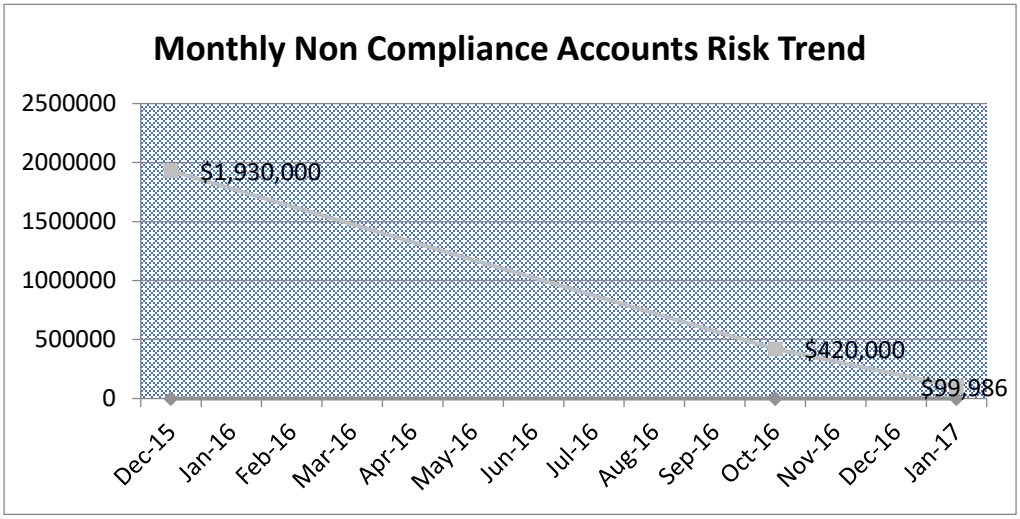
Impact of the CMS Two Midnight Rule at A Large Academic Center: A Case Study

Scope of Engagement

Goal: This case study describes the efforts of multiple stakeholders including Compliance, Physician Advisers, Clinical Informatics, and the Physician Builder group to reduce the 2 midnight admit order compliance risk to the organization from approximately $1.9 M/Month in Dec 2015 to under $100K/Month in Jan 2017.



Background

By CMS rule, an inpatient admission is acceptable when the provider expects the patient to stay in the hospital for at least 2 midnights and admits the patient based on this expectation using a physician order. As stated in the CY 2014 IPPS final rule, **if the order is not properly documented in the medical record, the hospital should not submit a claim for Part A payment (78 FR 50941).** Documented exceptions for this rule include unexpected death of the patient, a transfer to hospice care or another hospital, AMA discharge and unexpected clinical improvement.

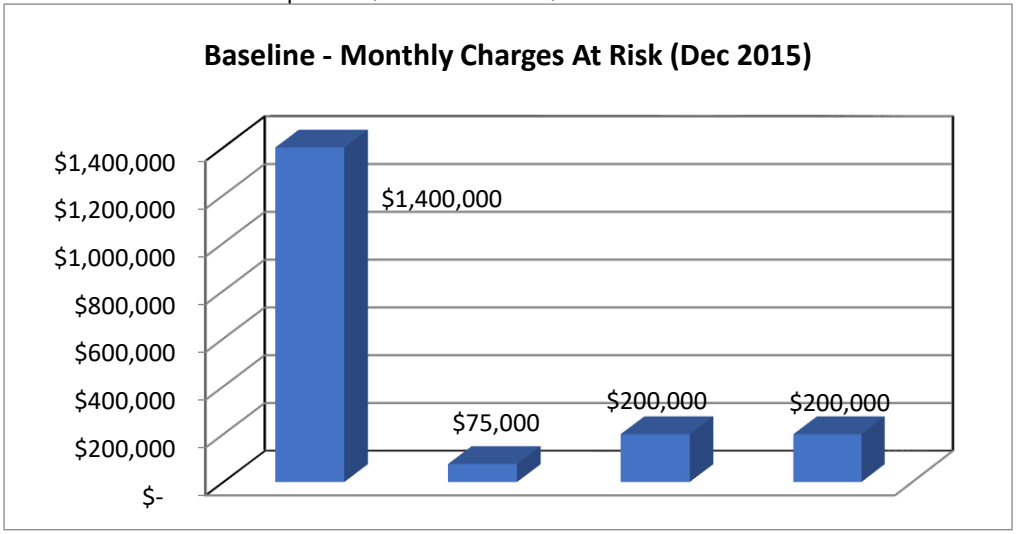
The "2 Midnight Rule" enforcement begins from the time the patient starts receiving treatment in the ED or an outpatient procedure; and when a patient starts receiving inpatient services for direct admits. Physician Assistants, Nurse Practitioners, or Residents (under our current PECOS registration model) can enter the admit order but it must be authenticated (co-signed) by an attending or covering physician prior to discharge.

External review for non-compliance with this regulation by QIOs (Quality Improvement Organizations) and subsequent referral to Recovery Audit Contractors process began in 2016. Acute care facilities showing high level of non-compliance (>20%) and insignificant improvement post audit education may be referred by CMS for RAC audits.

Case Summary

Review and implement processes to reduce 2 midnight admit order compliance risk at a 750+ beds academic medical center

- Implement a process to identify non-compliant claims to Medicare and refund payments to avoid future audit of non-compliance issues
- The admission may be non-compliant and ineligible for Medicare Part A Reimbursement if one of 2 situations arises:
  - Admission order is missing or
  - Admission order in not fully authenticated (cosigned) prior to discharge
- Provider Order Non-Compliance Risk can cause:
  - **Facility Implications**: Hospital may self-deny and bill CMS for Part B services
  - **Patient Implications**: Patient may be negatively impacted due to high co-pays and potential implications for SNF eligibility

Methodology	A. Phase I: Initial assessment of baseline risk to organization (12/2015) a. Analyzed the baseline risk to the organization (EPIC Facilities) using a custom-built query of the Epic database b. 4 Health System Facilities: 1.93M/Month or apprx. 23M/Year i. Hospital A: $1.4M/Month or Approximately $17M/Year ii. Hospital B: $200K/Month or $2.4 M/Year iii. Hospital C: $75K/Month or $900K/Year iv. Hospital D: $200K/Month or $2.4M  B. Phase II: Workflow & Processes Assessment a. Total Charges for Non-Compliant Accounts from Jan-Oct 2016: i. Hospitals A-D: 4.2 M or Approximately $5M annually b. Review of current workflows for admission orders c. Lack of clarity on operational ownership, action steps to monitor & address non-compliant cases d. No monitoring of accounts that were not fully signed prior to discharge e. No process in place to stop non-compliant claims from going out f. Received payments for inpatient stays for non-compliant admit orders C. Phase III. Assessment of the implemented processes and identify any missed opportunities a. Lack of clarity about operational ownership b. Further action steps to monitor and to address non-compliant cases i. Inpatient non-compliant cases identification ii. Post-discharge non-compliant cases identification
Actions Taken	A. Phase I: Custom-built Application Tool of EPIC Database (12/2015) a. Identified admission order non-compliance for all facility EPIC hospitals and other pieces of documentation that put them at risk of Medicare Inpatient denials B. Phase II: Workflow Changes (01/2016-10/2016) a. Created patient lists for admit orders alerts b. Admission order Best Practice Alerts (BPAs) c. Missing or co-sign admit order alerts d. Discharge order hard stops, if admit order missing/not signed C. Phase III: Analytics & Data Reporting (11/2016) a. Developed a new report to identify patients with non-compliant admit orders post discharge b. Implemented a hard stop for printing of Patient Discharge Summary and Discharge Order if admit order is not fully signed c. Separate report to track patients that were discharged without a fully authenticated admit order **D.** Phase IV: Operational Ownership/Plan to review non-compliance cases a. Operational Ownership i. Determine distribution schedule and ownership of new report to identify fallouts

	b. Compliance review of all non-compliant cases since January 2016 and develop plan to address**:** i. Accounts billed/paid since Jan 2016 ii. Process going forward for identifying these cases immediately and determine the appropriate billing process **iii.** Plan for any potential patient financial and eligibility impact and actions steps to correct these issue
Documented Results	**Team's Accomplishments** ○ **Financial Risk Trend:** Annualized charge value of accounts at risk down from **$23Million/Year in December 2015** to app. **$1Million/Year in December 2016** ○ **Ownership Team**: CMO office (Physician Advisors), Case Management, Compliance, and Central Billing Office ○ **Implementation Plan Status** a. Orders Optimization: Completed b. Targeted Decision Support: Completed c. Hard stops: Completed d. In-patient non-compliant patient identification: Completed e. Post-discharge non-compliant patient identification: Completed f. Non-Compliant Case Resolution i. Claims Already Submitted: Completed ii. Claims not submitted: Completed ○ **Reports & Patient Lists** i. Proactive: In place ii. Retrospective: Developed; being optimized
Checklist to assess the level of risk and compliance with this process	Does the organization have: - a) **Patient lists and Reports**: To identify at any given time during the hospitalization the **Medicare Inpatients** that don't have a fully signed admit order by the physician, & patients that were **discharged without a fully signed admit order.** b) **Decision Support:** To alert provider to sign the admit order and prevent patient discharges from happening without a fully signed admit order. c) **Process** to pro-actively engage the provider to sign the admit order prior to patient's discharge. d) **Process & Team** to review the patients that were discharged without a signed admit order & Identify Exclusions e) **Process** to determine 'to bill or to not bill' Medicare for the inpatient admissions where admit order was not fully signed prior to discharge from hospital f) **Process** to identify claims that were non-compliant but may have been billed in error to Medicare g) **Process** to refund money to Medicare for claims where payment was received in error h) **Process** to understand and communicate impact to patients where inpatient order was not fully signed on time. i) **Governance Structure with the right membership to drive ownership and accountability for above.**