On July 8, 2015, the Centers for Medicare and Medicaid Services ("CMS") issued the 2016 proposed rule for the Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgery Center ("ASC") payment system ("Proposed Rule"). While the Proposed Rule includes the expected annual modifications to Medicare payments in outpatient settings, it contains a few unexpected changes. Some, including the proposed revisions to the heavily criticized “two-midnight rule” for short inpatient stays, may be welcomed by the provider community. Others, like the proposed 2 percent conversion factor cut for OPPS billings, are unlikely to receive warm commentary.

Proposed “Two-Midnight Rule” Changes

The two-midnight rule, adopted effective October 1, 2013, elicited such confusion and pushback from providers that CMS eventually suspended enforcement under its Recovery Audit Contractor (“RAC”) audit program. Pursuant to the rule, Medicare considers a patient appropriate for inpatient admission under Part A if the admitting practitioner expects that the patient’s hospital care will cross at least two midnights. Care for a patient who is not expected to require two midnight’s worth of inpatient care must be billed as outpatient services, typically at a substantial financial difference.

Subsequent to the two-midnight rule’s publication, CMS issued a guidance document acknowledging that “rare and unusual” exceptions could be made to allow for Part A payment, even where a patient had an expected length of hospital stay of less than two midnights. The exception was narrow, limited only to unusual circumstances published on the CMS website or in guidance, and to services expressly designated as inpatient by CMS. Providers clamored for greater deference to physician decision-making, and the Proposed Rule appears to be CMS’s response.

The Proposed Rule, if finalized, will permit Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark, provided the documentation in the medical record supports either: (i) the admitting physician’s reasonable expectation that the patient will require hospital care spanning at least two midnights; or (ii) the admitting physician’s determination, based on certain factors, that the patient requires formal admission to the hospital on an inpatient basis. CMS notes in the Proposed Rule commentary that the following
“determinative factors,” among others, would be relevant to ascertaining whether a patient requires inpatient admission:

- 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).

The Proposed Rule also provides for the elimination of routine RAC audits that would scrutinize two-midnight decisions. Instead, the Proposed Rule shifts reviews of short inpatient stays to Quality Improvement Organization (“QIO”) contractors, reserving RAC auditing for those providers who are referred by the QIO for high denial rates, consistent failure to adhere to the two-midnight rule, and failing to improve performance after QIO educational intervention.

Unfortunately, an outright revocation of the two-midnight timeframe is not part of the Proposed Rule. Rather, CMS reiterated in its commentary that it “continue[s] to believe that use of the two-midnight benchmark gives appropriate consideration to the medical judgment of physicians and also furthers the goal of clearly identifying when an inpatient admission is appropriate for payment under Medicare Part A.”

**Proposed Conversion Factor Changes**

The Proposed Rule also brought news announcing further reimbursement cuts. Specifically, CMS proposed cuts to the “conversion factor”—a scaling factor used by Medicare to convert the geographically adjusted number of relative value units for each service in the Medicare physician payment schedule into a dollar payment amount. The degree of cuts is dependent on the provider’s compliance with the Hospital Outpatient Quality Reporting (“OQR”) requirements. Under the proposed rule, 2016 OPPS payments will be cut by 0.3 percent if providers satisfy the OQR requirements but will jump by 2 percent if OQR requirements are not satisfied. Ambulatory surgery centers, on the other hand, would see a 1.1 percent increase, provided they meet the requirements of the ASC Quality Reporting (“ASCQR”) program. Those ASC providers who fall short of ASCQR standards will similarly receive a 2 percent conversion factor cut.

**Key Provider Takeaways**

In addition to the proposed changes to the two-midnight rule and conversion factors, the Proposed Rule includes code-specific proposals that may be of significant interest to particular providers, particularly those billing chronic care management services through the OPPS. Providers should review the Proposed Rule in detail to determine how it will affect them specifically.

Inpatient and outpatient providers alike should train physicians on documentation best practices, with focus on CMS’ expectations for supporting an admissions decision. The training should focus on elements cited by CMS in the Proposed Rule commentary, including:

**Establishing consistent review and documentation practices.**

The Proposed Rule states that, while CMS will consider implementing clinical criteria for reviewers evaluating inpatient admissions in the future, for the time being, payment is based upon the more general “clinical judgment” of a medical reviewer. The medical reviewer’s clinical judgment would involve, according to CMS’s commentary, “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.” Reviewers are also permitted to take into account evidence-based guidelines and commercial utilization tools; therefore, providers should keep apprised and remain trained in current documentation standards, methods, and tools.

**Documenting “reasonableness” and “medical necessity.”**

While these standards are nothing new to Medicare providers, their somewhat nebulous nature can present a documentation challenge, particularly when a clinician believes the need for an admission is self-evident from the medical record. The Proposed Rule commentary reiterates that an admissions decision must be reasonable and medically necessary.
Reviewing the Medicare Benefit Policy Manual (Section 10, Chapter 1) and other Medicare guidance for situations Medicare considers rarely appropriate for inpatient admission. The Proposed Rule commentary emphasizes that for patients who undergo minor surgery or other treatment that should require only a few hours’ stay in the hospital, inpatient admission is likely inappropriate, regardless of the hour the patient arrives at the hospital, whether or not a bed is used, and whether the patient remains in the hospital past midnight. Providers should ensure that admitting practitioners do not consider these factors as a basis for admitting a patient.

Internal audit processes and compliance plans may also be revisited. Legal and compliance counsel can assist with this process.

Parties wishing to submit comments to CMS on the Proposed Rule should do so by 5:00 p.m. on August 1, 2015.

Lawyer Contacts

For further information, please contact your principal Firm representative or one of the lawyers listed below. General email messages may be sent using our “Contact Us” form, which can be found at www.jonesday.com/contactus/.

David W. Grauer
Columbus
+1.614.281.3855
dgrauer@jonesday.com

Kristen Pollock McDonald
Atlanta
+1.404.581.8498
kmcdonald@jonesday.com

Rebekah N. Plowman
Atlanta
+1.404.581.8240
rplowman@jonesday.com

Heather M. O’Shea
Chicago
+1.312.269.4009
hoshea@jonesday.com

James R. Dutro
San Francisco
+1.415.875.5839
jduetro@jonesday.com

Stephen G. Sozio
Cleveland
+1.216.586.7201
sgsozio@jonesday.com

Thomas E. Dutton
Columbus
+1.614.281.3897
tedutton@jonesday.com

Heidi A. Wendel
New York
+1.212.326.8322
hwendel@jonesday.com

Jeffrey L. Kapp
Cleveland
+1.216.586.7230
jlkapp@jonesday.com

Elizabeth Trende
Columbus
+1.614.281.3875
etrende@jonesday.com

John M. Kirsner
Columbus
+1.614.281.3700
jkirsner@jonesday.com

Claire E. Castles
Los Angeles
+1.213.243.2629
ccastles@jonesday.com

Laura Lemmle-Weidenfeld
Washington
+1.202.879.3496
lweidenfeld@jonesday.com

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