DEALING WITH THE TWO-MIDNIGHT RULE

Comprehensive Regulatory and Operational Reference

Traditional Medicare (Fee-For-Service)

I. Scope and Applicability

This reference addresses the CMS Two-Midnight Rule as it applies to **Traditional Medicare (Fee-For-Service).**

Although Medicare Advantage (MA) plans must comply with Medicare coverage standards, their utilization management processes, authorization requirements, and appeal pathways are contract-driven and may differ operationally. MA-specific processes are outside the scope of this document.

II. Regulatory Foundation

The Two-Midnight Rule was established in the **FY 2014 IPPS Final Rule**, published August 19, 2013:

- **78 Fed. Reg. 50946–50949 (Aug. 19, 2013)**

The rule became effective for discharges beginning October 1, 2013.

The governing regulation is codified at:

- **42 CFR §412.3 – Admissions**

While the Federal Register language originates in 2013, the regulatory authority remains active and current through the Code of Federal Regulations.

III. The Two-Midnight Framework

The Two-Midnight Rule consists of two distinct but related concepts:

1. The Benchmark (clinical decision standard)
2. The Presumption (medical review standard)

A. The Two-Midnight Benchmark

Clinical Decision Standard

CMS stated:

"The decision to admit the beneficiary should be based on the cumulative time spent at the hospital beginning with the initial outpatient service. In other words, if the physician makes the decision to admit after the beneficiary arrived at the hospital and began receiving services, he or she should consider the time already spent receiving those services in estimating the beneficiary's total expected length of stay."
— 78 Fed. Reg. 50946 (Aug. 19, 2013)

Operational Meaning

- Time begins when medically necessary hospital services start.
- This includes ED time or outpatient services prior to inpatient order.
- The admitting physician must reasonably expect hospital care to span **at least two midnights.**
- The expectation must be:
    - Based on clinical judgment
    - Documented in the medical record
    - Reasonable given the patient's presentation

The Benchmark governs the admission decision.

B. The Two-Midnight Presumption

Medical Review Standard

CMS stated:

"Under the 2-midnight presumption, inpatient hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic

gaming, abuse or delays in the provision of care…"
— 78 Fed. Reg. 50949 (Aug. 19, 2013)

Operational Meaning

- The Presumption applies during contractor review.
- It does not replace the Benchmark.
- It does not eliminate documentation requirements.
- It does not guarantee payment if documentation is insufficient.

Presumption is a review prioritization concept — not a clinical decision rule.

IV. Codified Regulation – 42 CFR §412.3

42 CFR §412.3 governs inpatient admissions under Medicare Part A.

Key requirements include:

- Formal inpatient admission order.
- Order written by physician or qualified practitioner permitted by state law and hospital bylaws.
- Medical necessity documentation supporting inpatient level of care.
- Expectation of care spanning two midnights, unless an exception applies.

The CFR is the controlling authority; the Federal Register explains intent.

V. Inpatient Admission Order Requirements

A. Formal Order

An inpatient admission must be supported by a formal inpatient order that:

- Clearly indicates inpatient status.
- Is signed, dated, and timed.
- Is written by a practitioner with admitting privileges.
- Is entered prior to discharge.

Reference: 42 CFR §412.3

B. IMPORTANT REGULATORY UPDATE

FY 2019 IPPS Final Rule

The inpatient admission order is **no longer a strict condition of payment.**

Federal Register citation:

- **83 Fed. Reg. 41144, 41546–41547 (Aug. 17, 2018)**

CMS stated:

"We are finalizing our proposal to remove the requirement that the order to admit as an inpatient be a specific condition of payment under Medicare Part A. The order continues to be required under the hospital Conditions of Participation, but an omission or defect in the order would not by itself lead to the denial of payment for medically necessary inpatient hospital services."

What This Means

Before FY 2019:

- Order defects could result in automatic Part A denial.

After FY 2019:

- The order remains required under CoPs and medical record standards.
- However, an omission or technical defect alone does not automatically invalidate payment.
- Payment depends on:
    - Medical necessity
    - Proper application of the Two-Midnight Benchmark
    - Adequate documentation

This distinction is critical in denial defense and appeals.

VI. Verbal and Telephone Admission Orders

Hospital Conditions of Participation

Under **42 CFR §482.24 (Medical Records):**

- Verbal orders are permitted.

- They must be authenticated promptly.
- Authentication requirements must align with hospital policy and state law.

CMS survey guidance has historically referenced authentication within 48 hours unless state law specifies otherwise.

Failure to authenticate properly may result in survey citations under CoPs.

VII. Critical Access Hospital (CAH) Requirements

CAHs are governed under:

- **42 CFR Part 485, Subpart F**

A. Medical Record Requirements – 42 CFR §485.638

"All patient records must contain information to justify admission and continued care, support the diagnosis, and describe the patient's progress and response to medications and services."

B. Verbal Orders – CAH

- Permitted per written policy.
- Must be authenticated promptly.
- Must comply with state law.
- Survey interpretation appears in State Operations Manual Appendix W.

Common survey tags include C-1100 and C-1102.

VIII. One-Day Inpatient Stays

An inpatient stay of fewer than two midnights may still be appropriate if:

- The physician reasonably expected a two-midnight stay.
- The expectation was documented at admission.
- Clinical circumstances justified inpatient level of care.

Examples of shorter stays that remain defensible:

- Rapid improvement
- Transfer
- AMA discharge
- Death

The focus is the reasonableness of expectation at the time of admission.

IX. Exceptions to the Benchmark

Certain procedures and clinical circumstances may justify inpatient admission independent of expected length of stay.

Following phase-out of the Inpatient-Only list, individualized medical necessity analysis is increasingly important.

Physician Advisors should assess:

- Clinical risk
- Comorbidities
- Post-operative monitoring needs
- Anticipated complications
- Intensity of services required

X. Documentation Requirements

Justifying Admission and Continued Care

Medical records must allow a reviewer to determine:

1. Why hospital-level care was required.
2. Why inpatient admission was reasonable.
3. Why continued hospitalization was necessary.
4. How the patient responded to treatment.

A. Justifying Admission

Include:

- Detailed H&P
- Severity and instability
- Risk assessment
- Expected hospital course
- Comorbidities influencing LOS

B. Justifying Continued Care

Include:

- Daily progress notes
- Ongoing monitoring needs
- IV medications
- Oxygen support
- Escalation risk
- Diagnostic uncertainty

C. Supporting Diagnosis

Include:

- Diagnostic findings
- Physician interpretation
- Differential diagnosis
- Evolving problem list

D. Response to Medications and Services

Include:

- Medication administration record
- Nursing documentation
- Procedure notes
- Therapy notes
- Discharge summary

A reviewer must be able to reconstruct the full clinical narrative.

XI. Traditional Medicare vs Medicare Advantage

The Two-Midnight Rule governs Traditional Medicare.

Medicare Advantage plans:

- May require prior authorization.
- May apply proprietary criteria.
- May follow different appeal timelines.

Compliance must consider plan-specific contractual requirements.

XII. Operational Guidance for Physician Advisors

Physician Advisors should:

- Validate admission expectation documentation.
- Ensure cumulative time calculation is considered.
- Confirm presence of compliant admission order.
- Identify documentation vulnerabilities early.
- Anchor denial defense to regulatory language.
- Distinguish Benchmark from Presumption during appeal.
- Understand payment vs participation distinctions post-FY2019.

The Two-Midnight Rule is not a time clock.
It is a clinical expectation standard grounded in documentation and regulation.

XIII. Key Regulatory References

- 42 CFR §412.3 – Admissions
- 42 CFR §482.24 – Medical Records
- 42 CFR §485.638 – CAH Medical Records
- 78 Fed. Reg. 50946–50949 (Aug. 19, 2013) – FY 2014 IPPS Final Rule
- 83 Fed. Reg. 41144, 41546–41547 (Aug. 17, 2018) – FY 2019 IPPS Final Rule
- CMS Two-Midnight Guidance Documents

- State Operations Manual Appendix W (CAH)

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