Department:	Utilization Management	**Original Approval:**	12/19/2023
Policy & Procedure No:	UM447	**Last Approval:**	12/18/2025
Policy and Procedure Title:	Medicare Inpatient Admissions and the Two Midnight Rule Policy and Procedure		
Approved By:	Clinical Services Leadership Team		
Dependencies:	UM 211 Hospital Admission Patient Management Policy		

Purpose

This policy clarifies how CHPW Medicare Inpatient Admission reviews align with the CMS Two Midnight Rule.

Policy & Procedure

Evaluating Requests for Inpatient Hospital Admissions for Medicare Members:

CMS 2024 Medicare Advantage Final rule (CMS 4201-F) outlines that the requirements of 42 C.F.R. § 412.3, commonly referred to as the Two Midnight Rule, are applicable to Medicare Advantage Plans. The Two Midnight Rule states, in brief, that a patient is generally appropriate for an inpatient admission if the admitting clinician expects the beneficiary to require medically necessary hospital care spanning two or more midnights and the medical record documentation supports the clinician's expectation.

In Medicare Part A, the Two Midnight Rule has two parts: the Two Midnight Benchmark and the Two Midnight Presumption. Only the Two Midnight Benchmark is applicable to MA plans.

- CMS plainly states that the Two Midnight Presumption (that all inpatient claims that cross two midnights following the inpatient admission are presumed appropriate for payment) "does not apply to MA plans." 88 Fed. Reg. 22120, 22191 (Apr. 12, 2023).
- CMS explains that the Two Midnight Presumption is a medical review instruction that applies to Medicare contractors (e.g., Quality Improvement Organizations (QIO's) to help them prioritize claims for review. CMS has not established requirements or limits for MA organizations regarding which claims to prioritize for review, so it does not have authority to make the Two Midnight Presumption applicable to MA plans.

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- In contrast, CMS explains that the Two Midnight Benchmark is applicable because payment is how MA plans provide coverage of benefits. That rule, which appears in regulations at 42 CFR 412.3(d), states that an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights. The rule goes on to require that the physician's clinical expectation should be based on complex medical factors that must be documented in the medical record to be granted consideration. As explained in the regulation, these complex medical factors include the patient's history and comorbidities, the severity of signs and symptoms, current medical needs, and risk of an adverse event (See 42 CFR 412.3(d)(1)(i)).

- In discussing the applicability of the Two Midnight Benchmark to MA Plans, CMS makes clear that "MA plans may still use prior authorization or concurrent case management review of inpatient admissions based on whether the complex medical factors documented in the medical record support the medical necessity of the inpatient admission, under either the two-midnight benchmark or the case-by-case exception." 88 Fed. Reg. at 22192. Further, 42 C.F.R. § 422.101(c)(1) requires MA Plans to make medical necessity determinations based all of the following: Medicare coverage and benefit criteria; whether the provision of items and services is reasonable and necessary under the statute; the enrollee's medical history; and with the involvement of the organization's medical director, if appropriate. Consequently, the clinical documentation must clearly support the severity of the member's illness and required intensity of services for the inpatient level of care to be medically necessary.

CHPW reviews all Medicare inpatient admissions for Medical Necessity in accordance with the applicable CMS regulations, contract requirements, and guidance. To enable such review and in compliance with Medicare rules, providers must submit clinical documentation demonstrating the complex medical factors that support the clinical expectation of the treating provider that the patient will require hospital level of care crossing two midnights. The provider must clearly document the need in a manner that allows CHPW to understand clinical decision making. A provider documenting "I expect two or more midnights" is not sufficient to support medical necessity.

List of Appendices

None.

Citations & References

CFR	42 C.F.R. § 422.101; 42 C.F.R § 412.3

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WAC		
RCW		
LOB & Contract Citation	☐ **WAHIMC**	
	☐ **BHSO**	
	☐ **Wraparound**	
	☐ **SMAC**	
	☐ **HH**	
	☐ **AHE**	
	☒ **MA/DSNP**	P&P supports all LOB requirements
	☐ **CS**	
Other Requirements	88 Fed. Reg. 22120, 22189-22200 (Apr. 12, 2023); 42 U.S.C. § 1395y(a)(1)	
NCQA Elements		
References		

Revision History

SME Review:	12/06/2023; 12/10/2024
Approval:	12/19/2023

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Appendix A: Detailed Revision History

Revision Date	Revision Description	Revision Made By
12/06/2023	Creation of Policy	Justin Fowler and LuAnn Chen
12/19/2023	Approval	Clinical Services Leadership Team
12/10/2024	Reviewed, no changes	Yves Houghton, RN BSN
12/29/2024	Approval	Ma'ata Hardman
01/02/2025	Approval	Clinical Services Leadership Team
11/17/2025	Reviewed, no changes	Yves Houghton
12/08/2025	Approval	Angie Davis
12/14/2025	Approval	Ma'ata Hardman
12/18/2025	Approval	Clinical Services Leadership Team

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