October 16, 2013

Dear Colleague,

The Centers for Medicare & Medicaid Services (CMS or Medicare) recently finalized new regulations governing the admission of Medicare beneficiaries to hospitals. The regulation referred to as the "2-Midnight rule" is an attempt by CMS to clarify its medical review criteria for medical necessity and payment.

Although these regulations are extensive and are subject to ongoing clarification, as of October 1st, 2013 physicians and other admitting practitioners are expected to follow these requirements for the inpatient admission of Medicare patients.

The 3 areas most important to physicians are:

1. The Time the patient is expected to stay in the hospital
2. The Order to "admit to inpatient" or "refer for observation/outpatient"
3. The Documentation & Certification of medical necessary to support the patient's inpatient admission

Here are the key takeaways for physicians.

**Time:**

If the patient medically requires hospital inpatient services and the physician believes that the patient will need to stay in the hospital at least 2 midnights, the physician should order inpatient admission. If the patient does not **medically** require inpatient hospital services or the physician does not expect the patient to stay past 2 midnights, the physician should order observation or outpatient services.

**Guidelines:**

- **If you believe 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.**

Of note, order changes (inpatient ➠ observation or observation ➠ inpatient) can be made after the initial order is written as the hospitalization evolves. The case management team and EHR will work with you and assist if any order changes are needed.

**Order:**

CMS continues to require the attending physician to write or cosign the order for status. In addition, CMS clarified few areas related to the order:

- The attending or supervising physician must cosign residents and midlevel provider's order prior to discharge of the patient.
- Verbal orders are acceptable in accordance with state law and hospital bylaws.

**Guidelines:**

- **Inpatient Cases: should include the words Admit and Inpatient to be a valid inpatient order**
  - **"Admit to Tower 7" or "Admit to Dr. Smith" are not recommended**
- **Observation/Outpatient Cases: Should include the phrase "refer for Observation Services" or "place in outpatient status"**
  - **Avoid using "admit" and "Observation or Outpatient" in the same order. CMS considers this to be contradictory**

**Documentation & Certification**:

CMS requires *physician certification* of the patient's admission in the medical record, which consists of statements establishing that the services were reasonable and necessary and signed by the responsible physician prior to the patient's discharge. The **certification** includes:

- Order for inpatient admission (as above)
- Diagnosis and rationale for hospitalization/ inpatient medical treatment
- Documentation of the estimated time the patient will need to remain in the hospital (as above)
- Plans for post-hospital care, if appropriate

The certification must be signed and documented in the medical record prior to patient discharge. Hospitals may choose to have physicians record these elements of the certification either on a specific form or throughout the medical record such as in the orders, history and physical, or physician progress notes.

**Guidelines:**

- **Excellent patient care should continue to be the top priority.**
- **Document the diagnosis, medical rationale, plan of care and anticipated discharge.**
- **Sign the admission order and certification (if appropriate) prior to discharge.**

EHR has some educational resources available if you are interested. Please contact me if you are interested and I can send along details.

Thank you for continued support and please contact me with any questions or concerns.

Regards,

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