggested, 75 is the new 65, we really don't need any apocalyptic thoughts on numeric finiteness. Physicians in general are trained to prolong life.

Closer to home, 85-year old CHOP neuropathologist Dr Lucy Rorke Adams gets to her office at 4:30 am, puts in a full work day… and recently got married. I am reminded of something a mentor used to tell surgical residents: "It's not how far you are from the beginning that matters; it's how close you are to the end.

What does this all mean for today's doctors? Well, first of all, if everyone followed Dr. Ezekiel's plan there wouldn't be much work for us. Just some treating of Alzheimer's and dementia and filling out a lot of legal paperwork.

But if, as has been suggested, 75 is the new 65, we really don't need any apocalyptic thoughts on numeric finiteness. Physicians in general are trained to prolong life. This physician in particular has a fully booked schedule for the next several years; moreover, I have absolutely no intention of zooming off into the ether 24 months from now. Nor should you.

Dr. Padula is president of PCMS.

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Two-Midnight *continued from page 1*

More documentation for physicians

Physicians can expect increasing pressure from hospitals to meet rigorous documentation requirements. Admitting physicians must document the medical necessity for a two-night stay in the hospital, along with providing an assessment and care plan. Only physicians with admitting privileges can determine inpatient status, but the hospitalization does not necessarily have to be ordered by the attending physician. Inpatient stays begin only after a physician signs off on the order for admission, which means that the time a patient spends in observation will not be counted toward the length of stay requirement.

The medical record must contain the physician's certification to support a two-night inpatient stay. This documentation can be included in the H&P, progress notes, and discharge summary.

Clinical documentation must also contain the patient history and co-morbidities; severity of signs and symptoms; risk of adverse events; and current medical needs requiring inpatient care.

Long-stay observation cases grew from 3% to 8% of all cases between 2006 and 2011. The two-midnight rule aims to curtail the growth of observation stays longer than 48 hours. And according to Moody's Investor Services, the new rule has the potential to reduce reimbursement per case by $3,000 to $4,000.

Enterovirus D68 activity in Philadelphia

In September, the Centers for Disease Control and Prevention notified the Philadelphia Department of Public Health that two of the three positive enterovirus-D68 (EV-D68) results from Pennsylvania occurred in Philadelphia residents, confirming that the virus is circulating locally.

Recently, PDPH has identified increases of asthma and respiratory-related visits to local pediatric emergency departments. Respiratory and asthma-related ED visits often increase in the fall — a reflection of the spread of respiratory viruses once children are back in school.

EV-D68 may be contributing to the increase in activity, but it is unlikely to be the sole cause. Although the number of respiratory-related ED visits is higher than usual for this time of year, the rate of admissions at these institutions has remained stable relative to previous late summer/early fall admission rates.

Guidance on EV-D68 testing at CDC

The CDC recommends laboratory testing of respiratory specimens for enteroviruses when the cause of respiratory illness in severely ill patients is unclear. Currently, specimens must be referred to CDC to determine if EV-D68 is specifically present. Once EV-D68 has been confirmed in a community, routine testing is no longer indicated.

Due to the volume of specimens being submitted, CDC is prioritizing EV-D68 testing in order to enhance the epidemiologic characterization of the outbreak across the country. Specimens that have tested positive for enterovirus/rhinovirus may be referred for further analysis if there is a compelling epidemiologic reason to do so, including when the patient:

- is from a locality that has not established the presence of the virus;
- represents a unique population in which infection has not yet been defined;
- resides in a vulnerable congregant setting where results may influence control measures; and
- has an unusual clinical presentation or death.

For more information about specimen submission requirements for molecular sequencing at CDC, please visit: *www.cdc.gov/non-polio-enterovirus/lab-testing/specimen-collection.html.*

Enteroviral infections, including EV-D68, are generally not reportable; however, suspected clusters or outbreaks should be reported to the PDPH Division of Disease Control at 215-685-6740.

Prescribers of Part D drugs required to enroll in Medicare

Section 6405 of the Affordable Care Act requires that physicians and eligible professionals who order durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) or certify home healthcare for beneficiaries be enrolled in Medicare.

The statute also permits the Secretary to extend these Medicare enrollment requirements to physicians and eligible professionals who order or certify all other categories of Medicare items or services, including covered Part D drugs.

Accordingly, CMS will require that physicians and eligible professionals who write prescriptions for covered Part D drugs must be enrolled in Medicare, or have a valid record of opting out of Medicare for their prescriptions to be covered under Part D.

This requirement will help CMS ensure that Part D drugs are only prescribed by qualified individuals. This provision is effective June 1, 2015.

The documentation would be the affidavit that physicians complete when they opt out of Medicare. The link below is the answer to documentation.

www.cms.gov/Newsroom/MediaRelease-Database/Fact-sheets/2014-Fact-sheets-items/2014-05-19.html

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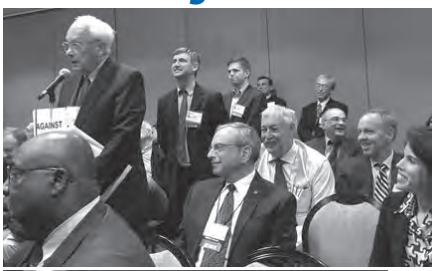

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