The Two-Midnight Rule: History and Recent Updates

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I. The Two-Midnight Rule: Background

Due to increasing concerns regarding hospitals’ use of outpatient stays (lasting two nights or longer) and short inpatient stays (lasting fewer than two nights) and in an effort to provide more clarity to physicians regarding inpatient status orders, the Centers for Medicare and Medicaid Services (“CMS”) issued a proposed rule (the “Two-Midnight Rule”), now finalized and impacting providers nationally. In addition to clarifications regarding inpatient status orders, CMS’s intent behind the Two-Midnight Rule and accompanying new time-frame guidance included an expectation that both the number of outpatient stays lasting two nights or longer and the number of “short” inpatient stays would be reduced.

Prior CMS time-frame guidance directed physicians to use a 24-hour period as a benchmark (the “24-Hour Benchmark”), ordering an inpatient admission for patients expected to need hospital care for 24 hours or more, and treating other patients on an outpatient basis. However, the 24-Hour Benchmark was one of many other factors a physician considered when making the decision to admit a patient as an inpatient and, if used alone, it did not ensure coverage under Medicare Part A. CMS policy stated that the decision to admit or discharge a patient could be made within 24 hours and should rarely take longer than 48 hours.

II. The Two-Midnight Rule: A New Policy

CMS issued the Inpatient Prospective Payment Systems (“IPPS”) Fiscal Year (“FY”) 2014 Final Rule (the “Final Rule”) on August 2, 2013 with an effective date of October 1, 2013, providing a short time period for providers to comply with the Final Rule. In the Final Rule, CMS finalized its new time-frame policy, the Two-Midnight Rule, and clarified requirements for physician documentation of orders and certification of inpatient admissions, specifically requiring an inpatient admission order as a condition of payment. The Two-Midnight Rule establishes that inpatient hospital services spanning two midnights are generally deemed appropriate and reimbursable under Medicare Part A. In addition, the Two-Midnight Rule outlines the new process for Medicare contractor reviews of hospital inpatient claims and the appropriateness of such claims for reimbursement under the new time-frame requirements.

Presumption vs. Benchmark: The New Process for Medicare Inpatient Claim Reviews

Under the “Two Midnight Presumption,” an inpatient hospital claim with a length of stay greater than two midnights following a formal order for an inpatient admission is “presumed” generally appropriate for payment under Medicare Part A. For medical review purposes, inpatient hospital claims that meet the Two Midnight Presumption will not be the focus of medical reviews (although these claims may be reviewed for medical necessity generally). While inpatient hospital claims meeting the Two Midnight Presumption will not be the focus of medical reviews, if CMS finds “evidence of systematic gaming, abuse or delays in the provision of care” in an attempt to circumvent CMS’s requirements and meet the qualifications for the Two Midnight Presumption, the provider will be subject to targeted review and may face greater scrutiny and liability for non-compliance. Now, CMS will concentrate medical reviews on inpatient hospital claims that fail to meet the Two Midnight Presumption. CMS contracted reviewers will apply criteria under the Two Midnight Benchmark to determine whether such claims are appropriate for payment under Medicare Part A. The Two Midnight Benchmark review criteria are based upon a physician’s expectation that a beneficiary will require medically necessary inpatient hospital services spanning at least two midnights. In determining whether the Two Midnight Benchmark is met, CMS contracted reviewers will consider both the duration of inpatient hospital services and the beneficiary’s time spent receiving outpatient services within the hospital prior to the formal inpatient admission. The time spent receiving outpatient services within the hospital prior to the formal inpatient admission may include services such as observation services, treatments in the emergency department, and procedures provided in the operating room or other treatment areas. Regardless of which medical review process applies, providers must ensure compliance with the requirements for documentation of the inpatient order and accompanying physician certification, including adequate documentation.
supporting the expected duration of the inpatient stay and medical necessity of such care.

III. Litigation History and Current Challenges to the Changing Inpatient Landscape

In connection with the adoption of the Two-Midnight Rule, CMS expected a shift from outpatient to inpatient stays with consequential increases in reimbursement. In order to offset this cost, CMS implemented an across the board 0.2 percent reduction in the standardized Medicare payment amounts for all inpatient stays with discharges occurring on or after October 1, 2013.14 The American Hospital Association (“AHA”) along with several state hospital associations and four hospitals filed a hearing request challenging CMS’s actions with the Provider Reimbursement Review Board (“PRRB”), taking the first steps to getting the 0.2 percent payment reduction issue before a federal court since the PRRB lacks the power to grant the requested relief.15

The parties then filed suit in the District of Columbia District Court on April 14, 2014 (the “Complaint”), attacking the reasoning behind CMS’s determination that Medicare payments to hospitals would increase due to the shift from outpatient to inpatient stays as a result of the Two-Midnight Rule.16 The Complaint states that CMS in “[u]sing the new two-midnights rule as a fig leaf […] also decided to cut the payments hospitals receive for treating Medicare patients.”17 Continuing, the Complaint states that “CMS claimed--without setting forth its actuaries’ reasoning or calculations--that the two-midnights rule and other related policy changes would result in a net increase in the number of inpatient hospital stays that Medicare covers under Part A...cost[ing] the Medicare program $220 million in fiscal year 2014.”18

The Complaint challenges CMS’s resulting 0.2 percent payment reduction “on the grounds that it is arbitrary and capricious [thereby alleging violations under the Administrative Procedure Act (“APA”) due to CMS’ reliance on indefensible assumptions and failure to explain its assumptions], invalid for failure to undergo adequate notice and comment [further alleging violations under the APA], and contrary to federal law [the 0.2 percent reduction was discussed in the preamble to the Final Rule, but not codified in the Code of Federal Regulations thereby raising allegations of violations under both the APA and the Medicare Act].”19

In a related lawsuit (the “Second Complaint”) also filed on April 14, 2014, AHA and the co-plaintiffs challenged CMS’s policy in the Final Rule requiring physicians to certify the expectation that an inpatient admission would span two midnights.20 Specifically, the lawsuit challenges three Medicare policies which the plaintiffs allege in the Second Complaint “burden hospitals with arbitrary standards and documentation requirements and deprive hospitals of Medicare reimbursement to which they are entitled.”21

The Second Complaint notes that the Medicare Act has never included a definition of “what it means to be an ‘inpatient.’” Instead, for more than 50 years, the Secretary of the U.S. Department of Health & Human Services, acting through CMS to administer the program, has committed the decision whether to admit a patient to the hospital to the expert judgment of the treating physician.”22 Arguing that the Final Rule “unwisely permits the government to supplant treating physicians' judgment[,]” the Second Complaint reiterates that the “question whether to admit a patient as an inpatient is fact-sensitive and a matter of judgment.”23 The Second Complaint notes that the Final Rule ignores long-standing history of committing admission decisions to a particular patient’s treating physician, and that the Final Rule instead “applies regardless of the ‘level of care’ the physician expects the patient to need” and which “provides that a Medicare beneficiary is not an “inpatient” unless the admitting physician expects that beneficiary to need...hospital [care]... spanning two midnights.”24

IV. Legislative Attempts to Address the Two-Midnight Rule

The Two-Midnight Rule Delay Act of 2013 was introduced to delay the “enforcement of the Medicare two-midnight rule for short inpatient hospital stays until the implementation of a new Medicare payment methodology for short inpatient hospital stays,” thereby prohibiting the Secretary from enforcing the Two-Midnight Rule for admissions occurring before Oct. 1, 2014.25 The bill also prohibits the Secretary from increasing the sample of “probe and educate” claims established as of November 4, 2013 and further prohibits Medicare review contractors from denying inpatient claims for discharges that meet certain criteria which occur before Oct. 1, 2014.

V. The Two-Midnight Rule: Ongoing Probe Audits Continue in the Midst of Proposed Legislation and Lawsuits

The Two-Midnight Rule became effective on October 1, 2013 with simultaneous commencement of the “probe and educate” audits (the “Probe Audits”); and, in the midst of legislative attempts and law suits challenging the recovery audit landscape and CMS’ alleged abuses of its authority in related rule-making, the Probe Audits continue. In recent guidance, CMS
reiterated that “CMS will direct Medicare review contractors to apply CMS-1599-F and the additional guidance CMS plans to issue in conducting patient status reviews for claims submitted by acute care inpatient hospital facilities, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs) and Inpatient Psychiatric Facilities (IPFs) for dates of admission on or after [October 1, 2013].”26 Per CMS-1599-F Inpatient Rehabilitation Facilities patient status reviews are specifically excluded from the 2-midnight inpatient admission and medical review guidelines.27 During the Probe Audits, when reviewing inpatient claims with dates of admission on or after October 1, 2013, MACs will assess hospital compliance with admission order requirements, certification requirements, and the Two Midnight Benchmark.28 MACs will also apply the Two Midnight payment policy when conducting prepayment reviews for inpatient claims where the surgical procedure is cancelled. Recently CMS announced that MACs will also re-review its denied claims under the Probe Audits “to ensure the claim decision and subsequent education is consistent with the most recent clarifications.”29 MACs will also identify providers who need additional education if a MAC encounters high claim error rates, which can expand the Probe Audit universe of claims. MACs will send detailed results letters and will offer providers the option of a telephone call if moderate to major corrective action is indicated. Finally, although Recovery Audit contractors will not be conducting post-payment reviews of inpatient claims with dates of admission on or after October 1, 2013 through March 31, 2015, RAs may continue audits of inpatient admissions with dates of service prior to October 1, 2013.30

VI. Conclusion

Despite the continuing “full-impact delays” and the uncertainty regarding the outcome of ongoing legal challenges and legislative proposals, the Two-Midnight Rule is effective and Probe Audits are ongoing. Providers should be self-auditing to ensure accurate documentation and compliance with physician orders and certifications. Providers should ensure that they continue to protect both their legal and appeal rights as they work with their legal counsel in a proactive manner when implementing operational changes to maintain compliance with the requirements under the Final Rule.

1 See Hospital Outpatient Prospective Payment Final Rule (77 Federal Register 68210, 68427 (Nov. 15, 2012)) discussing that “[i]n the proposed rule, [CMS] indicated that [it] heard from various stakeholders that hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services, often for longer periods of time, rather than admitting them as inpatients; see also the Medicare Part B Inpatient Billing Proposed Rule (78 Fed. Reg. 16632 (March 18, 2013)) addressing CMS’ concerns regarding hospitals’ use of outpatient stays; see also Inpatient Prospective Payment Systems (IPPS) Proposed Rule (78 Fed. Reg. 27486 (May 10, 2013)) and IPPS FY 2014 Final Rule (78 Fed. Reg. 50496 (August 19, 2013)); see also Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, (OEI-02-12-00040 (July 29, 2013) issued after CMS proposed the Two-Midnight Rule, the Office of Inspector General (“OIG”) issued a Memorandum Report (the “Report”) discussing hospital use of observation stays and short inpatient stays in 2012. The Report noted that on average, short inpatient stays cost Medicare and beneficiaries more than observation stays.


4 See MBPM (CMS Pub. 100-02) Ch. 1, § 10 noting that the decision to admit a patient is a “complex medical judgment” and is considered with other factors; see also 78 Fed. Reg. at 50907, discussing CMS’ prior 24-Hour Benchmark; see also The Social Security Act §§ 226, 1811, 1812, 1831, and 1832, 42 U.S.C. §§ 426, 1395c, 1395d(a)(1), 1395j, and 1395k delineating entitlement and scope of benefits coverage under Medicare Part A and Medicare Part B. Generally, Medicare Part A, the hospital insurance program, covers inpatient hospital services and Medicare Part B, the supplemental medical insurance program, covers certain physician services, hospital outpatient services and “medical and other health services” that are not covered under Medicare Part A.

5 MBPM (CMS Pub. 100-02) Ch. 6, § 20.6.


7 78 Fed. Reg. at 50938-50942; although not discussed fully herein, Inpatient-Only procedures are also generally deemed appropriate and reimbursable under Medicare Part A.

8 78 Fed. Reg. at 50952; see also Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013, (Last Updated: March 12, 2014) available at: http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html where CMS notes in Section E. that “[i]t is not necessary for a beneficiary to meet an inpatient ‘level of care,’ as may be defined by a commercial screening tool, in order for [a Medicare] Part A payment to be appropriate. In addition, meeting an inpatient “level of care,” as may be defined by a commercial screening tool, does not make [Medicare] Part A payment appropriate in the absence of an expected length of stay of 2 or more midnights.” This further complicates providers’ current utilization management processes (i.e. where screening tools may be required or used as guidance when determining the appropriateness of inpatient admissions for other payers).

9 Id.
10 Id.

11 Id. at 50950-50951.

12 Id. at 50952.


15 The Hospital Associations include the following entities: Greater New York Hospital Association, Healthcare Association of New York State, New Jersey Hospital Association and The Hospital & Healthsystem Association of Pennsylvania; the Hospitals include the following entities: Banner Health (Arizona), Einstein Healthcare Network (Pennsylvania), Wake Forest Baptist Medical Center (North Carolina), and The Mount Sinai Hospital (New York).


17 Id. at ¶ 5.

18 Id.

19 Id. at ¶¶ 5, and Counts I-V.


21 Id.

22 Id. at ¶ 1.

23 Id. at ¶¶ 3 and 4.

24 Id. at ¶ 3.

25 (H.R. 3698) introduced by Representatives Jim Gerlach and Joseph Crowley, referred to Committee on Dec. 11, 2013 and has a 7% chance of getting past the committee and a 2% chance of being enacted; see also related (S. 2082) Two-Midnight Rule Coordination and Improvement Act of 2014, sponsored by Senator Robert Menendez which provides “for the development of criteria under the Medicare program for medically necessary short inpatient hospital stays...” and has a 2% chance of getting past Committee and 0% chance of being enacted.


27 Id.


29 See Reopenings and Appeals of Inpatient Probe and Educate Claims. (Last Updated: February, 24, 2014) available at: http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html. CMS is urging providers to work with their MACs to determine if a claim has been re-reviewed prior to submitting an appeal request. “To ensure that the re-review process does not affect the ability of a provider to file a timely appeal of a denied claim, CMS will waive the 120 day timeframe for filing redetermination requests received before September 30, 2014 for claim denials under the Probe & Educate process that occurred on or before January 30, 2014. Claim denials under the Probe & Educate process that occurred on or before January 30, 2014 for which an appeal has been filed will also be subject to re-review. Claims determined payable following re-review will be adjusted accordingly. Claims for which the denial is affirmed following re-review will be transferred to appeals automatically for a redetermination.”

30 See (H.R. 4302) signed into law on April 1, 2014 by President Barack Obama, specifically Sec. 111, delaying yet again the “full-impact” of the Two-Midnight Rule by excluding RAs from the auditing window as noted supra, “unless there is evidence of systematic gaming, fraud, abuse or delays in the provision of care by a service provider.”