



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 11: Coverage of Hospital Inpatient Services

I. Inpatient Admission Order

A. Inpatient Order Requirement

1. A patient is only considered an inpatient when they are formally admitted pursuant to an order for inpatient admission by a qualifying admitting practitioner. <See 42 C.F.R. 412.3(a), see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B>
 - a. For orders written prior to the patient presenting to the hospital (e.g., pre-surgery orders), the time of admission occurs when hospital care services are provided to the patient. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.4>
 - b. For orders written after hospital care has started, including initial orders and verbal orders as discussed below, the time of admission is the time the inpatient order is documented. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.d, B.4>

B. Qualifications of the Admitting Practitioner

1. The admitting practitioner must be licensed by the state, have privileges to admit to the hospital and be knowledgeable about the patient's hospital course, medical plan of care and condition at the time of admission. <See 42 C.F.R. 412.3(b), see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2>

Caution: A mid-level practitioner may be an admitting/ordering practitioner OR a proxy practitioner (discussed below) OR may be restricted from acting in either capacity depending on applicable state law and hospital by-laws and privileging standards. The QIO KEPRO recommends sending copies of by-laws regarding mid-level practitioners when submitting requested records for short stay reviews involving mid-level practitioner orders.

2. The admitting practitioner must be knowledgeable about the patient's care and condition at the time of admission. <See 42 C.F.R. 412.3(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.3>

CMS specifies the following practitioners to have sufficient knowledge of the patient's hospital course to be the admitting practitioner:

- The admitting ("attending") physician of record (or physician on call)
- Primary or covering hospitalist caring for the patient
- Patient's primary care practitioner (or physician on call)
- Surgeon responsible for major surgical procedure (or physician on call)
- Emergency or clinic practitioner caring for the patient at admission
- Practitioner qualified to admit patients and actively treating the patient at admission

3. Practitioners acting as a "Proxy" for the Admitting Practitioner

- a. Individuals, such as residents, physician assistants, nurse practitioners, or emergency department physicians, may write initial inpatient admission orders (e.g., "bridge orders", "initial orders") on behalf of an admitting practitioner if:
 - i. The individual is authorized under state law to admit patients;
 - ii. The individual is allowed by hospital by-laws or policies to make initial admission decisions; and
 - iii. The admitting practitioner approves and accepts responsibility for the admission decision by countersigning the order. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.a>

C. Verbal Orders

1. An individual (e.g., registered nurse) may receive and document a verbal order for admission, in accordance with their scope of practice, hospital policies and medical staff bylaws, rules and regulations. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.b>
 - a. A verbal order for admission must be documented at the time it is received, identify the ordering practitioner, and be countersigned by the ordering practitioner. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.2.b>

D. Clarification of Ambiguous Orders

1. If an admission order is ambiguous, a hospital may obtain a clarification order from the ordering practitioner before billing to Medicare. A clarification should, but does not need to be, completed before discharge. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5>
2. Orders that specify typically outpatient services (e.g., admit to observation or admit to same day surgery) are not considered ambiguous. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5>

E. Signature or Authentication of Orders

1. An inpatient order, including an initial or verbal order, should be authenticated (i.e., signed or countersigned) prior to discharge. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B>
 - a. The time of discharge does not always coincide with the order for discharge. Discharge occurs when the ordering practitioner's discharge orders are effectuated, including activities specified as having to occur prior to discharge (e.g., discharge after supper, discharge after patient voids). <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B>

Caution: The Benefit Policy Manual indicates if the order, including an initial or verbal order, is not signed before discharge, the patient is not considered an inpatient and the provider should not submit an inpatient Part A claim. This guidance appears to have been superseded by regulatory amendments and policy statements in the FY2019 IPPS Final Rule, effective October 1, 2018, discussed below. The applicable Benefit Policy Manual sections have not been updated or replaced at the time of publishing.

F. Missing or Defective Orders

1. Technical discrepancies in the inpatient order, such as signature after discharge or missing signatures, co-signatures or authentications, do not necessarily prevent inpatient Part A payment. <See 83 *Fed. Reg.* 41507>
 - a. Documentation such as progress notes or the medical records as a whole must support that coverage criteria have been met, including medical necessity, and the hospital must be operating in accordance with Conditions of Participation, such as delivery of the Important Message from Medicare. <See 83 *Fed. Reg.* 41507>

2. If the inpatient admission order is missing or defective, but the intent, decision, and recommendation of the qualifying ordering practitioner to admit the patient as an inpatient is clear, review contractors have the discretion to determine the information in the record constructively satisfies the requirement for an inpatient order. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5; 83 *Fed. Reg.* 41508-510>
3. Constructive satisfaction of inpatient admission order requirements should be extremely rare and may only be applied at the discretion of the contractor. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 B.5; 83 *Fed. Reg.* 41507-510>

II. Inpatient Certification

A. Certification at Prospective Payment System (PPS) Hospitals

1. Timing

- a. For stays 20 days or greater, a physician certification must be documented and signed no later than the 20th day. <See 42 C.F.R. 424.13(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2>
- b. For cost outlier cases, a physician certification must be documented and signed no later than the date the hospital requests outlier payment, unless certification was made by day 20. <See 42 C.F.R. 424.13(b) and (f)(2)>

Caution: Inpatient Psychiatric Facilities (IPFs) have additional inpatient certification requirements. See 42 C.F.R. 424.14.

2. Content of Certification

- a. There are three elements to the PPS certification:
 - i. The reason for continued hospitalization of the patient for inpatient medical treatment or diagnostic testing, OR the special or unusual services for cost outlier cases. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.a; see 42 C.F.R. 424.13(a)(1)>
 - ii. The estimated time the patient requires hospitalization if completed before discharge or the actual time in the hospital if completed at discharge. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.b; see 42 C.F.R. 424.13(a)(2)>

- a) Documentation of the estimated or actual length of stay is commonly reflected in the physician's assessment and plan or as part of routine discharge planning but may also appear in a separate certification form. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.b>
- iii. The plans for post discharge care, if appropriate. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.c; see 42 *CFR* 424.13(a)(3)>
- b. Documentation of Inpatient Rehabilitation Facility (IRF) coverage criteria (preadmission screening, post admission evaluation and admission orders) may be used to satisfy certification requirements for IRF patients. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.e.>

B. Certification at Critical Access Hospitals

1. Timing

- a. For a CAH, all certification requirements must be completed and signed no later than 1 day before the date on which the claim for payment for the inpatient service is submitted. <See 42 *C.F.R.* 424.15(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2>

2. "Good faith" certification in a CAH

- a. Medicare only pays for inpatient admissions at a CAH if a physician certifies in good faith that the patient may reasonably be expected to be discharged from the CAH or transferred to another hospital within 96 hours after admission to the CAH, even if an unforeseen event occurs that causes the patient to stay longer at the CAH. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.d>
 - (i) A problem will not occur regarding the CAH's designation if a stay longer than 96 hours does not cause the CAH to exceed the 96-hour annual average length of stay.
 - (ii) Time spent as an outpatient or time spent in a CAH's swing bed does not count towards the 96-hour certification requirement.
- b. If a physician cannot in good faith certify that a patient is expected to be discharged from the CAH or transferred to another hospital within 96 hours after inpatient admission, the CAH will not receive Medicare reimbursement for any portion of the admission. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.d>

- (i) NOTE: For medical record reviews conducted on or after October 1, 2017, CMS has directed Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractor (SMRC), and Recovery Auditors to make the 96-hour certification requirement a low priority during medical record reviews. This non-enforcement will only be applied absent any concerns of probable fraud, waste, or abuse. <82 Fed. Reg. 38296>
- (ii) CMS also stated that reviews by other entities, including Zone Program Integrity Contractors (ZPICs), the Office of Inspector General, and the Department of Justice will continue, as appropriate. <82 Fed. Reg. 38296>

Caution: The 96-hour certification requirement is statutory and cannot be amended or changed by CMS. Even though CMS will direct its contractors to make the certification a low priority during medical record review, failure to comply with CMS' provider screening and revalidation requirements or other medical review issues, may initiate additional documentation requests.

C. Qualifications of the Certifying Physician

1. The certifying practitioner must be a physician (i.e., MD/DO), or a dentist or podiatrist in limited circumstances, who has knowledge of the case. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.3>

CMS specifies the following physicians to have sufficient knowledge of the patient's hospital course to make the inpatient certification:

- The admitting ("attending") physician of record (or a physician on call)
- Surgeon responsible for major surgical procedure (or a physician on call)
- Hospital staff physician, on behalf of non-physician admitting

D. Format of the Certification

1. The elements of the certification may be entered on forms, notes or records signed by the physician or on a separate form, as long as the method of documentation permits verification. <See 42 CFR 424.11(b); see *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.4; *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.5>

2. There must be a separate signed statement that inpatient services are, were or continue to be medically necessary for each certification. <See 42 CFR 414.11(b); see *Medicare Benefit Policy Manual*, Chapter 1 § Section 10.2 A.4; *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.5>
 - a. The provider does not need to repeat the elements or state the location of the information supporting the separate signed statement if the supporting information can be verified in signed provider records such as progress notes or the discharge summary. <See 42 C.F.R. 424.11(b); *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.4>

E. Certification if No SNF Bed is Available

1. If an inpatient could be treated at a skilled nursing facility (SNF) but no SNF bed is available at a participating SNF, continued hospitalization is covered if the physician certifies the need for continued hospitalization on that basis. <See 42 C.F.R. 424.13(c); *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.6>
2. Alternate placement days certified as necessary because no SNF bed is available are covered days and are counted toward the three-day stay requirement for SNF coverage. <*Medicare Benefit Policy Manual*, Chapter 8 § 20.1>
3. Coverage of additional hospitalization days certified by a physician as necessary when no SNF bed is available continues until:
 - a. A bed becomes available in a participating SNF;
 - b. The patient no longer needs SNF level of care; or
 - c. The patient exhausts their Part A inpatient hospital benefits. <*Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.6>

III. Requirements for Part A Payment of an Inpatient Admission

Two requirements for Part A payment of an inpatient admission:

- Certification
 - At a PPS hospital, if
 - Cost outlier; or
 - Length of stay of 20 days or greater
 - OR
 - “Good faith” certification at a CAH
- Appropriate for Part A payment:
 - An inpatient only procedure; or
 - Physician’s expectation the patient will require medically necessary hospital care for two midnights or longer; or
 - Physician’s case-by-case determination to admit the patient based on their clinical judgment, supported in the medical record

- A. CMS published an algorithm entitled “BFCC QIO 2 Midnight Claim Review Guideline” that provides helpful guidance on application of the 2 Midnight Rule to determine whether cases are appropriate for payment under Part A. Handout 13 is the “BFCC QIO 2 Midnight Claim Review Guideline”.

Link: Inpatient Hospital Reviews under Medicare-Related Sites - Hospital

IV. Inpatient-Only Procedures

- A. CMS has determined certain procedures are not appropriate to be provided in a hospital outpatient department and designates them “inpatient only” procedures. <Medicare Claims Processing Manual, Chapter 4 § 180.7>
- B. Inpatient admission and Part A payment is appropriate if a medically necessary inpatient-only procedure is performed and documented in the medical record. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.A>
1. Inpatient admission is appropriate based on the presence of an inpatient-only procedure, regardless of the patient’s expected length of stay. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I.E.1>

C. Exemption from Certain Medical Review Activities

1. Procedures removed from the inpatient-only list on or after January 1, 2020 are exempt from certain medical review activities for a period of 2 years from their removal from the list. <86 *Fed. Reg.* 63740; 42 *C.F.R.* 412.3 (d)(2)(i)>

Note: In CY2022, CMS amended section 412.3(d)(2)(i), providing for a two-year exemption period for procedures removed on or after January 1, 2020, as discussed in the CY2022 OPPS Final Rule. However, CMS did not remove or amend section 412.3(d)(2)(ii) which continues to provide that procedures removed on or after January 1, 2021, are exempt until the secretary determines the procedure is more commonly performed in the outpatient setting. This appears to be an error based on the discussion in the CY2022 OPPS Final Rule.

2. During the period of exemption, claims for procedures removed from the inpatient only list are not exempt from review, but are exempt from:
 - a. Site of service claim denials under Medicare Part A;
 - b. QIO referral to RACs for noncompliance with the 2-Midnight Rule; and
 - c. RAC reviews for site of service. <86 *Fed. Reg.* 63740>

V. Two Midnight Benchmark

- A. The physician should order inpatient care if the physician has a reasonable expectation that the patient will require two midnights of medically necessary hospital care. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A, A.I.B; 78 *Fed. Reg.* 50946>

CMS has indicated they do not expect a patient receiving medically necessary hospital care to pass a second midnight without an order for inpatient care.

- B. The physician should consider the following timeframes in determining whether the patient will require two midnights of hospital care:

1. The physician should consider anticipated medically necessary inpatient care expected to be provided after the order for inpatient admission and initiation of care. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A, A.I.B>
 - a. Do not include time anticipated at another facility after transfer. <See *Reviewing Short Stay Hospital Claims for Patient Status: Admissions on or After January 1, 2016*, B.4>

2. The physician should consider time the patient spent receiving medically necessary inpatient or outpatient care at a transferring hospital prior to arrival at the admitting hospital. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
 - a. Reviewing contractors may request the admitting hospital provide records from the transferring hospital to verify medical necessity and confirm when hospital care began. <*Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
3. The physician should consider time the patient spent receiving medically necessary outpatient services (e.g., in the ED, observation, outpatient surgery) prior to the order for admission. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>

Do not consider:

- Triaging activities, such as vital signs, before initiation of medically necessary care responsive to the patient's clinical presentation; or
- Time spent in the waiting room prior to initiation of care.

- a. If the patient has received two midnights of medically necessary outpatient care without an inpatient order, the physician may write the inpatient order on the third day even if the patient is being discharged that day. <See KEPRO Short Stay Reviews FAQ, pg. 15; see BFCC QIO 2 Midnight Claim Review Guideline algorithm>
 - b. Hospitals may report Occurrence Span Code (OSC) 72 to indicate a contiguous outpatient day prior to an inpatient admission for one midnight to demonstrate compliance with the two-midnight benchmark. <One Time Notification Transmittal 1334>
- C. Livanta, the Short Stay Review auditor, has published several “*Claim Review Advisors*” that walk through the “BFCC QIO 2 Midnight Claim Review Guideline” (Handout 13) and how the two-midnight benchmark applies to clinical scenarios such as chest pain, atrial fibrillation, and congestive heart failure. The “*Claim Review Advisors*” are available on Livanta’s website.

Link: QIO Livanta Provider Resources under Medicare-Related Sites – Hospital

D. Unforeseen Circumstances

1. If the physician had a reasonable expectation the patient would stay two midnights for medically necessary hospital care, but the patient unexpectedly stays less than two midnights due to unforeseen circumstances, the stay may nevertheless qualify for inpatient payment under Part A. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.C; see 42 C.F.R. 412.3(d)(1)(ii)>

Examples of unforeseen circumstances:

- Unforeseen death or transfer
- Departure against medical advice
- Election of hospice in lieu of continued hospital treatment
- Unexpected clinical improvement

Caution: To avoid later denials, the UR committee should review cases of unexpected clinical improvement carefully to determine the expectation of two midnights of medically necessary care was reasonable when the order was written.

Case Study 1

Facts: A patient is scheduled on Monday morning for a total knee arthroplasty (CPT code 27447). The surgeon documents in her plan the expectation that the patient will be discharged at the end of the day on Wednesday or Thursday morning, depending on pain control and the patient's response to the start of therapy. What status should the surgeon order?

Modified Facts: On Tuesday the patient is doing better than expected and the physician discharges the patient home Tuesday evening with plans for outpatient PT beginning on Wednesday. Is this case still appropriate for inpatient Part A payment?

E. Care that is Not Medically Necessary Hospital Care

1. The physician should not consider time the patient spent or will spend receiving care that is not medically necessary hospital care (e.g., skilled nursing, nursing or custodial care). <See BFCC QIO 2 Midnight Claim Review Guideline algorithm; see *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B; 78 Fed. Reg. 50947-48>

2. Delays in Care

- a. The physician should exclude extensive delays in the provision of medical necessary care when determining the expected length of stay (e.g., delays in the availability of diagnostic tests or consultations). <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>

3. Convenience Care

- a. Care provided for the convenience of the patient is not considered medically necessary. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
- b. Factors resulting in inconvenience to the patient, such as time and money to care for the patient at home or to travel to and from medical care, may be considered if they affect the patient's health or are accompanied by medical conditions. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>

4. Social Admissions

- a. Social admissions, when there is no available, safe placement in the community, are not covered regardless of the expected length of stay. <78 *Fed. Reg.* 50947-48>

Case Study 2

Facts: A Medicare patient presents to the outpatient surgery department on Wednesday for an outpatient laparoscopic cholecystectomy. The patient experiences unusual pain and bleeding following the procedure and is placed in observation at 2pm on Wednesday by their surgeon.

On Thursday morning, nurses contact the surgeon because the patient is experiencing shortness of breath and chest pain. The surgeon refers the patient to the hospitalist for evaluation. The hospitalist sees the patient that morning, while the patient is still in observation, and begins to evaluate the patient's cardiac status.

At 7pm on Thursday, the hospitalist determines the patient will need to stay at the hospital an additional night for continued evaluation of their cardiac status, as well as post-operative complications and writes an inpatient admission order. The patient improves by Friday and is discharged home on Friday afternoon.

Is this case appropriate for inpatient payment under Part A (i.e. does the case meet the 2-Midnight benchmark)? What is the patient's inpatient length of stay?

Modified Facts: On Thursday afternoon at 1 pm following diagnostic testing, the hospitalist is able to determine the patient is not having a cardiac event and diagnoses the patient with anxiety not necessitating further observation. The surgeon also sees the patient on Thursday afternoon at 3 pm and determines the post-operative complications have resolved and the patient is ready for discharge.

The patient is quite anxious and states that her daughter is flying in from another state on Friday and she does not want to be discharged until the next morning when her daughter arrives. The surgeon writes an order to discharge the patient the next morning and the patient is discharged at 10am on Friday. Should the surgeon have written an inpatient admission order on Thursday because the patient was staying a second night at the hospital?

VI. Admission on a Case-by-Case Basis

- A. Inpatient admission may be appropriate when the admitting physician expects less than a two midnight stay, but determines admission is appropriate on a case-by-case basis, based on their clinical judgment, supported by the medical documentation. <See 42 C.F.R. 412.3(d)(3), 80 Fed. Reg. 70545>

1. Effective January 1, 2016, this exception expanded the former sub-regulatory rare and unusual exception policy under the Two-Midnight Rule, which formerly only included newly initiated mechanical ventilation. <80 Fed. Reg. 70541, 70545; *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.E.2>
 - B. CMS has stated that rarely would a stay of less than 24 hours qualify for a case-by-case exception to the two-midnight benchmark. <*Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.E.3>
 - C. CMS provided an example of a case-by-case admission in *MLN Matters Special Edition SE19002*, Case #2, in which the patient has numerous co-morbidities, including cardiac comorbidities that cause a complication requiring treatment during the one day stay. <See *MLN Matters SE19002*, Case #2>
- Note: A prior version of SE19002 had an example of an appropriate case-by-case admission, with similar risks and comorbidities to Case #2 in the current version. However, in the rescinded version of SE19002, no complications occurred and the patient was discharged without cardiac incident. It is unclear if this implies that risk alone is insufficient for an appropriate case-by-case admission.
- D. Admission under the case-by-case exception is subject to the clinical judgment of the medical reviewer. <80 Fed. Reg. 70541>
 1. Livanta, the Short Stay Review auditor, has published several “*Claim Review Advisors*” that walk through the “BFCC QIO 2 Midnight Claim Review Guideline” (Handout 13) and review how they will apply case-by-case judgment to clinical scenarios such as chest pain, atrial fibrillation, and congestive heart failure. The “*Claim Review Advisors*” are available on Livanta’s website.

Caution: To avoid later denials, the UR committee should review admissions based on case-by-case determinations of the admitting physician to ensure documentation supports the need for inpatient care at the time the order was written.

VII. Documentation and Use of Screening Tools

- A. The physician’s assessment and plan should reflect the need for admission and the expected length of stay, based on complex medical factors such as:
 1. Medical history and comorbidities,
 2. The severity of signs and symptoms,
 3. Current medical needs, and

4. The risk/probability of an adverse event occurring during the time period being considered for hospitalization. <See 42 C.F.R. 412.3(d)(1)(i), see *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
- B. Auditors will review physician documentation based on the information known to the physician at the time of admission. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>
1. Although the entire record may be used to support the physician's expectation for the need and length of admission, entries after the point of admission are only used by auditors in the context of determining what the physician knew and expected at the point of admission. <See *Reviewing Short Stay Hospital Claims for Patient Status: Admissions on or After January 1, 2016*, B.2>
- C. The physician need not specifically state the expected length of stay (e.g., two midnights) if this information can be inferred from the physician's other documentation such as the plan of care, treatment orders, and notes. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.B>

Caution: If the physician does not specify the expected length of stay, an auditor may review the case under the higher standard of a case-by-case admission rather than under the reasonable expectation standard.

D. Inpatient Utilization Screening Tools

1. Physicians may, but are not required, to consider commercial utilization screening tools (e.g., InterQual® or MCG criteria) as part of the complex medical judgment that guides his or her decision to keep the beneficiary in the hospital and the formulation of the expected length of stay. <Medicare Program Integrity Manual, Chapter 6 § 6.5.1>
2. Livanta, who was granted the national short stay audit contract, noted during prior short stay audits that the final decisions of their clinical reviewers will be based on their clinical knowledge and expertise and will not be based solely on Interqual® or MCG criteria. Livanta announced Interqual® or MCG criteria will only be used as a point of reference for further consultation. <See Livanta Provider Questions and Answers for Two-Midnight Rule>

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A patient is scheduled on Monday morning for a total knee arthroplasty (CPT code 27447). The surgeon documents in her plan the expectation that the patient will be discharged at the end of the day on Wednesday or Thursday morning, depending on pain control and the patient's response to the start of therapy. What status should the surgeon order?

Analysis: The procedure has a status indicator J1 (i.e., it is not designated as inpatient-only) so the surgeon should consider the expected length of stay of the patient. The patient is expected to have a 2 or 3 midnight stay based on the physician's plan and should be admitted as an inpatient for the procedure based on this expectation. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 A.I>

Modified Facts: On Tuesday the patient is doing better than expected and the physician discharges the patient home Tuesday evening with plans for outpatient PT beginning on Wednesday. Is this case still appropriate for inpatient Part A payment?

Analysis: Yes, assuming the physician's original documented plan was reasonable, the fact the patient was unexpectedly discharged after one midnight due to clinical improvement does not prevent the case from qualifying for Part A payment. <Medicare Program Integrity Manual, Chapter 6 § 6.5.2 C>

Case Study 2

Facts: A Medicare patient presents to the outpatient surgery department on Wednesday for an outpatient laparoscopic cholecystectomy. The patient experiences unusual pain and bleeding following the procedure and is placed in observation at 2pm on Wednesday by their surgeon.

On Thursday morning, nurses contact the surgeon because the patient is experiencing shortness of breath and chest pain. The surgeon refers the patient to the hospitalist for evaluation. The hospitalist sees the patient that morning, while the patient is still in observation, and begins to evaluate the patient's cardiac status.

At 7pm on Thursday, the hospitalist determines the patient will need to stay at the hospital an additional night for continued evaluation of their cardiac status, as well as post-operative complications and writes an inpatient admission order. The patient improves by Friday and is discharged home on Friday afternoon.

Is this case appropriate for inpatient payment under Part A (i.e., does the case meet the 2-Midnight benchmark)? What is the patient's inpatient length of stay?

Analysis: Yes, at the time the hospitalist wrote the inpatient order on Thursday, the patient had already spent one night in the hospital receiving outpatient services and based on their expectation that the patient would need one additional night of hospital services, the inpatient admission meets the 2-Midnight benchmark and is appropriate. The inpatient length of stay is one night. <42 C.F.R. 412.3(d)(1); 78 Fed. Reg. 50946>

Modified Facts: On Thursday afternoon at 1 pm following diagnostic testing, the hospitalist is able to determine the patient is not having a cardiac event and diagnoses the patient with anxiety not necessitating further observation. The surgeon also sees the patient on Thursday afternoon at 3 pm and determines the post-operative complications have resolved and the patient is ready for discharge.

The patient is quite anxious and states that her daughter is flying in from another state on Friday and she does not want to be discharged until the next morning when her daughter arrives. The surgeon writes an order to discharge the patient the next morning and the patient is discharged at 10am on Friday. Should the surgeon have written an inpatient admission order on Thursday because the patient was staying a second night at the hospital?

Analysis: No, the patient no longer needed hospital care and could have been discharged home on Thursday after one medically necessary night at the hospital. The remaining care is custodial in nature and cannot be counted towards the 2-Midnight benchmark.

<Reviewing Hospital Claims for Patient Status: Admissions on or after January 1, 2016>

Version 01/09/2023
Check for Updates

ELECTRONIC CODE OF FEDERAL REGULATIONS

SEE AMENDED VERSION ON NEXT PAGE - THIS VERSION PROVIDED FOR EDUCATIONAL PURPOSES ONLY RELATED TO INPATIENT ORDERS

[Title 42](#) → [Chapter IV](#) → [Subchapter B](#) → [Part 412](#) → [Subpart A](#) → §412.3

Title 42: Public Health

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

Subpart A—General Provisions

§412.3 Admissions. Deleted text represents the amendment effective October 1, 2018.

[Link to an amendment published at 83 FR 41700, Aug. 17, 2018.](#)

(a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. ~~This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.~~ In addition to these physician orders, inpatient rehabilitation facilities also must adhere to the admission requirements specified in §412.622 of this chapter.

(b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.

(c) The physician order must be furnished at or before the time of the inpatient admission.

(d)(1) Except as specified in paragraphs (d)(2) and (3) of this section, 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.

(i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

(ii) If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and payment for an inpatient hospital stay may be made under Medicare Part A.

(2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under §419.22(n) of this chapter is generally appropriate for payment under Medicare Part A, regardless of the expected duration of care.

(3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

[78 FR 50965, Aug. 19, 2013, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70602, Nov. 13, 2015]

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 412 - Prospective Payment Systems for Inpatient Hospital Services

Subpart A - General Provisions

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 50 FR 12741, Mar. 29, 1985, unless otherwise noted.

§ 412.3 Admissions.

- (a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§ 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. In addition, inpatient rehabilitation facilities also must adhere to the admission requirements specified in § 412.622.
- (b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.
- (c) The physician order must be furnished at or before the time of the inpatient admission.
- (d)
 - (1) Except as specified in paragraphs (d)(2) and (3) of this section, 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.
 - (i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.
 - (ii) If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and payment for an inpatient hospital stay may be made under Medicare Part A.
 - (2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under § 419.22(n) of this chapter is generally appropriate for payment under Medicare Part A regardless of the expected duration of care. Procedures no longer specified as inpatient only under § 419.22(n) of this chapter are appropriate for payment under Medicare Part A in accordance with paragraph (d)(1) or (3) of this section. Claims for services and procedures removed from the inpatient only list under § 419.22 of this chapter on or after January 1, 2020 are exempt from certain medical review activities.

- (i) For those services and procedures removed on or after January 1, 2020, the exemption in this paragraph (d)(2) will last for 2 years from the date of such removal.
 - (ii) For those services and procedures removed on or after January 1, 2021, the exemption in this paragraph (d)(2) will last until the Secretary determines that the service or procedure is more commonly performed in the outpatient setting.
- (3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

[78 FR 50965, Aug. 19, 2013, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70602, Nov. 13, 2015; 83 FR 41700, Aug. 17, 2018; 85 FR 86300, Dec. 29, 2020; 86 FR 63992, Nov. 16, 2021]

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 424 - Conditions for Medicare Payment

Subpart B - Certification and Plan Requirements

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 53 FR 6634, Mar. 2, 1988, unless otherwise noted.

§ 424.13 Requirements for inpatient services of hospitals other than inpatient psychiatric facilities.

- (a) **Content of certification and recertification.** Medicare Part A pays for inpatient hospital services (other than inpatient psychiatric facility services) for cases that are 20 inpatient days or more, or are outlier cases under subpart F of part 412 of this chapter, only if a physician certifies or recertifies the following:
- (1) The reasons for either -
 - (i) Continued hospitalization of the patient for medical treatment or medically required diagnostic study; or
 - (ii) Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of part 412 of this chapter).
 - (2) The estimated time the patient will need to remain in the hospital.
 - (3) The plans for posthospital care, if appropriate.
- (b) **Timing of certification.** For outlier cases under subpart F of part 412 of this chapter, the certification must be signed and documented in the medical record and as specified in paragraphs (e) through (h) of this section. For all other cases, the certification must be signed and documented no later than 20 days into the hospital stay.
- (c) **Certification of need for hospitalization when a SNF bed is not available.**
- (1) The physician may certify or recertify need for continued hospitalization if he or she finds that the patient could receive proper treatment in a SNF but no bed is available in a participating SNF.
 - (2) If this is the basis for the physician's certification or recertification, the required statement must so indicate; and the certifying physician is expected to continue efforts to place the patient in a participating SNF as soon as a bed becomes available.
- (d) **Signatures -**
- (1) **Basic rule.** Except as specified in paragraph (d)(2) of this section, certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff.

This content is from the eCFR and is authoritative but unofficial.

Title 42 - Public Health

Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

Subchapter B - Medicare Program

Part 424 - Conditions for Medicare Payment

Subpart B - Certification and Plan Requirements

Authority: 42 U.S.C. 1302 and 1395hh.

Source: 53 FR 6634, Mar. 2, 1988, unless otherwise noted.

§ 424.11 General procedures.

- (a) **Responsibility of the provider.** The provider must -
 - (1) Obtain the required certification and recertification statements;
 - (2) Keep them on file for verification by the intermediary, if necessary; and
 - (3) Certify, on the appropriate billing form, that the statements have been obtained and are on file.
- (b) **Obtaining the certification and recertification statements.** No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided in paragraph (d) of this section for delayed certifications, there must be a separate signed statement for each certification or recertification. If supporting information for the signed statement is contained in other provider records (such as physicians' progress notes), it need not be repeated in the statement itself.
- (c) **Required information.** The succeeding sections of this subpart set forth specific information required for different types of services.
- (d) **Timeliness.**
 - (1) The succeeding sections of this subpart also specify the timeframes for certification and for initial and subsequent recertifications.
 - (2) A hospital or SNF may provide for obtaining a certification or recertification earlier than required by these regulations or vary the timeframe (within the prescribed outer limits) for different diagnostic or clinical categories.
 - (3) Delayed certification and recertification statements are acceptable when there is a legitimate reason for delay. (For instance, the patient was unaware of his or her entitlement when he or she was treated.) Delayed certification and recertification statements must include an explanation of the reasons for the delay.
 - (4) A delayed certification may be included with one or more recertifications on a single signed statement.
 - (5) For all inpatient hospital services, including inpatient psychiatric facility services, a delayed certification may not extend past discharge.

- (e) **Limitation on authorization to sign statements.** A certification or recertification statement may be signed only by one of the following:
- (1) A physician who is a doctor of medicine or osteopathy.
 - (2) A dentist in the circumstances specified in § 424.13(d).
 - (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under State law.
 - (4) A nurse practitioner or clinical nurse specialist as defined in paragraph (e)(5) or (e)(6) of this section, or a physician assistant as defined in section 1861(aa)(5)(A) of the Act, in the circumstances specified in § 424.20(e).
 - (5) For purposes of this section, to qualify as a nurse practitioner, an individual must -
 - (i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the services of a nurse practitioner in accordance with State law; and have a master's degree in nursing;
 - (ii) Be certified as a nurse practitioner by a professional association recognized by CMS that has, at a minimum, eligibility requirements that meet the standards in paragraph (e)(5)(i) of this section; or
 - (iii) Meet the requirements for a nurse practitioner set forth in paragraph (e)(5)(i) of this section, except for the master's degree requirement, and have received before August 25, 1998 a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.
 - (6) For purposes of this section, to qualify as a clinical nurse specialist, an individual must -
 - (i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the services of a clinical nurse specialist in accordance with State law; and have a master's degree in a defined clinical area of nursing;
 - (ii) Be certified as a clinical nurse specialist by a professional association recognized by CMS that has at a minimum, eligibility requirements that meet the standards in paragraph (e)(6)(i) of this section; or
 - (iii) Meet the requirements for a clinical nurse specialist set forth in paragraph (e)(6)(i) of this section, except for the master's degree requirement, and have received before August 25, 1998 a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

[53 FR 6634, Mar. 2, 1988, as amended at 56 FR 8845, Mar. 1, 1991; 60 FR 38272, July 26, 1995; 78 FR 47968, Aug. 6, 2013; 78 FR 50969, Aug. 19, 2013; 79 FR 50359, Aug. 22, 2014; 83 FR 41706, Aug. 17, 2018]

- (2) **Exception.** If the intermediary requests certification of the need to admit a patient in connection with dental procedures, because his or her underlying medical condition and clinical status or the severity of the dental procedures require hospitalization, that certification may be signed by the dentist caring for the patient.
- (e) **Timing of certifications and recertifications: Outlier cases not subject to the prospective payment system (PPS).**
- (1) For outlier cases that are not subject to the PPS, certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories.
- (2) The first recertification is required no later than as of the 18th day of hospitalization.
- (3) Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.
- (f) **Timing of certification and recertification: Outlier cases subject to PPS.** For outlier cases subject to the PPS, certification is required as follows:
- (1) For day outlier cases, certification is required no later than 1 day after the hospital reasonably assumes that the case meets the outlier criteria, established in accordance with § 412.80(a)(1)(i) of this chapter, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses) but not less frequently than every 30 days.
- (2) For cost outlier cases, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier. If possible, certification must be made before the hospital incurs costs for which it will seek cost outlier payment. In cost outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses).
- (g) **Recertification requirement fulfilled by utilization review.**
- (1) At the hospital's option, extended stay review by its UR committee may take the place of the second and subsequent recertifications required for outlier cases not subject to PPS and for PPS day-outlier cases.
- (2) A utilization review that is used to fulfill the recertification requirement is considered timely if performed no later than the seventh day after the day the recertification would have been required. The next recertification would need to be made no later than the 30th day following such review; if review by the UR committee took the place of this recertification, the review could be performed as late as the seventh day following the 30th day.
- (h) **Description of procedures.** The hospital must have available on file a written description that specifies the time schedule for certifications and recertifications, and indicates whether utilization review of long-stay cases fulfills the requirement for second and subsequent recertifications of all outlier cases not subject to PPS and of PPS day outlier cases.

[78 FR 50969, Aug. 19, 2013, as amended at 79 FR 67033, Nov. 10, 2014]

completed a cost reporting period under the demonstration payment methodology beginning in FY 2013 are available. The actual costs of the demonstration as determined from these finalized cost reports fell short of the estimated amount that was finalized in the FY 2013 IPPS final rule by \$5,398,382.

We note that the amounts identified for the actual cost of the demonstration for each of FYs 2011, 2012, and 2013 (determined from finalized cost reports) is less than the amount that was identified in the final rule for the respective year. Therefore, in keeping with previous policy finalized in situations when the costs of the demonstration fell short of the amount estimated in the corresponding year's final rule, we are including this component as a negative adjustment to the budget neutrality offset amount for the current fiscal year.

e. Total Final Budget Neutrality Offset Amount for FY 2019

For this FY 2019 IPPS/LTCH PPS final rule, we are incorporating the following components into the calculation of the total budget neutrality offset for FY 2019:

Step 1: The amount determined under section IV.L.4.c.(3) of the preamble of this final rule, representing the difference applicable to FY 2018 between the sum of the estimated reasonable cost amounts that would be paid under the demonstration to participating hospitals for covered inpatient hospital services and the sum of the estimated amounts that would generally be paid if the demonstration had not been implemented. The determination of this amount includes prorating to reflect for each participating hospital the fraction of the number of months for the cost report year starting in FY 2018 falling into the overall 12 months of the fiscal year. This estimated amount is \$31,070,880.

Step 2: The amount, determined under section IV.L.4.c.(4) of the preamble of this final rule representing the corresponding difference of these estimated amounts for FY 2019. No prorating is applied in the determination of this amount. This estimated amount is \$70,929,313.

Step 3: The amount determined under section IV.L.4.d. of the preamble of this final rule according to which the actual costs of the demonstration for FY 2011 for the 16 hospitals that completed a cost reporting period beginning in FY 2011 differ from the estimated amount that was incorporated into the budget neutrality offset amount for FY 2011 in the FY 2011 IPPS/LTCH PPS final rule.

Analysis of this set of cost reports shows that the actual costs of the demonstration fell short of the estimated amount finalized in the FY 2011 IPPS/LTCH PPS final rule by \$29,971,829.

Step 4: The amount determined under section IV.L.4.d. of the preamble of this final rule, according to which the actual costs for the demonstration for FY 2012 for the 23 hospitals that completed a cost reporting period beginning in FY 2012 differ from the estimated amount in the FY 2012 final rule. Analysis of this set of cost reports shows that the actual costs of the demonstration for FY 2012 fell short of the estimated amount finalized in the FY 2012 IPPS/LTCH PPS final rule by \$8,500,373.

Step 5: The amount, also determined under section IV.L.4.d. of the preamble of this final rule, according to which the actual costs of the demonstration for FY 2013 for the 22 hospitals that completed a cost reporting period beginning in FY 2013 differ from the estimated amount in the FY 2013 final rule. Analysis of this set of cost reports shows that the actual costs of the demonstration for FY 2013 fell short of the estimated amount finalized in the FY 2013 IPPS/LTCH PPS final rule by \$5,398,382.

In keeping with previously finalized policy, we are applying these differences, according to which the actual costs of the demonstration for each of FYs 2011, 2012, and 2013 fell short of the estimated amount determined in the final rule for each of these fiscal years, by reducing the budget neutrality offset amount to the national IPPS rates for FY 2019 by these amounts.

Thus, the total budget neutrality offset amount that we are applying to the national IPPS rates for FY 2019 is: The amount determined under Step 1 (\$31,070,880) plus the amount determined under Step 2 (\$70,929,313) minus the amount determined under Step 3 (\$29,971,829) minus the amount determined under Step 4 (\$8,500,373) minus the amount determined under Step 5 (\$5,398,382). This total is \$58,129,609.

In addition, in accordance with the policy finalized in the FY 2018 IPPS/LTCH PPS final rule, we will incorporate the actual costs of the demonstration for the previously participating hospitals for cost reporting periods starting in FYs 2015, 2016, and 2017 into a single amount to be included in the calculation of the budget neutrality offset amount to the national IPPS rates in a future final rule after such finalized cost reports become available. We expect to do this in FY 2020 or FY 2021.

In response to the FY 2019 IPPS/LTCH PPS proposed rule, we received one public comment in support of continuing the demonstration. We appreciate the commenter's support.

M. Revision of Hospital Inpatient Admission Orders Documentation Requirements Under Medicare Part A

1. Background

In the CY 2013 OPPTS/ASC final rule with comment period (77 FR 68426 through 68433), we solicited public comments for potential policy changes to improve clarity and consensus among providers, Medicare, and other stakeholders regarding the relationship between hospital admission decisions and appropriate Medicare payment, such as when a Medicare beneficiary is appropriately admitted to the hospital as an inpatient and the cost to hospitals associated with making this decision. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50938 through 50942), we adopted a set of policies widely referred to as the "2 midnight" payment policy. Among the finalized changes, we codified through regulations at 42 CFR 412.3 the longstanding policy that a beneficiary becomes a hospital inpatient if formally admitted pursuant to the order of a physician (or other qualified practitioner as provided in the regulations) in accordance with the hospital conditions of participation (CoPs). In addition, we required that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment. In response to public comments that the requirement of a written admission order as a condition of payment is duplicative and burdensome on hospitals, we responded that the physician order reflects affirmation by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and the "order serves the unique purpose of initiating the inpatient admission and documenting the physician's (or other qualified practitioner as provided in the regulations) intent to admit the patient, which impacts its required timing." Therefore, we finalized the policy requiring a written inpatient order for all hospital admissions as a specific condition of payment. We acknowledged that in the extremely rare circumstance the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record, medical review

contractors are provided with discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record.

2. Revisions Regarding Admission Order Documentation Requirements

As discussed in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20447 and 20448), despite the discretion granted to medical reviewers to determine that admission order information derived from the medical record constructively satisfies the requirement that a written hospital inpatient admission order is present in the medical record, as we have gained experience with the policy, it has come to our attention that some medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders. Common technical discrepancies consist of missing practitioner admission signatures, missing co-signatures or authentication signatures, and signatures occurring after discharge. We have become aware that, particularly during the case review process, these discrepancies have occasionally been the primary reason for denying Medicare payment of an individual claim. In looking to reduce unnecessary administrative burden on physicians and providers and having gained experience with the policy since it was implemented, we have concluded that if the hospital is operating in accordance with the hospital CoPs, medical reviews should primarily focus on whether the inpatient admission was medically reasonable and necessary rather than occasional inadvertent signature documentation issues unrelated to the medical necessity of the inpatient stay. It was not our intent when we finalized the admission order documentation requirements that they should by themselves lead to the denial of payment for medically reasonable and necessary inpatient stays, even if such denials occur infrequently.

Therefore, in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20447 and 20448), we proposed to revise the admission order documentation requirements by removing the requirement that written inpatient admission orders are a specific requirement for Medicare Part A payment. Specifically, we proposed to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment.

Hospitals and physicians are still required to document relevant orders in the medical record to substantiate medical necessity requirements. If other available documentation, such as the physician certification statement when required, progress notes, or the medical record as a whole, supports that all the coverage criteria (including medical necessity) are met, and the hospital is operating in accordance with the hospital conditions of participation (CoPs), we stated that we believe it is no longer necessary to also require specific documentation requirements of inpatient admission orders as a condition of Medicare Part A payment. We stated that the proposal would not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission. While this continues to be a requirement, as indicated earlier, technical discrepancies with the documentation of inpatient admission orders have led to the denial of otherwise medically necessary inpatient admission. To reduce this unnecessary administrative burden on physicians and providers, we proposed to no longer require that the specific documentation requirements of inpatient admission orders be present in the medical record as a condition of Medicare Part A payment.

Accordingly, we proposed to revise the regulations at 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A. We note that we did not propose any changes with respect to the “2 midnight” payment policy.

Comment: Numerous commenters supported CMS’ proposal. One commenter conveyed that there are instances where medical records clearly indicate inpatient intent but the associated claim is denied only because the inpatient admission order was missing a signature. Another commenter agreed with CMS’ proposal because the requirement for an inpatient admission order to be present in the medical record is duplicative in nature. One commenter explained that alleviating this requirement will result in significant burden reduction for physicians and providers.

Response: We appreciate the commenters’ support.

Comment: Some commenters were concerned that the proposal may render the inpatient admission order completely insignificant and not required for any purpose. In addition,

and in further context, the commenters referenced previous CMS subregulatory guidance from January 2014 which explained that if a practitioner disagreed with the decision to admit a patient to inpatient status, the practitioner could simply refrain from authenticating the inpatient admission order and the patient would remain in outpatient status. The commenters were concerned that if CMS no longer requires a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment, CMS would not be able to distinguish between orders that were simply defective and orders that were intentionally not signed.

Other commenters believed that the proposal would make the payment process even more difficult, especially in instances where patients were not registered by the hospital admissions staff, did not receive the required notice of their inpatient status, and there was no valid admission order related to their visit. The commenters were concerned that these particular cases would prevent patients from being knowledgeable of their appeal rights and financial liability.

Some commenters believed that, without an inpatient admission order, Medicare coverage of SNF services would be at risk due to issues such as lack of clarity in the medical record or a MAC’s misinterpretation of physician intent, and stated that denial of such needed services would negatively impact patients’ health.

Response: Our proposal does not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. The physician order remains a significant requirement because it reflects a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and initiates the process for inpatient admission.

Regarding the concerns of some commenters regarding orders that were intentionally not signed because the practitioner responsible for signing disagreed with the decision to admit, it should never have been the case that the only evidence in the medical record regarding this uncommon situation was the absence of the physician’s or other qualified practitioner’s signature. The medical record as a whole should reflect whether there was a decision by a physician or other qualified practitioner to admit the beneficiary as an inpatient or not. This fact is precisely why, under our current guidance, we acknowledged

that in the extremely rare circumstance where the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record, medical review contractors have discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record. We disagree with these commenters that reliance only on the absence of the signature in these uncommon situations reflected good medical documentation practice.

Regarding the commenters who were concerned that our proposal would remove the requirement for an order altogether, affecting patient appeal rights, or increase financial liability, as stated earlier, the physician order remains a requirement for purposes of reflecting a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, initiating the inpatient admission. Additionally, regardless of this proposal and other physician order requirements described earlier, the hospital CoPs include the requirement that all Medicare inpatients must receive written information about their hospital discharge appeal rights.

Comment: Commenters inquired about situations where a patient in outpatient status under observation spent two medically necessary midnights and was subsequently discharged. The commenters stated that, in these situations, providers are allowed to obtain an admission order at any time prior to formal discharge. The commenters inquired whether providers can review this stay after discharge, determine the 2-midnight benchmark was met, and submit a claim for inpatient admission.

Response: Again, the proposal would not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. As noted previously, the physician order reflects the determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and initiates the inpatient admission. With respect to the question about reviewing an outpatient stay after discharge and submitting an inpatient claim for that stay, we refer readers to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50942) in our response to comments where we stated that “The physician order cannot

be effective retroactively. Inpatient status only applies prospectively, starting from the time the patient is formally admitted pursuant to a physician order for inpatient admission, in accordance with our current policy.”

Comment: Some commenters asked whether condition code 44 was still required to change a patient's status from inpatient to outpatient. Other commenters asked whether condition code 44 could still be used by hospitals without the presence of an inpatient admission order.

Response: We consider these comments regarding the use of condition code 44 to be outside the scope of the proposed rule because we did not make a proposal regarding changing patient status from inpatient to outpatient. Therefore, we are not responding to these comments in this final rule.

Comment: Some commenters wanted to know how the proposed policy changes the process for moving a patient from observation status to inpatient status and the timing of inpatient billing related to this process. Some commenters stated that the proposed policy change appears to suggest that the completion of admission orders would now be optional and other available documentation could be used to create retroactive orders.

Response: As stated earlier, the proposal does not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. In addition, this proposal does not change the fact that hospitals are required to operate in accordance with appropriate CoPs.

Regarding the comment about retroactive orders, it has been and continues to be longstanding Medicare policy to not permit retroactive orders. The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (for example, for a prescheduled surgery), but the inpatient admission does not occur until hospital services are provided to the beneficiary.

Comment: Commenters also discussed how the proposed policy may affect procedures on the inpatient only list. Specifically, the commenters wanted to know how this policy proposal applies to patients who receive procedures on the inpatient only list when the patient is an outpatient. In instances when a patient's status changes to inpatient prior to an inpatient order being placed, the commenters questioned whether hospitals would be able to determine the inpatient only procedure was

performed and submit a bill for Medicare Part A payment.

Response: The proposed revision does not include revisions to the policy for processing payment for inpatient only list procedures. As noted previously, our proposal does not change the requirement that, for purposes of Part A payment, an individual becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission. The physician order remains a significant requirement because it reflects a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and initiates the process for inpatient admission. We did not understand the comment regarding a patient's status changing prior to an order being placed. Therefore, we are unable to specifically respond to that comment.

Comment: Commenters inquired if the proposal would change the requirements regarding which practitioners are allowed to furnish inpatient admission orders.

Response: The proposed revision relating to hospital inpatient admission order documentation requirements under Medicare Part A does not include revisions to the requirements regarding which practitioners are allowed furnish inpatient admission orders.

Comment: A number of commenters had specific questions regarding technical discrepancies. Specifically, the commenters wanted to know if CMS will be publishing a list of acceptable and unacceptable technical discrepancies considered by medical review contractors for the purposes of approving or denying Medicare Part A payment for inpatient admissions. In addition, the commenters wanted to know if CMS will require a specific error rate for compliance with inpatient physician orders, such as for provider technical errors that may be deemed excessive or unacceptable. The commenters also inquired whether providers will be required to document in the medical record whether technical discrepancies occurred in order for Medicare Part A payment to be considered. For example, the commenters wanted to know if an inpatient order for a medically necessary inpatient admission is not signed prior to the patient's discharge, will the facility need to document why the technical discrepancy occurred.

Response: We have not considered developing a list of acceptable or unacceptable technical discrepancies nor have we considered requiring a technical discrepancy error rate.

✦ In regards to the comment regarding whether this proposed policy would require documentation of how a technical discrepancy occurred, we refer readers to the following subregulatory guidance from the Medicare Benefits Policy Manual (MBPM), Chapter 1, Section 10.2.: “The order to admit may be missing or defective (that is, illegible, or incomplete, for example ‘inpatient’ is not specified), yet the intent, decision, and recommendation of the ordering practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these situations, contractors have been provided with discretion to determine that this information provides acceptable evidence to support the hospital inpatient admission. However, there can be no uncertainty regarding the intent, decision, and recommendation by the ordering practitioner to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.” This guidance will remain in effect after this rule is finalized.

Comment: Some commenters recommended that CMS change the audit requirements for contractors so that claims are not denied solely on technical issues found in the inpatient admission order. The commenters also suggested that CMS amend its Medicare Manual to clarify if an inpatient admission order is deemed defective.

Response: We thank the commenters for their recommendations and suggestions. In carrying out their work, medical review contractors are required to follow CMS regulations and policy guidance. If necessary, we may revise our manuals and/or issue additional subregulatory guidance as appropriate with respect to the finalized regulation.

Comment: Some commenters submitted information to demonstrate that CMS had indeed at one point intended to require orders and deny payment based on the absence of orders. As such, the commenters indicated that CMS’ FY 2019 proposed policy would institute a change in language that may confuse hospitals due to lack of clarity. The commenters stated that any change should be accompanied with further changes to relevant CoPs and codified through provider education mechanisms.

The commenters stated that because of perceived uncertainty and lack of clarity in comparing previous CMS guidance and rulemaking language to the language in the policy proposal, providers are going to need assistance in how to proceed in determining how to document inpatient admission orders

and ensure proper processing of Medicare Part A payment. The commenters requested that the proposed policy be incorporated into hospital’s post-discharge review in addition to the audits performed by Medicare contractors.

In addition, commenters believed that the 2-midnight rule amended the Medicare CoPs to require an inpatient admission order. The commenters explained that if CMS proceeds with its proposal, the Agency would have to revise the CoPs to clarify that an order is no longer a condition for Medicare Part A payment.

Response: In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50938 through 50942), we adopted a set of policies widely referred to as the “2-midnight” payment policy, as well as codified the requirement that a physician order for inpatient admission was a specific condition for Part A payment. In that rulemaking, we acknowledged that, in the extremely rare circumstance that the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record, medical review contractors are provided with discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record.

However, as we have gained experience with the policy, it has come to our attention that, despite the discretion granted to medical reviewers to determine that admission order information derived from the medical record constructively satisfies the requirement that a written hospital inpatient admission order is present in the medical record, some medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders.

Particularly during the case review process, these discrepancies have occasionally been the primary reason for denying Medicare payment of an individual claim. We note that when we finalized the admission order documentation requirements in past rulemaking and guidance, it was not ✦ intent that admission order documentation requirements should, by themselves, lead to the denial of payment for medically reasonable and necessary inpatient stay, even if such denials occur infrequently. It is our intention that this revised policy will properly adjust the focus of the medical review process towards determining

whether an inpatient stay was medically reasonable and necessary and intended by the admitting physician rather than towards occasional inadvertent signature or documentation issues unrelated to the medical necessity of the inpatient stay or the intent of the physician.

Regarding whether CMS would also need to make revisions to the CoPs in order to support this finalized revised regulation, we note that CMS did not make any amendments to the CoPs when we adopted the 2-midnight payment policy or our current inpatient admission order policy; therefore, there is no need to revise the CoPs as a result of the regulatory change we are now finalizing.

Comment: Commenters also asked if the proposal includes any changes to physician certification policy or regulations and whether physician certification will still be required to support payment for an inpatient Medicare Part A claim. Commenters believed CMS’ preamble language that “(i)f other available documentation, such as the physician certification statement when required, progress notes, or the medical record as a whole . . .” implied that physician certification statements were not always required.

Response: The proposed revision of hospital inpatient admission orders documentation requirements under Medicare Part A did not include any changes to physician certification requirements. Not all types of covered services provided to Medicare beneficiaries require physician certification. Physician certification of inpatient services is required for cases that are 20 inpatient days or more (long-stay cases), for outlier cases of hospitals other than inpatient psychiatric facilities, and for cases of CAHs. We refer readers also to the CY 2015 OPPS/ASC final rule with comment period (79 FR 66997), and 42 CFR part 412, subpart F, 42 CFR 424.13, and 42 CFR 424.15.

Comment: Commenters wanted to know if the proposed revision of hospital inpatient admission orders documentation requirements under Medicare Part A has an effective date or whether the guidance will be retroactive.

✦ *Response:* The proposed revision of hospital inpatient admission orders documentation requirements under Medicare Part A will be effective for dates of admission occurring on or after October 1, 2018. Previous guidance in our manual regarding constructive satisfaction of hospital inpatient admission order requirements still applies to dates of admission before

October 1, 2018, and will continue to apply after the effective date of this final rule.

Comment: Commenters were concerned that the proposal to revise 42 CFR 412.3(a) to remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A, will not reduce the administrative burden to providers. The commenters expressed that inpatient admissions will still be denied based solely on timeliness or completion of the attending physician's order and that other Medicare regulations will be referenced as the source of denial.

Response: We will continue to stay engaged with medical review contractors, as we have historically, so that there is awareness and understanding of this revision. As indicated earlier, if necessary, we may revise our manuals and/or issue additional subregulatory guidance as needed.

Comment: Commenters also suggested alternative options to address CMS' concerns regarding hospital inpatient admission order documentation requirements under Medicare Part A, including policy proposals that would substantively change the 2-midnight rule.

Response: We did not propose changes to the 2-midnight rule with this proposal to revise hospital inpatient admission orders documentation requirements. However, we will continue to monitor this policy and may propose additional changes in future rulemaking, or issue further clarifications in subregulatory guidance, as necessary.

Comment: Some commenters believed that removing the hospital inpatient admission order documentation requirement will have negative effects on both the cost and quality of care by losing the assurance that a qualified physician has close involvement in the decision to admit the patient, that they are involved early in the patients care, and that admitting physicians are free from postdischarge financial pressures from the hospital.

Response: We refer readers to our impact discussion regarding this proposal in Appendix A—Economic Analyses, Section I.H.10. of the preamble of this final rule where we state, “our actuaries estimate that any increase in Medicare payments due to the change will be negligible, given the anticipated low volume of claims that will be payable under this policy that

would not have been paid under the current policy.” Furthermore and as stated earlier, this policy proposal would not change the requirement that a beneficiary becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission (nor that the documentation must still otherwise meet medical necessity and coverage criteria); only that the documentation requirement for inpatient orders to be present in the medical record will no longer be a specific condition of Part A payment.

Comment: Some commenters expressed concern that the proposal to revise the inpatient admission order policy presents a problem for the capture of specific data elements necessary for compliance with electronic clinical quality measures.

Response: As indicated earlier, this proposal would not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission. The physician order reflects affirmation by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and serves the purpose of initiating the inpatient admission and documenting the physician's (or other qualified practitioner's, as provided in the regulations) intent to admit the patient. Accordingly, inpatient admission order documentation information should continue to be available in electronic health records.

Comment: Commenters pointed out that this policy proposal only applies to the inpatient prospective payment system and that to encourage consistency across payment systems and reduce documentation burden, CMS should make the same change to documentation requirements at other sites where there will be an inpatient admission, such as in psychiatry and rehabilitation. The commenters acknowledged that this will require rulemaking and encourages CMS to make these changes as soon as possible.

Response: We appreciate the recommendations made by the commenters and will take these comments into consideration in future rulemaking. After consideration of the public comments we received, we are finalizing our proposal to revise the inpatient admission order policy to no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment. Specifically, we are finalizing our proposal to revise the regulation at 42 CFR 412.3(a) to

remove the language stating that a physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A.

V. Changes to the IPPS for Capital-Related Costs

A. Overview

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services in accordance with a prospective payment system established by the Secretary. Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. We initially implemented the IPPS for capital-related costs in the FY 1992 IPPS final rule (56 FR 43358). In that final rule, we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based payment methodology to a prospective payment methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period that was established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for almost all acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). (We refer readers to the FY 2002 IPPS final rule (66 FR 39910 through 39914) for additional information on the methodology used to determine capital IPPS payments to hospitals both during and after the transition period.)

The basic methodology for determining capital prospective payments using the Federal rate is set forth in the regulations at 42 CFR 412.312. For the purpose of calculating capital payments for each discharge, the standard Federal rate is adjusted as follows:

$$(\text{Standard Federal Rate}) \times (\text{DRG Weight}) \times (\text{Geographic Adjustment Factor (GAF)}) \times (\text{COLA for hospitals located in Alaska and Hawaii}) \times (1 + \text{Capital DSH Adjustment Factor} + \text{Capital IME Adjustment Factor, if applicable}).$$

In addition, under § 412.312(c), hospitals also may receive outlier payments under the capital IPPS for extraordinarily high-cost cases that

Caution: Portions have been superseded by discussion
in the FY2019 IPPS Final Rule

10.1.6.1 - Assignment Consistent With Program Purposes

(Rev. 1, 10-01-03)

A3-3101.1.F.1, HO-210.1.F.1

It is considered to be consistent with the program's purposes to assign the patient to ward accommodations if all semiprivate accommodations are occupied, or the facility has no semiprivate accommodations. However, the patient must be moved to semiprivate accommodations if they become available during the stay.

Some hospitals have a policy of placing in wards all patients who do not have private physicians. Such a practice may be consistent with the purposes of the program if the A/B MAC (A) determines that the ward assignment inures to the benefit of the patient. In making this determination, the principal consideration is whether the assignment is likely to result in better medical treatment of the patient (e.g., it facilitates necessary medical and nursing supervision and treatment). The A/B MAC (A) should ask a provider having this policy to submit a statement describing how the assignments are made, their purpose, and the effect on the care of patients so assigned.

If the A/B MAC (A) makes a favorable determination on a practice affecting all ward assignments of Medicare patients in the institution, a reference should be made on the appropriate billing form for patients to whom the hospital assigned a ward pursuant to such practice.

10.1.6.2 - Assignment Not Consistent With Program Purposes

(Rev. 1, 10-01-03)

A3-3101.1.F.2, HO-210.1.F.2

It is not consistent with the purposes of the law to assign a patient ward accommodation based on their social or economic status, their national origin, race, or religion, or their entitlement to benefits as a Medicare patient, or any other such discriminatory reason. It is also inconsistent with the purposes of the law to assign patients to ward accommodations merely for the convenience or financial advantage of the institution. Additionally, under DRGs, there no longer is a reduction to payment or an adjustment to the end of year settlement.

10.1.7 - Charges

(Rev. 1, 10-01-03)

A3-3101.1.G, HO-210.1.G

Customary charges means amounts which the hospital or skilled nursing facility is uniformly charging patients currently for specific services and accommodations. The most prevalent rate or charge is the rate that applies to the greatest number of semiprivate or private beds in the institution.



10.2 – Hospital Inpatient Admission Order and Certification

(Rev. 234, Issued: 03-10-17, Effective: 01-01-16, Implementation: 06-12-17)

The order to admit as an inpatient (“practitioner order”) is a critical element in clarifying when an individual is considered an inpatient of a hospital, including a critical access hospital (CAH), and is therefore required for all hospital inpatient cases for hospital inpatient coverage and payment under Part A. As a condition of payment for hospital inpatient services under Medicare Part A, according to section 1814(a) of the Social Security Act, CMS is requiring, only for long-stay cases and outlier cases, separate physician certification of the medical necessity that such services be provided on an inpatient basis. The signed physician certification is considered, along with other documentation in the medical record, as evidence that hospital inpatient service(s) were reasonable and necessary.

The following guidance applies to all inpatient hospital and CAH services unless otherwise specified. For the remainder of this guidance, references to hospitals includes CAHs. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B, and requirements for admission orders are found at 42 CFR 412.3.

A. Physician Certification. Physician certification of inpatient services is required for cases that are 20 inpatient days or more (long-stay cases), for outlier cases of hospitals other than inpatient psychiatric facilities and for cases of CAHs. (See CY 2015 Outpatient Prospective Payment System Final Rule, 79 FR 66997 and 42 CFR 412 Subpart F, 42 CFR 424.13 and 42 CFR 424.15):

1. Content: The physician certification includes the following information:

- a. Reason for inpatient services: The physician certifies the reasons for either— (i) Continued hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for outlier cases under the applicable prospective payment system for inpatient services. For example, documentation of an admitting diagnosis could fulfill this part of the certification requirement.
- b. The estimated (or actual) time the beneficiary requires or required in the hospital: The physician certifies the estimated time in the hospital the beneficiary requires (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed at discharge). Estimated or actual length of stay is most commonly reflected in the progress notes where the practitioner discusses the assessment and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, the regulations at 42

CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

- c. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.
- d. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Time as an outpatient at the CAH does not count towards the 96 hour certification requirement. The clock for the 96 hour certification requirement only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour certification requirement.

The 96-hour certification requirement is based on an expectation at the time of admission. If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH, and something unforeseen occurs that causes the individual to stay longer at the CAH, the CAH would be paid for that unforeseen extended inpatient stay as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay. This would be determined based on a medical review of the case.

All certification requirements must be completed, signed, and documented in the medical record no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted, as provided in the FY15 IPPS Final Rule and 42 CFR 424.11 and 42 CFR 424.15.

- e. Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

2. **Timing:** Outlier cases must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. For all other long stay cases, the certification must be signed and documented no later than 20 days into the inpatient portion of the hospital stay.
3. **Authorization to sign the certification:** The certification or recertification may be signed only by one of the following:
 - (1) A physician who is a doctor of medicine or osteopathy.
 - (2) A dentist in the circumstances specified in 42 CFR 424.13(d).
 - (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.

Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff (or by the dentist as provided in 42 CFR 424.11 and 42 CFR 424.13). CMS considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician: the admitting physician of record ("attending") or a physician on call for him or her; a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her; a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above. The admitting physician of record may be an emergency department physician or hospitalist. CMS does not require the certifying physician to have inpatient admission privileges at the hospital.

4. **Format:** As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.

B. Inpatient Order: A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by an ordering practitioner. As stated in the FY 2014 IPPS Final Rule, 78 FR 50908 and 50941, and as conveyed in 42 CFR 482.24, if the order is not properly documented in the medical record prior to discharge, the hospital should not submit a claim for Part A payment. Meeting the two midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A. Rather, as provided in Medicare regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by an ordering practitioner.

With regard to the time of discharge, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the ordering practitioner as having to occur prior to discharge (e.g., “discharge after supper” or “discharge after voids”). Thus, discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the ordering practitioner’s order for discharge is effectuated.

1. **Content:** The ordering practitioner’s order contains the instruction that the beneficiary should be formally admitted for hospital inpatient care. The order must specify admission for inpatient services. Inpatient rehabilitation facilities (IRFs) must adhere to the admission requirements specified in 42 CFR 412.622. The two midnight benchmark does not apply in IRFs.
2. **Qualifications of the ordering/admitting practitioner:** The order must be furnished by a physician or other practitioner (“ordering practitioner”) who is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient’s hospital course, medical plan of care, and current condition at the time of admission. See section (B)(3) for a discussion of the requirements to be knowledgeable about the patient’s hospital course. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision. The ordering practitioner is not required to write the order but must authenticate (sign, or in the case of an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)), countersign) the order reflecting that he or she has made the decision to admit the patient for inpatient services.

The admission decision (order) may not be delegated to another individual who is not authorized by the state to admit patients, or has not been granted admitting privileges by the hospital's medical staff. However, a medical resident, physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner provided they are authorized under state law to admit patients and the requirements outlined below are met (FY 14 IPPS Final Rule and 42 CFR 412.3(b)).

- a. **Residents and non-physician practitioners authorized to make initial admission decisions** - Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same. The ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by authenticating (countersigning) the order prior to discharge. (See (A)(2) for guidance regarding the definition of discharge time and (B)(3) for more guidance regarding knowledge of a patient's hospital course). In authenticating (countersigning) the order, the ordering practitioner approves and accepts responsibility for the admission decision. This process may also be used for practitioners (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or "bridge" inpatient admission orders.
- b. **Verbal orders-** At some hospitals, individuals who lack the authority to admit inpatients under state laws and hospital by-laws (such as a registered nurse) may nonetheless enter the inpatient admission order as a verbal order. In these cases, the ordering practitioner directly communicates the inpatient admission order to staff as a verbal (not standing) order, and the ordering practitioner need not separately record the order to admit. Following discussion with and at the direction of the ordering practitioner, a verbal order for inpatient admission may be documented by an individual who is not qualified to admit patients in his or her own right, as long as that documentation (transcription) of the order for inpatient admission is in accordance with state law including; scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. In this case, the staff receiving the verbal order must document the verbal order in the medical record at the time it is received. The order must identify the ordering practitioner and must be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge. Example: "Admit to inpatient per Dr. Smith" would be considered an acceptable method of identifying the ordering practitioner and would meet the verbal order requirement if the verbal order (1) is appropriately documented in the medical record by the individual receiving the verbal order when the order is received; and (2) is authenticated (countersigned) by Dr. Smith promptly, prior to discharge.
- c. **Standing orders and protocols** - The inpatient admission order cannot be a standing order. While Medicare's rules do not prohibit use of a protocol or algorithm that is part of a protocol, only the ordering practitioner, or a resident or other practitioner acting on his or her behalf under section

(B)(2)(a) can make and take responsibility for the inpatient admission decision.

- d. Commencement of inpatient status** - Inpatient status begins at the time of formal admission by the hospital pursuant to the order, including an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)) that is authenticated (countersigned) timely, by authorized individuals, as required in this section. If the practitioner responsible for authenticating (countersigning) an initial order or verbal order does not agree that inpatient admission was appropriate or valid (including an unauthorized verbal order), he or she should not authenticate (countersign) the order and the beneficiary is not considered to be an inpatient. The hospital stay may be billed to Part B as a hospital outpatient encounter.
- 3. Knowledge of the patient's hospital course:** CMS considers only the following practitioners to have sufficient knowledge about the beneficiary's hospital course, medical plan of care, and current condition to serve as the ordering practitioner: the admitting physician of record ("attending") or a physician on call for him or her, primary or covering hospitalists caring for the patient in the hospital, the beneficiary's primary care practitioner or a physician on call for the primary care practitioner, a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her, emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission, and other practitioners qualified to admit inpatients and actively treating the beneficiary at the point of the inpatient admission decision. A utilization review committee physician functioning in that role does not have direct responsibility for the care of the patient and is therefore not considered to be sufficiently knowledgeable to order the inpatient admission. The order must be written by one of the above practitioners directly involved with the care of the beneficiary, and a utilization committee physician may only write the order to admit if he or she is not acting in a utilization review capacity and fulfills one of the direct patient care roles, such as the attending physician. Utilization review may not be conducted by any individual who was professionally involved in the care of the patient whose case is being reviewed (42 CFR 482.30(d)(3)).
- 4. Timing:** The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (e.g., for a pre-scheduled surgery), but the inpatient admission does not occur until hospital care services are provided to the beneficiary. Conversely, in the unusual case in which a patient is admitted as an inpatient prior to an order to admit and there is no documented verbal order, the inpatient stay should not be considered to commence until the inpatient admission order is documented. CMS does not permit retroactive orders. Authentication by the ordering practitioner of the order (either by signature or, in the case of an initial order

under (B)(2)(a) or a verbal order under (B)(2)(b), countersignature) is required prior to discharge for all inpatient cases.

5. **Specificity of the Order:** The regulations at 42 CFR 412.3 require that, as a condition of payment, an order for inpatient admission must be present in the medical record. The preamble of the FY 2014 IPPS Final Rule at 78 FR 50942 states, “the order must specify the admitting practitioner’s recommendation to admit ‘to inpatient,’ ‘as an inpatient,’ ‘for inpatient services,’ or similar language specifying his or her recommendation for inpatient care. While CMS does not require specific language to be used on the inpatient admission order, it is in the interest of the hospital that the ordering practitioner use language that clearly expresses intent to admit the patient as inpatient that will be commonly understood by any individual who could potentially review documentation of the inpatient stay. CMS does not recommend using language that may have specific meaning only to individuals that work in a particular hospital (e.g., “admit to 7W”) that will not be commonly understood by others outside of the hospital.

If admission order language used to specify inpatient or outpatient status is ambiguous, the best course of action would be to obtain and document clarification from the ordering practitioner before initial Medicare billing (ideally before the beneficiary is discharged). Under this policy, CMS will continue to treat orders that specify a typically outpatient or other limited service (e.g., admit “to ER,” “to Observation,” “to Recovery,” “to Outpatient Surgery,” “to Day Surgery,” or “to Short Stay Surgery”) as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.

The admission order is evidence of the decision by the ordering practitioner to admit the beneficiary to inpatient status. In extremely rare circumstances, the order to admit may be missing or defective (that is, illegible, or incomplete, for example “inpatient” is not specified), yet the intent, decision, and recommendation of the ordering practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these extremely rare situations, contractors have been provided with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the order, there can be no uncertainty regarding the intent, decision, and recommendation by the ordering practitioner to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.

This narrow and limited alternative method of satisfying the requirement for documentation of the inpatient admission order in the medical record should be extremely rare, and may only be applied at the discretion of the contractor.

20 - Nursing and Other Services

(Rev. 1, 10-01-03)

A3-3101.2, HO-210.2

Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered under hospital insurance and included in the Prospective Payment system payment.

NOTE: The services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such noncovered services.

Where the hospital acts on behalf of a patient, the services of the private-duty nurse or other attendant under such an arrangement are not inpatient hospital services regardless of the control which the hospital may exercise with respect to the services rendered by such private-duty nurse or attendant.

20.1 - Anesthetist Services

(Rev. 1, 10-01-03)

A3-3101.2.A, HO-210.2.A

If the hospital engages the services of a nurse anesthetist or other nonphysician anesthetist (either on a salary or fee-for-service basis) under arrangements which provide for billing to be made by the hospital, the cost of the service when provided to an inpatient could be covered under Part A. (See the Medicare Claims Processing Manual for more information.)

20.2 - Medical Social Services to Meet the Patient's Medically Related Social Needs

(Rev. 1, 10-01-03)

A3-3101.2.B, HO-210.2.B

Medical social services are services which contribute meaningfully to the treatment of a patient's condition. Such services include, but are not limited to:

- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the facility;

Medicare Program Integrity Manual, Chapter 6

6.5.2 - Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions


(Rev. 10184; Issued: 06-19-2020; Effective: 07-21-2020; Implementation: 07-21-2020)


This section applies to Unified Program Integrity Contractors (UPIC), Medicare Administrative Contractors (MAC), Supplemental Medical Review Contractor (SMRC), Recovery Audit Contractors and the Comprehensive Error patient Rate Testing (CERT) contractor.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors shall conduct reviews of medical records for inpatient acute IPPS hospital, Critical Access Hospital (CAH), Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) claims, as appropriate and as so permitted by CMS, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay, and that the stay was appropriate for Medicare Part A payment.

A. Determining the Appropriateness of Part A Payment

The term “patient status review” refers to reviews conducted by Medicare contractors to determine a hospital’s compliance with Medicare requirements to bill for Medicare Part A payment. Medicare contractors shall conduct such reviews in accordance with two distinct, but related, medical review policies: a 2-midnight presumption, which helps guide contractor selection of claims for medical review, and a 2-midnight benchmark, which helps guide contractor reviews of short stay hospital claims for Part A payment. “Patient status reviews” may result in determinations that claims are not properly payable under Medicare Part A; “patient status reviews” do not involve changing a beneficiary’s status from inpatient to outpatient.

 Per the 2-midnight presumption, Medicare contractors shall presume hospital stays spanning 2 or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Medicare contractors shall not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption.

 Per the 2-midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights, and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than 2 midnights. If a stay is not reasonably expected to span 2 or more midnights, Medicare contractors shall assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

- If the procedure is on the Secretary's list of "inpatient only" procedures (identified through annual regulation);
- If the procedure is a CMS-identified, national exception to the 2-midnight benchmark; or
- If the admission otherwise qualifies for a case-by-case exception to the 2-midnight benchmark because the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2- midnight expectation. Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The 2-midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

I. Reviewing Hospital Claims for Patient Status: The 2-Midnight Benchmark

A. Determine if the stay involved an "Inpatient Only" procedure

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor shall determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the Secretary as an "inpatient only" procedure is performed. "Inpatient only" procedures are so designated per 42 C.F.R. § 419.22(n), and are detailed in the annual Outpatient Prospective Payment System (OPPS) regulation.

Medicare contractors shall review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are



present, then the Medicare review contractor shall deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay.

If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the 2-midnight benchmark.

B. Calculating Time Relative to the 2-Midnight Benchmark

Per the 2-midnight benchmark, Medicare contractors shall assess short stay (i.e., less than 2 midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor identifies information in the medical record supporting a reasonable expectation on the



part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least two midnights.

Medicare review contractor reviews shall assess the information available at the time of the original physician/practitioners' decision. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner's standard medical documentation, such as his or her plan of care, treatment orders, and progress notes. Medicare contractors shall consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary's medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.

For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning 2 or more midnights at the time of admission, the Medicare contractors shall take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission. This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area. If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the 2-midnight benchmark at the recipient hospital, the Medicare contractors shall take into account the time and treatment provided to the beneficiary at the initial hospital. That is, the start clock for transfers begins when the care begins in the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor shall request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.

Medicare contractors shall continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors shall exclude extensive delays in the provision of medically necessary care from the 2-midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors shall consider them in determining whether Part A payment is appropriate for an inpatient admission.

NOTE: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not

qualify as inpatient time. (See Pub. 100-02, Ch. 1, Section 10.2 for additional information regarding the formal order for inpatient admission.)



C. Unforeseen Circumstances Interrupting Reasonable Expectation

The 2-midnight benchmark is based on the expectation at the time of admission that medically necessary hospital care will span 2 or more midnights. Medicare contractors shall, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span 2 or more midnights, Medicare contractors shall look to see if there was an intervening event that nonetheless supports the reasonableness of the physician/practitioner's original judgment. An event that interrupts an otherwise reasonable expectation that a beneficiary's stay will span 2 or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.

D. Stays Expected to Span Less than 2 Midnights

When a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than 2 midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor shall assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.



E. Exceptions to the 2-Midnight Rule

1. Medicare's Inpatient-Only List

As discussed above, inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for Part A payment regardless of expected or actual length of stay.

2. Nationally-Identified Rare & Unusual Exceptions to the 2-Midnight Rule

If a general exception to the 2-midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor shall consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met.

CMS has identified the following national or general exception to the 2-midnight rule:

Mechanical Ventilation Initiated During Present Visit

CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than 2 midnights, and to embody the same characteristics as those procedures included in Medicare's inpatient-only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.



3. Physician-Identified Case-by-Case Exceptions to the 2-Midnight Rule

For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors shall consider, when assessing the physician's decision, complex medical factors including, but not limited to:

- The beneficiary history and comorbidities;
- The severity of signs and symptoms;
- Current medical needs; and
- The risk of an adverse event.

Medicare contractors shall note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the 2- midnight benchmark, and as such, may be prioritized for medical review.

A. Determining Whether Covered Care Was Given at Any Time During a Stay in a PPS Hospital

Medicare contractors shall utilize the medical record to determine whether procedures and diagnoses were coded correctly. If the medical record supports that they were, pay the claim as billed. If the medical record supports that they were not, then utilize ICD-9-CM or ICD-10-CM coding guidelines to adjust the claim and pay at the appropriate DRG. See section 6.5.4 of this chapter for further details on DRG validation review. When you determine that the beneficiary did not, at the time of admission, have an expected length of stay of 2 or more midnights, or otherwise meet CMS standards for payment of an inpatient admission, but that the beneficiary's condition changed during the stay and Part A payment became appropriate, you shall review the case in accordance with the following procedures:

- The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission;

- The deemed date of admission applies when determining cost outlier status (i.e., days or services prior to the deemed date of admission are excluded for outlier purposes); and
- The diagnosis determined to be chiefly responsible for the beneficiary's need for covered services on the deemed date of admission is the principal diagnosis.
- Adjust the claim according to the diagnosis determined to be responsible for the need for medically necessary care to have been provided on an inpatient basis.

When you determine that the beneficiary did not meet the requirements for Part A payment at any time during the admission, deny the claim in full.

6.5.3 - DRG Validation Review

(Rev. 608, Issued: 08-14-15, Effective: 01-01-12, Implementation: 09-14-15)

The contractor shall perform DRG validation on PPS, as appropriate, reviewing the medical record for medical necessity and DRG validation. The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record. Reviewers shall validate principal diagnosis, secondary diagnoses, and procedures affecting or potentially affecting the DRG.

NOTE: For PPS waived/excluded areas, review shall be performed appropriate to your area.

A. Coding

The contractor shall use individuals trained and experienced in ICD coding to perform the DRG validation functions. The validation is to verify the accuracy of the hospital's ICD coding of all diagnoses and procedures that affect the DRG.

The contractor shall base DRG validation upon accepted principles of coding practice, consistent with guidelines established for ICD coding, the Uniform Hospital Discharge Data Set data element definitions, and coding clarifications issued by CMS. The contractor shall not change these guidelines or institute new coding requirements that do not conform to established coding rules.

The contractor shall verify a hospital's coding in accordance with the coding principles reflected in the ICD Coding Manual. Contractors shall use the ICD version in place at the time the services were rendered, and the official National Center for Health Statistics and CMS addenda, which update the ICD Manual annually. The annual addenda are effective on October 1 of each year and apply to discharges occurring on or after October 1. The contractor shall use only ICD Manual volumes based on official ICD Addendum and updates when performing DRG validation.



KNOWLEDGE • RESOURCES • TRAINING

Total Knee Arthroplasty (TKA) Removal from the Medicare Inpatient-Only (IPO) List and Application of the 2-Midnight Rule

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PROVIDER TYPE AFFECTED

This MLN Matters Special Edition Article is intended for hospital providers that submit hospital inpatient or outpatient claims for Total Knee Arthroplasty (TKA) procedures. The Two-Midnight Rule impacts acute-care hospitals, inpatient psychiatric facilities, long-term care hospitals (LTCHs), and Critical Access Hospitals (CAHs). CMS recognizes that such facilities may vary in their billing for TKAs.

CMS recognizes that a MLN article on the 2-Midnight Rule has already been published and can be found at the following link: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf>

This article is distinguished by its focus on TKA procedures and application of the 2-Midnight Rule now that this procedure has been removed from Medicare's inpatient-only (IPO) list.

*NOTE: Throughout this document the term "Provider" when used means "Hospital".

What You Need To Know

The Centers for Medicare & Medicaid Services (CMS) removed the Current Procedural Terminology (CPT) code describing TKA procedures from Medicare's Inpatient-Only List (IPO) effective January 2018. This allows TKA procedures to be performed on an *inpatient* or *outpatient* basis. In other words, it allows Medicare payment to be made to the hospital for TKA procedures regardless of whether a beneficiary is admitted to the hospital as an inpatient or as an outpatient, assuming all other criteria are met. This does not have any impact on CMS' 2-midnight policy.

CMS policy does not dictate a patient's hospital admission status and has no default determination on whether a TKA procedures should be done on an inpatient or outpatient basis.

Rather, CMS continues its long-standing recognition that the decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary, and should consider the individual beneficiary's unique clinical circumstances.

The Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) are contracted by CMS to review a sample of Medicare fee-for-service (FFS) short-stay inpatient claims (claims with hospital stays lasting less than 2 midnights after formal inpatient admission) for compliance with the 2-Midnight Rule.

BACKGROUND

The 2-Midnight Rule

Effective October 1, 2013, CMS finalized the 2-Midnight rule which directed how claims are to be reviewed by Medicare review contractors to determine the appropriateness of Medicare Part A payment. The regulation established two distinct but related medical review policies, the two midnight **presumption** and the two-midnight **benchmark**.

2-Midnight Presumption (helps guide contractor selection of claims for medical review): Hospital claims with lengths of stay greater than 2 midnights after the formal admission are presumed to be reasonable and necessary for Medicare Part A payment. Although these claims may be submitted among a sample of cases received, the BFCC-QIOs generally will not focus their medical review efforts on stays spanning 2 or more midnights after formal inpatient admission, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the Two-Midnight presumption.

2-Midnight Benchmark (helps guide contractor reviews of short stay hospital claims for Part A payment): Hospital claims are generally payable under Medicare Part A if the admitting practitioner reasonably expects the beneficiary to require medically necessary hospital care spanning 2 or more midnights and this expectation is supported by the medical record documentation. The time a beneficiary has spent receiving hospital care prior to inpatient admission will be considered when assessing whether this benchmark is met.

CMS revised the 2-Midnight Rule, effective January 2016 in the CY 2016 Hospital Outpatient Prospective Payment System (OPPS) [CMS-1633-F](#) to add the **Case-by-Case Exception**. The case-by-case exception states that for hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital inpatient care despite lack of a 2-midnight expectation based on complex medical factors including but not limited to:

- Patient's history, co-morbidities, and current medical needs
- Severity of signs and/or symptoms

- Risk of Adverse Events

Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs)

BFCC-QIOs are tasked by CMS to review a sample of Medicare fee-for-service short-stay inpatient claims for compliance with the 2-Midnight Rule. CMS began using BFCC-QIOs, rather than Medicare Administrative Contractors (MAC) or Recovery Audit Contractors (RACs), to conduct the initial medical reviews of providers who submit claims for short stay inpatient admissions on October 1, 2015.

The focus of these reviews is also for BFCC-QIOs to educate admitting physicians/practitioners and providers about the Part A payment policy for inpatient admissions.

CMS instructs BFCC-QIOs to conduct routine analysis of hospital billing and target for review hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy.

TKAs, like any other condition or procedure not on the IPO list, are subject to medical review by CMS contractors. The review is based on documentation in the medical record that supports either the 2-Midnight Benchmark or the Case-by-Case Exception. It is important to note that CMS does NOT target condition or disease-specific claims, such as TKA procedures, for BFCC-QIO review.

BFCC-QIO reviewers look for documentation in the medical record that supports:

- the admitting physician/practitioner's reasonable expectation that the beneficiary will require medically necessary hospital services spanning 2 midnights or longer and admits the patient to the hospital based on that expectation

OR:

- the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite lack of a 2-midnight expectation based on complex medical factors including but not limited to
 - Patient's history, co-morbidities and current medical needs;
 - Severity of signs and/or symptoms
 - Risk of adverse events.

The BFCC-QIO reviews the entire medical record for supporting documentation.

What does Removing TKA from the IPO list mean?

1. This **allows** TKA procedures to be paid by Medicare FFS when performed in **either** the hospital inpatient or hospital outpatient setting, assuming all other criteria are met.
2. This **allows** TKA short-stay inpatient claims (if chosen in a sample of claims) to be reviewed by the BFCC-QIOs for compliance with the 2-Midnight Benchmark or Case-by-Case exception (note that the two-year prohibition of RAC review for patient status continues to apply regardless of whether the case is performed on an inpatient or outpatient basis.)

NOTE: The cost-sharing amount the beneficiary is responsible for will differ based on whether the surgery is performed on an inpatient or outpatient basis (and will vary based on other factors such as geographic location).

What does Removing TKA from the IPO list NOT mean?

1. It does not mean that all TKAs must be performed on a hospital outpatient/observation basis nor does it mean that there is a presumption about where TKAs are performed.
2. It does not mean that TKA Short Stay inpatient claims are targeted for review by CMS.

NOTE: CMS has not made any pre-determinations on the number of patients receiving TKA procedures that should be treated as an inpatient or outpatient.

This MLN Matters article further clarifies and provides context for statements in the preamble for the CY 2018 OPPS final rule. In the CY 2018 OPPS final rule, CMS also prohibited Recovery Audit Contractor (RAC) patient status reviews for TKA procedures performed in the hospital inpatient setting for a period of two (2) years (CY 2018-2019).

Examples of TKA Cases and Rationale for Payment Determinations:

NOTE: The time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, but such time does not qualify as inpatient time. (See the Medicare Benefit Policy Manual, Chapter 1, Section 10, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf> for additional information regarding the formal order for inpatient admission.)

Case #1: Documentation Supports 2-Midnight Benchmark:

Dates of Service: On 1/6/18, patient was receiving hospital observation services; on 1/07/18, the physician order was written for inpatient admission; on 1/8/18, the patient was discharged home. (2 Midnights total; 1 Midnight after inpatient admission)

Case Summary: This 65-year-old female presented to the facility on January 6, 2018 for elective TKA surgery. She was placed in observation after receiving routine post-operative care.

She had a medical history of arthritis, diabetes mellitus, arrhythmia, sleep apnea, and chronic pain. The Physical Therapy (PT) progress notes from the morning on Post-op Day (POD) 1, indicated that the patient complained of feeling shaky and dizzy and was unable to complete her PT. The patient returned to her room, ate breakfast and her regular insulin dose was administered. Further nurse assessment noted that she remained light-headed. After a check of her blood sugar, the patient was found to be hypoglycemic and a snack was administered with improvement in her symptoms. However during afternoon PT session on POD 1, documentation in the medical record indicated that the patient again became shaky and complained of feeling hot. The patient was again returned to their room, sugars were assessed and the physician alerted—resulting in adjustments to her diabetic medications. The patient was admitted as an inpatient on 1/7/18 for continued monitoring and glucose stabilization. PT progress notes on the morning of POD 2 indicate the patient tolerated the session well, progressed as expected without other complaints. The patient was discharged 1/8/18.

Rationale for Approval: Medical management provided surgical repair, anesthesia administration, pre- and post-operative monitoring, pain and glucose management. No intraoperative complications were noted. On January 8, 2018, she was discharged home. Despite the lack of a 2 midnight stay after formal inpatient admission, the medical record documented symptoms during PT and two episodes of hypoglycemia, requiring adjustment of her insulin and close blood sugar monitoring post-op. This documentation provided a reasonable expectation, at the time the inpatient order was written, of medically appropriate hospital care spanning 2-Midnights.

Case #2: Medical Record Documentation Supports Case-by-Case Exception

Dates of Service: 02/12/2018 - 02/13/2018 (one midnight)

Case Summary: This 73-year-old male presented for elective total left knee replacement surgery on February 12, 2018, and was admitted to inpatient status the same day after developing post-operative bradycardia. He had a history of coronary artery disease, atrial fibrillation, complete heart block with pacemaker placement, diabetes, osteoarthritis, and hypertension. Medical management consisted of urgent evaluation by electrophysiology and correction of pacemaker malfunction, intravenous hydration, cardiac monitoring, laboratory testing, analgesics, antiemetics, anticoagulant, and IV antibiotic and home medications. On February 13, 2018 he was discharged to home.

Rationale for Approval: This was an elective admission for a TKA. The procedure was performed without complications, and the patient was quickly mobilized. His pain was controlled with oral pain medication soon after the procedure, however the patient demonstrated clinical decompensation of a chronic medical problem requiring urgent evaluation and treatment. The medical record documents that while this patient was previously physically active, due to the patient's extensive cardiac history with decompensation and need for urgent evaluation and treatment, it is reasonable to approve this case based upon patient history and comorbidities and current medical needs, severity of signs and symptoms, and presence of risk factors for an adverse event.

Case #3: Medical Record Documentation Did Not Support the 2-Midnight benchmark or the case by case exception:

Dates of Service: 03/6/18 - 03/07/18 (one midnight)

Case Summary: This 77 year-old female presented on March 6, 2018 for an elective TKA surgery and was admitted to inpatient status that same day. The patient had a history of gastroesophageal reflux disease. No other medical comorbidities were documented in the medical record. Medical management provided consisted of the surgical procedure of left TKA, pre- and post-operative monitoring, imaging, laboratory studies. Medications administered during this hospitalization included intravenous fluids, prophylactic antibiotics and post-op pain medication. The patient was discharged to her home on March 7, 2018. No potential intraoperative or potential post-operative complications were noted in the medical record.

Rationale: 77 year old presented for elective left TKA. Medical review is based on associated risk factors, comorbidities, and/or complications. The procedure was performed without any intraoperative complications. Patient comorbidities were minor and no adverse concerns were documented. The patient was monitored post operatively with good pain control, stable vital signs and was discharged the next day. The documentation did not support that hospital services were expected to span 2-midnights or more, nor did it support a case-by-case exception. There were no intra or post-operative complications documented in the medical record that supported inpatient status.

FREQUENTLY ASKED QUESTIONS

Question 1: Will CMS target TKA procedures for patient status review now that they are not on Medicare FFS IPO list?

Response 1: **No.** Claim selection is not condition or disease-specific. Sampling is done at the hospital level not at the claim level. Accordingly, TKA procedures are not targeted for review by CMS. CMS instructs BFCC-QIOs to conduct routine analysis of a sample of hospital claims with high or increasing numbers of inpatient stays less than 2-Midnights. When TKA or any type of claim is reviewed for Part A eligibility, BFCC-QIOs identify and educate the hospital on opportunities for improvement.

Question 2: Does removal of TKA from Medicare's FFS IPO list mean that this procedure should only be performed on a hospital outpatient basis?

Response 2: **No.** Removing a procedure from Medicare's FFS IPO list does not require the procedure to be performed on an outpatient basis. Rather, it allows the procedure to be performed in a hospital inpatient or hospital outpatient status.

Question 3: Who determines patient status as a hospital inpatient or outpatient?

Response 3: CMS continues its long-standing recognition that the decision to admit a patient as an inpatient is a complex medical decision, based on the physician's clinical expectation of how long hospital care is anticipated to be necessary, considering the individual beneficiary's unique clinical circumstances. CMS policy does not dictate patient status.

Question 4: What do BFCC-QIOs look for when evaluating a TKA or other short-stay inpatient claim, for compliance with the 2-Midnight Rule?

Response 4: BFCC-QIOs look for:

- documentation in the medical record that supports a reasonable expectation of medically necessary hospital services for 2 midnights or longer including all outpatient/observation and inpatient care time

OR

- documentation in the medical record that supports the admitting physician's determination that the patient required inpatient care despite the lack of a 2-midnight expectation based upon complex medical factors including but not limited to:
 - Patient's history, co-morbidities and current medical needs
 - Risk of adverse events
 - Severity of signs and symptoms

Question 5: Are there plans to remove other orthopedic inpatient surgical procedures from Medicare's FFS IPO list?

Response 5: Any future plans to remove orthopedic procedures from Medicare's FFS IPO will be communicated through the rulemaking process. This allows for stakeholder comments to be submitted and reviewed prior to release of CMS final rules.

ADDITIONAL INFORMATION

MLN Matters Article, MM10417, January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS) Update with the removal of TKA from the IPO is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10417.pdf>.

MLN Matters Article, MM10080, Clarifying Medical Review of Hospital Claims for Part A Payment, is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10080.pdf> for additional information of the 2-midnight rule.

CMS-1633 is available at <https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf>. A fact sheet on the Two-Midnight Rule Fact Sheet is available at <https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
January 24, 2019	CMS reissued the article to clarify information.
January 11, 2019	CMS rescinded the article.
January 8, 2019	Initial article released.

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