COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 31, Number 45. December 19, 2022
Proposed Rules: MA Plans Must Follow Two-Midnight Rule, IPO List and Expedite Prior Auth

By Nina Youngstrom

In a Dec. 14 proposed regulation, CMS put teeth into the requirement that Medicare Advantage (MA) plans follow traditional Medicare's two-midnight rule, inpatient-only (IPO) list and case-by-case exception, experts say.[1] It's one of two rules CMS proposed in the space of 10 days that potentially would curb some of what providers consider the excesses of MA plans.

The rule, which also addresses prior authorization, utilization review and other areas, proposes to codify regulatory language that would explicitly require MA plans to live by coverage criteria for inpatient admissions under Part A (42 C.F.R. § 412.3), said Edward Hu, M.D., system executive director of physician advisor services at UNC Health in North Carolina.

"In general, CMS has published a resounding 'no' as to whether Medicare Advantage organizations can rely on internal coverage criteria to be more restrictive than traditional Medicare, with the only exception being areas where Medicare lacks clear policy coverage and high-quality evidence-based literature exists to guide coverage," Hu noted. "Not only does this apply to services received by a beneficiary, but also the setting of care that traditional Medicare would cover it in, and the payment to the provider for those services."

Although CMS doesn't specifically mention the two-midnight rule, it's clearly stating it believes MA plans should be following traditional (fee-for-service) Medicare inpatient status regulations, he explained.

Of equal importance, Hu said, CMS repeatedly asserts that MA plans must stick to the rules on two-midnights, the IPO list and case-by-case exceptions (which allow hospitals to bill for inpatient admissions even when physicians don't expect a two-midnight stay in rare and unusual circumstances). According to the proposed rule, "MA organizations may not limit coverage through the adoption of policies and procedures – whether those policies and procedures are called utilization management and prior authorization or the standards and criteria that the MA organization uses to assess and evaluate medical necessity – when those policies and procedures result in denials of coverage or payment where the Traditional Medicare program would cover and pay for the item or service furnished to the beneficiary. In addition, this means that limits or conditions on payment and coverage in the Traditional Medicare program—such as who may deliver a service and in what setting a service may be provided, the criteria adopted in relevant NCDs and LCDs, and other substantive conditions—apply to set the scope of basic benefits as defined in § 422.100(c)." If finalized, CMS is, among other things, putting an end to prior authorization denials based on MA internal criteria that goes beyond Medicare coverage rules.