



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE

Module 11: Coverage, Notices, and Billing for 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. Requirements for Part A Payment for Inpatient Admission

Requirements for Part A payment for an inpatient admission:

- *Physician certification*
 - *For a CAH, a physician is required to certify that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.*
 - *For a PPS hospital, certification is required for stays that are 20 days or greater or for stays that reach cost outliers.*
- *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.*

III. Inpatient Certification

A. Timing of Inpatient Certification

1. 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>

B. 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 practitioner, after reviewing the case and entering a full certification (i.e., all elements)*

2. "Good faith" certification in a CAH

- a. If a physician certifies in good faith that a patient may reasonably be expected to be discharged from the CAH or transferred to another hospital within 96 hours after admission to the CAH and an unforeseen event occurs that causes the patient to stay longer at the CAH, Medicare will cover the costs of treating the patient. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.1.d>
 - i. A problem will not occur regarding the CAH's designation if that patient's stay 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. 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 *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.4>
2. There must be a separate signed statement for each certification. If the required content of the certification is in progress notes, the statement should indicate the medical record contains the required information and that inpatient services are or continue to be medically necessary. <See *Medicare Benefit Policy Manual*, Chapter 1 § 10.2 A.4>

IV. Inpatient-Only Procedures

- A. CMS has determined certain procedures are not appropriate to be provided in a hospital outpatient department and designates them as "inpatient-only" procedures. <*Medicare Claims Processing Manual*, Chapter 4 § 180.7>
- B. Inpatient admission and Part A payment are appropriate if a medically necessary inpatient-only procedure is performed and documented in the medical record. <See *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. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.E.1 >

As discussed in a prior module, the payment provisions related to inpatient only procedures do not apply to CAHs, however, the coverage provisions are applicable to patients admitted to a CAH for an inpatient only procedure.

C. Exemption from Certain 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: *There is a conflict between section (d)(2)(i) amended in the CY2022 OPPS Final Rule and section (d)(2)(ii) adopted in the CY2021 OPPS Final Rule. Section (d)(2)(ii) applies to procedures removed on or after January 1, 2021, even though CMS' stated intention was for the amended section (d)(2)(i), providing for a two year exemption period for procedures removed on or after January 1, 2020, to apply to all procedures removed from the list moving forward due to their reversal of inpatient-only policies adopted for 2021.*

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 Expectation

- A. CMS published an algorithm entitled "BFCC QIO 2 Midnight Claim Review Guideline" that provides helpful guidance on application of the 2 Midnight Rule, its exceptions, and case-by-case admission. The algorithm is located behind the outline.

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

B. Two Midnight Benchmark

1. 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.

2. The physician should consider the following timeframes in determining whether the patient will require two midnights of hospital care.
 - a. 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.>
 - i. Do not include time anticipated at another facility after transfer.
 - b. 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., A.I.B.>
 - i. Review contractors may request records from the transferring hospital to verify medical necessity and confirm when hospital care began.
 - c. 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., 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.*

- i. 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. <KEPRO Short Stay Reviews FAQ, pg. 15; see BFCC QIO 2 Midnight Claim Review Guideline algorithm>
- ii. 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>

Since the 1- and 3-day payment windows do not apply in the CAH setting and outpatient care provided prior to the inpatient admission is reported on a separate outpatient claim (TOB 0851), reporting OSC 72 on the inpatient claim will help a CAH attest to its compliance with the two-midnight expectation.

3. Unforeseen circumstances

- a. 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., A.I.C.; see 42 *C.F.R.* 412.3(d)(1)(ii)>

Examples of unforeseen circumstances substantiating less than a two midnight stay:

- *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 at the time 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?

4. Care that is not medically necessary hospital care

- a. 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 or custodial care). <See *Medicare Program Integrity Manual*, Chapter 6, § 6.5.2 A., A.I.B.; see 42 *C.F.R.* 412.3(d)(1)(ii)>
- b. Delays in Care
 - i. 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., A.I.B.>
- c. Convenience Care
 - i. Care provided for the convenience of the patient is not considered medically necessary. <See *Medicare Program Integrity Manual*, Chapter 6, § 6.5.2 A., A.I.B.>
 - ii. 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., A.I.B>

d. Social Admissions

- i. 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>
- ii. If the patient is properly admitted as an inpatient, continued hospitalization is covered if the physician certifies the need for continued hospitalization because the patient could be treated at a skilled nursing facility (SNF) but no SNF bed is available at a participating SNF. <See 42 *C.F.R.* 424.13(c); *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4 § 10.6>
- iii. Alternate placement days certified as necessary because no SNF bed is available are counted toward the three-day acute care qualifying stay requirement for SNF coverage. <*Medicare Benefit Policy Manual*, Chapter 8 § 20.1>

Coverage of additional hospitalization days continues until:

- *A bed becomes available in a participating SNF;*
- *The patient no longer needs SNF level care; or,*
- *The patient exhausts their Part A inpatient hospital benefits.*

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 2:00 p.m. 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 7:00 p.m. 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 1:00 p.m. following diagnostic testing, the hospitalist determines 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 3:00 p.m. 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 10:00 a.m. 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 benchmark, which formerly only included newly initiated mechanical ventilation. <80 *Fed. Reg.* 70541, 70545; see *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.E.2>
 2. 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. <See *Medicare Program Integrity Manual*, Chapter 6 § 6.5.2 A.I.E.3>
 3. CMS provided an example of a case-by-case admission in *MLN Matters Special Edition SE19002*, Case #2, in which the patient has numerous comorbidities, 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.

- B. Admission under the case-by-case exception is subject to the clinical judgment of the medical reviewer. <80 *Fed. Reg.* 70541>

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., 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., 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.
- 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., 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. 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>

VIII. Important Message from Medicare ("IM")

A. General Rule

1. Medicare beneficiaries have a right to an expedited review of their discharge when the hospital and their physician determine inpatient care is no longer necessary. <*Medicare Claims Processing Manual*, Chapter 30 § 200.2>
2. Hospitals are responsible for notifying beneficiaries of their right to an expedited determination through a standard form (the Important Message from Medicare). <*Medicare Claims Processing Manual*, Chapter 30 § 200.2, 200.3.3>

B. Scope of Requirement

1. All hospitals must comply, including PPS and non-PPS hospitals (e.g., CAHs). *<Medicare Claims Processing Manual, Chapter 30 § 200.1; 42 C.F.R. 405.1205(a)(1)>*
 2. The IM must be delivered to all beneficiaries covered by Medicare, including Medicare as a primary or secondary payer and beneficiaries with a Medicare Advantage plan. *<Medicare Claims Processing Manual, Chapter 30 § 200.2, 42 C.F.R. 422.620>*
 - a. The IM is delivered even if the beneficiary agrees with the hospital discharge. *<Medicare Claims Processing Manual, Chapter 30 § 200.3.3>*
 3. The IM is not delivered if the beneficiary is not entitled to an expedited determination, and hospitals should not provide an IM “just in case” or routinely to all beneficiaries. Situations in which the beneficiary is not entitled to an expedited determination include:
 - a. The beneficiary is not in a Medicare covered inpatient hospital stay.
 - b. The beneficiary transfers to another hospital at an inpatient level of care;
 - c. The beneficiary exhausts their benefits, including lifetime reserve days, prior to or while in the hospital;
 - d. The beneficiary ends care on their own initiative (e.g., elects hospice);
 - e. The hospital changes the beneficiary’s status under procedures for condition code 44;
 - f. The physician does not concur with the discharge. *<Medicare Claims Processing Manual, Chapter 30 §§ 200.2 and 200.2.1>*
- C. The Required Form
1. The IM is the required form for providing beneficiaries notice of their discharge appeal rights and is available in English, Spanish and large print versions. The current version of the form has expiration date 12/31/2025. Handout 16 is the current IM.

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General
 Use links on the left navigation to access FFS & MA IM

D. Timing of the IM Notice

1. First IM Notice

- a. The First IM is delivered at or near admission, but in all cases:

The IM must be provided within two specific timeframes related to:

- *The date of admission ("First IM"); and*
- *The date of discharge ("Follow-up Copy").*

- i. No more than seven calendar days before admission, as part of pre-admission protocols; and
- ii. No later than two calendar days after admission. *< Medicare Claims Processing Manual, Chapter 30 § 200.3.4.1 >*

2. Follow-up IM Notice

- a. The follow-up IM must be delivered within two calendar days of discharge and at least four hours before discharge. *< Medicare Claims Processing Manual, Chapter 30 § 200.3.4.2 >*
- i. The IM can be delivered once the discharge is planned. A discharge order is not required before giving the IM. *< Medicare Claims Processing Manual, Chapter 30 § 200.3.4.1 >*
 - ii. The follow-up IM applies when the beneficiary is physically discharged from the hospital or discharged to a lower level of care in the same hospital such as swing bed or custodial care. *< Medicare Claims Processing Manual, Chapter 30 § 200.2 >*
 - iii. The same notice may function as the First IM and the follow-up IM as long as it meets both specified timeframes. *< Medicare Claims Processing Manual, Chapter 30 § 200.3.4.2 >*

Example: Patient is admitted on Monday. The IM is provided on Wednesday. Patient is discharged on Friday. No additional notice is required because the IM on Wednesday occurred within two calendar days of discharge.

- b. The follow-up IM can be provided in two ways:

- i. Deliver a new copy of the IM and have the beneficiary sign and date the form again; or

- ii. Deliver a copy of the signed First IM and have the beneficiary initial and date in the "Additional Information" section. < *Medicare Claims Processing Manual*, Chapter 30 § 200.3.4.2, 200.3.8>

E. Delivery of the IM Notice

1. The IM is a standardized two page form and may not be altered except as allowed. Allowed alterations include:
 - a. Adding a hospital logo, provided it does not shift text to the second page;
 - b. Filling in the beneficiary's name and hospital issued number, which may not be the patient's Social Security Number, HICN, or Medicare Beneficiary Identifier(MBI);
 - c. Filling in the contact information for the QIO for the state;
 - d. Adding information in the "Additional Information" section relevant to the beneficiary's situation or delivery of the form. < *Medicare Claims Processing Manual*, Chapter 30 § 200.3.1, 200.3.2>
2. The hospital may provide the IM through electronic delivery (i.e., viewed on an electronic screen), including a digitally captured signature, but the beneficiary must have the option of requesting paper delivery and must be provided a paper copy of the completed, signed IM. < *Medicare Claims Processing Manual*, Chapter § 200.3.3>
3. Beneficiary Comprehension
 - a. If the beneficiary cannot read the contents of the IM or comprehend the oral explanation, the hospital must use translators, interpreters, or assistive technology to ensure comprehension of the notice. < *Medicare Claims Processing Manual*, Chapter § 200.3.6>
4. Provision to a Beneficiary's Representative
 - a. The IM may be delivered to a beneficiary's appointed representative, authorized representative, or a person representing the patient if there is no appointed or authorized representative. < *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>
 - i. An appointed representative is an individual designated by the beneficiary to act on their behalf via an "Appointment of Representative" form (CMS-1696). For more information, see *Medicare Claims Processing Manual*, Chapter 29 § 270. < *Medicare Claims Processing Manual*, Chapter 30 § 200.3.7>

- ii. An authorized representative is an individual who may make health care decisions on a beneficiary's behalf under State or other applicable law (e.g., a legal guardian or someone named in a durable power of attorney). <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
- b. If the beneficiary is incapacitated and has no appointed or authorized representative, a person the hospital has determined could reasonably represent the beneficiary may receive the IM on their behalf. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - i. The person acting on the beneficiary's behalf should act in their best interests, in manner protective of their interests and have no relevant conflict of interest. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - ii. When notice is provided to a person acting on the beneficiary's behalf, the hospital should document the name of the staff person initiating contact, the name of the person contacted and the date, time and method of contact (e.g., in person, telephone). <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
- c. Delivery to off-site representatives
 - i. If the beneficiary's representative or the person acting on their behalf is not physically present, the hospital may deliver the IM by telephone. The date of the telephone call is considered the date of receipt. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>
 - ii. When the hospital provides an IM by telephone they should:
 - a) Verbally convey all contents of the IM;
 - b) Document in the "Additional Information" section that the information was verbally communicated to the representative, along with the name of the staff person, the name of the representative, the date and time of the telephone contact and the telephone number called; and
 - c) Provide the representative with a copy of the IM by:
 - 1) Mailing a copy to the representative the same day as the telephone contact by certified, return receipt or other method with signed verification of receipt;

- 2) Emailing or faxing a copy via HIPAA compliant secure fax or email if the representative agrees. <Medicare Claims Processing Manual, Chapter 30 § 200.3.7>

5. Beneficiary or Representative Signature

- a. The beneficiary or their representative must sign and date the IM confirming their receipt and understanding. <Medicare Claims Processing Manual, Chapter 30 § 200.3.3>
- b. If the beneficiary refuses to sign the form, the hospital should annotate the form indicating the date of refusal of the notice, which is considered the date of receipt of the notice. <Medicare Claims Processing Manual, Chapter 30 § 200.3.5>

Case Study 3

Facts: A Medicare patient is admitted to the hospital as an inpatient on Sunday evening. The First IM was given to the patient on Monday morning. The hospital staff explained to the patient their discharge appeal rights and the patient indicated they understood the information and signed the IM form. On Tuesday, the physician discusses with the patient her plans to discharge the patient the following afternoon. Is the hospital required to provide a follow-up IM?

IX. Beneficiary Request for Expedited Review

- A. A beneficiary who disagrees with their discharge from the hospital may request an expedited review by contacting the QIO at the contact information provided in the IM. <Medicare Claims Processing Manual, Chapter 30 § 200.4.1.1>
 1. A beneficiary's request is considered timely if it is made before midnight on the day of discharge and the beneficiary has not left the hospital. <Medicare Claims Processing Manual, Chapter 30 § 200.4.1.1>
 - a. For a timely request, and the QIO agrees with the hospital, the patient's liability begins at noon on the day after the QIO notifies the beneficiary of their decision. <Medicare Claims Processing Manual, Chapter 30 § 200.4.2>
 - b. For a timely request, and the QIO agrees with the beneficiary, the hospital should issue a new follow-up IM when a new discharge date is determined. <Medicare Claims Processing Manual, Chapter 30 § 200.4.2>

2. The QIO must make its determination and notify the beneficiary and hospital no later than one calendar day after it receives all requested information. *<Medicare Claims Processing Manual, Chapter 30 § 200.5.6>*
 - a. The QIO must also notify the beneficiary of their right to an expedited reconsideration by the QIO and provide them with information regarding how to request a reconsideration. *<Medicare Claims Processing Manual, Chapter 30 § 200.5.6>*
 - b. If the QIO does not receive requested information from the hospital, the QIO may make their decision based on the information available or delay a decision until the information is provided, but the hospital will be financially liable for services during the delay. *<Medicare Claims Processing Manual, Chapter 30 § 200.5.6>*
3. A beneficiary may make an untimely request for an expedited review while still in the hospital or up to 30 days after discharge. *<Medicare Claims Processing Manual, Chapter 30 § 200.4.3>*
 - a. For an untimely request, and the patient remains in the hospital, the QIO is required to notify the beneficiary and hospital of their determination within 2 calendar days and the patient is not protected from liability while the QIO makes their determination. *<Medicare Claims Processing Manual, Chapter 30 § 200.4.3>*

Note: the beneficiary is still protected by the Limitations on Liability statute and the hospital must provide notice in the form of a Hospital Issued Notice of Non-coverage (HINN), discussed below, to hold the patient financially liable.

- b. For an untimely request, and the patient has been discharged from the hospital, the QIO is required to notify the beneficiary and the hospital of their determination within 30 calendar days. *<Medicare Claims Processing Manual, Chapter 30 § 200.4.3>*

X. Hospital Responsibilities when Beneficiary Requests Expedited Review

A. Detailed Notice of Discharge (DND)

1. When a beneficiary makes a request for an expedited review, the hospital must deliver a DND no later than noon of the day following notification of the request by the QIO. *<Medicare Claims Processing Manual, Chapter 30 §§ 200.4.4, 200.4.5>*

2. Required Form

- a. The DND is the required form for providing beneficiaries information about their discharge following an appeal and is available in English, Spanish and large print versions. The current version of the form has expiration date 12/31/2025. Handout 17 is the current DND.

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General
Use links on the left navigation to access FFS & MA IM

3. Completion of the DND

- a. The DND is a standardized one page form and may not be altered except as allowed. <Medicare Claims Processing Manual, Chapter 30 § 200.4.5>
- b. On the DND, the hospital must complete the form with:
 - i. The facts specific to the beneficiary's discharge and determination that coverage should end;
 - ii. A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered; and
 - iii. A description of and citation to Medicare coverage rules, instructions, or other policies relied on for the review. <Medicare Claims Processing Manual, Chapter 30 § 200.4.5>
- c. The DND does not have a signature line for the beneficiary to sign, but if the beneficiary refuses to accept the DND, the hospital should annotate the notice accordingly. <Medicare Claims Processing Manual, Chapter 30 § 200.4.5>

B. Documents Supplied to the QIO

- 1. The hospital must forward to the QIO the IM and DND provided to the beneficiary no later than noon of the day following notification of the request by the QIO. <Medicare Claims Processing Manual, Chapter 30 § 200.4.4>
- 2. The hospital must provide the QIO with all requested information by phone, in writing, or electronically. If information is provided by phone, the hospital must keep a written record of the information provided in the beneficiary's medical record. <Medicare Claims Processing Manual, Chapter 30 § 200.4.4>

C. Documents Supplied to the Patient

1. At the beneficiary's request, the hospital must provide access to or a copy of the information sent to the QIO, including written records of information provided by telephone. < *Medicare Claims Processing Manual*, Chapter 30 § 200.4.4>
 - a. The hospital must provide the requested information by close of the first business day following the request and may charge a reasonable copying/delivery fee. < *Medicare Claims Processing Manual*, Chapter 30 § 200.4.4>

Case Study 4

Facts: On Friday morning, hospital staff discuss with a patient the physician's plan to discharge the patient home that afternoon. The patient informs the hospital staff that her daughter, who is coming to care for her after her discharge, is not going to arrive until Monday morning. The patient explains to the hospital that she does not want to leave the hospital until her daughter arrives even though she understands that the hospital has determined her care is no longer medically necessary and her physician is planning to discharge her.

The patient elects to appeal her discharge to the QIO. The QIO notifies the hospital of the patient's appeal on Friday afternoon. How long does the hospital have to provide the Detailed Notice of Discharge?

XI. Inpatient Hospital Issued Notice of Non-Coverage (HINN)

A. General Rule

1. A properly prepared and delivered HINN using CMS model language satisfies the LOL notice requirement for inpatient services that are not considered reasonable and necessary or are custodial. < *Medicare Claims Processing Manual*, Chapter 30 §§ 200, and 240>
 - a. A Pre-Admission/Admission HINN may, but is not required, to be used for services that are never covered by Medicare. < *Medicare Claims Processing Manual*, Chapter 30 § 200.2>

B. HINN Forms

1. The HINN forms provided by CMS are considered model forms that may be modified; however, unapproved modification of a model notice may cause the notice to be defective. < *Medicare Claims Processing Manual*, Chapter 30 § 40.3.1>

- a. Handout 18 is a copy of the model forms for the two most common HINNs used for inpatient hospital non-covered services:
 - i. Pre-Admission/Admission Hospital Issued Notice of Non-Coverage
 - ii. HINN 12 – Non-covered Continued Stay

Link: Beneficiary Notice Initiative under Medicare-Related Sites – General
 Use links on the left navigation to access FFS HINNs

C. Timing of Delivery

1. Hospitals provide a HINN to beneficiaries prior to admission or at any point during an inpatient stay if they determine the care the beneficiary is or will receive is not covered because it is not medically necessary, not delivered in the most appropriate setting, or is custodial in nature. <CMS.gov, “FFS HINNs” website; *Medicare Claims Processing Manual*, Chapter 30 §§ 200 and 240>
2. Pre-Admission HINN
 - a. If the Pre-Admission HINN is provided prior to the beneficiary’s admission to the hospital, the beneficiary will be responsible for all charges during the non-covered stay. <*Medicare Claims Processing Manual*, Chapter 30 § 240.2>
3. Admission HINN
 - a. If the Admission HINN is provided upon admission, liability depends on when the patient is provided the HINN. <*Medicare Claims Processing Manual*, Chapter 30 § 240.2>
 - i. If the HINN is provided before 3:00 p.m., the beneficiary will be responsible for all charges incurred after provision of the notice.
 - ii. If the HINN is provided after 3:00 p.m., the beneficiary will be responsible for all charges beginning on the day following the date of the notice.
4. Continued Stay HINN
 - a. A HINN 12 may be delivered at the direction of the QIO following a beneficiary appeal or if the beneficiary’s continued stay is no longer necessary, but the beneficiary is not appealing their discharge.

D. Requirements for Delivery

1. Hospitals should follow the same requirements for in-person delivery, beneficiary representatives, beneficiary comprehension, signature, and date (including refusal to sign), and delivery and retention for HINNs as for the Important Message (IM) from Medicare, in *Medicare Claims Processing Manual*, Chapter 30 § 200.3.1. <*Medicare Claims Processing Manual*, Chapter 30 § 240.1>

Unlike the Preadmission/Admission HINN, detailed manual instructions for the delivery of HINN 12 have not been provided at the time of publishing. CMS published two pages of directions, "Instructions for Completion of the HINN 12" in the same zip file as the HINN forms.

Case Study 5

Facts: A Medicare beneficiary is scheduled for a total knee arthroplasty (TKA) as an inpatient. The surgeon documents in the admission H&P that patient has osteoarthritis in the medial compartment of the knee only. The surgeon also documents that the patient has requested a TKA instead of a uni-compartmental joint replacement so that he can continue with his active lifestyle and not have to undergo another surgery in the future. The patient's medical record does not indicate that non-surgical medical management was attempted or that conservative therapy was not appropriate for this patient.

The LCD for TKA states that when conservative, non-surgical medical management is not appropriate, the medical record must clearly document why such approach is not reasonable. The LCD also states that a failed previous uni-compartmental joint replacement is an indication for performing a total knee arthroplasty.

- Is the CAH required to provide the patient with a notice?
- If so, which notice would apply in this scenario?

XII. Treatment of Conditions Arising During or from a Non-Covered Inpatient Stay

- A. Handout 19 includes a summary of billing for non-covered inpatient services.
- B. Sometimes it is necessary for a hospital to treat conditions that arise during or from a non-covered inpatient stay such as a stay for custodial care, cosmetic surgery, etc.

1. Coverage depends on whether the treatment was "related to" the non-covered services and when the treatment was furnished. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - a. Related to
 - i. If the treatment was "related to" non-covered service and was provided during the non-covered inpatient stay, the treatment is not covered. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - a) Treatment of complications from non-covered services may be covered if the complications arise after the patient was discharged from the non-covered inpatient stay. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - 1) However, the services will not be covered if they would normally be part of a "global fee" for the non-covered service. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - b. Not related to
 - i. If the treatment or service is "not related to" the non-covered service, then it is covered even if it was furnished during an otherwise non-covered inpatient stay. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - C. Procedure for billing for covered services furnished during a non-covered stay <Medicare Claims Processing Manual, Chapter 3 § 40.2.1>
 1. Use the admission date for the entire stay, rather than the date the covered care started, in FL 6 (Statement from Date) and FL 12 (Admission Date)
 2. Occurrence Code 31 is used to indicate the date the hospital provided notice to the beneficiary of their liability for the non-covered portion of the stay (if applicable)
 - a. Presumably, this would be the Preadmission/Admission HINN.
 3. Value Code 31 is used to report the amount of non-covered services charged to the patient and report non-covered services in the non-covered charges column.
 4. Occurrence span code 76 must be used to report the dates from admission to the day before the covered care started.

5. The principal diagnosis is the diagnosis that “caused the covered level of care”.
6. Only report covered procedures furnished during the covered period of care.
 - a. If non-covered procedures are furnished during the inpatient stay, they may not be reported on the same claim. <Medicare Claims Processing Manual, Chapter 1 § 60.2.1>
 - i. Non-covered procedures may be reported on a separate claim with condition code 21 and the same Statement Covers Period – From/Through (FL 6) (i.e., for a Medicare denial). <Medicare Claims Processing Manual, Chapter 1 § 60.2.1>
 - ii. When the patient is responsible for payment because non-covered services were furnished, the hospital may bill the patient its “customary” charge for the services. <42 C.F.R. 412.42(e)>

XIII. Inpatient Utilization Review

- A. The Medicare *Condition of Participation (CoP)* at section 482.30(d) delineates requirements that hospitals must follow when making the determination as to whether an admission or discharge of a patient is or was medically necessary. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.1>
 1. A CAH should have a similar program for the evaluation of all services they furnish, including the quality and appropriateness of diagnoses and treatments furnished by their staff physician and non-physician practitioners. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.1>

Note: The Medicare Claims Processing Manual, Chapter 1 § 50.3.1 regarding condition code 44 and 42 CFR 414.5 regarding self-denial both reference the CAH CoP at 485.641. This CoP was revised in 2019 to remove references to utilization review and now refers only to Quality Assessment and Performance Improvement. Nevertheless, a determination under 482.30(d) appears to be required in order to comply with requirements for condition code 44 or a self-denial under § 414.5.

B. UR Committee

1. The *CoP* for UR at 42 *C.F.R.* 482.30 requires the UR committee consist of at least two doctors of medicine or osteopathy and other specified practitioners. <42 *C.F.R.* 482.30(b)>

Non-physician practitioners that may be on the UR committee, include:

- *Doctors of dental surgery or dental medicine*
- *Doctors of podiatric medicine*
- *Doctors of optometry*
- *Chiropractors*
- *Clinical psychologists*

C. Requirements for Determinations by the UR Committee

1. The UR committee must offer the attending physician or NPP an opportunity to present their views prior to making a determination an admission is not medically necessary. <42 *C.F.R.* 482.30(d)(2)>
2. One member of the UR committee may make the determination an admission is not medically necessary if the patient's attending physician or NPP concurs with the determination or does not present their views. <42 *C.F.R.* 482.30(d)(1)(i), see *MLN Matters Article SE0622, Background*>
3. Two members of the UR committee must make the determination an admission is not medically necessary if the patient's attending physician does not concur with the determination. <42 *C.F.R.* 482.30(d)(1)(ii), see *MLN Matters Article SE0622, Background*>
4. If the UR committee determines a patient's admission was not medically necessary, notice must be provided to the patient, the hospital, and the attending physician within 2 days of the determination. <42 *C.F.R.* 482.30(d)(3)>

D. Role of Non-physician Hospital Staff

1. CMS has clarified that case managers, who are not licensed practitioners authorized under state law to admit patients to the hospital, do not have the authority to make a determination an admission is not medically necessary or

CMS encourages and expects hospitals to employ case managers to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in decision making processes.

change a patient's status from inpatient to outpatient. <See *MLN Matters Article SE0622, Q.3*>

E. Timing of UR Determination

1. Determination prior to discharge (Condition Code 44)

- a. If the determination an admission is not medically necessary is made prior to the patient's discharge, the hospital may also convert the patient's status to outpatient if the following conditions are met:
 - i. The change in status is made while the patient is still in the hospital to allow the hospital to provide notice of the determination to the patient prior to discharge. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; see *MLN Matters Article SE0622, Q.8*>

Although the UR CoP allows 2 days to provide notice to the patient, in order to retroactively change the patient's status to outpatient, notice must be provided before discharge.

- ii. The hospital has not submitted an inpatient claim for the services. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
 - iii. The attending physician concurs with the UR committee's decision. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
 - iv. The physician's concurrence is documented in the medical record. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>
- b. If all conditions are met, the claim for the case should be submitted as an outpatient claim (bill type 085X) with condition code 44. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.1>

Condition code 44 is used by CMS and the QIOs to track and monitor these occurrences.

- i. When billing observation services following conversion to outpatient status with condition code 44, an appropriate, medically necessary order for observation is required prior to counting time for observation. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2; *Medicare Claims Processing Manual*, Chapter 4 § 290.2.2 and 290.5.2>
 - ii. The hospital may include charges representing the cost of all resources utilized in the care of the patient during the encounter, including monitoring and nursing care prior to an order for observation, if

applicable. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>

- a) Hours of monitoring and nursing care prior to a written order for observation may be reported on a line with revenue code 0762 (Observation Hours) without a HCPCS code. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.3.2>

2. Determination after discharge (Condition Code W2)

- a. If the determination an admission is not medically necessary is made by the UR committee after the patient's discharge (i.e., self-denial), the patient remains an inpatient and the case should be submitted as an inpatient Part B claim (bill type 012X) with condition code W2. <78 *Fed. Reg.* 50914; *MLN Matters Article SE1333*>

Case Study 6

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care.

- May the hospital change the patient's status to outpatient and bill with condition code 44?

XIV. Inpatient Part B (TOB 012X) Payment

A. Admission Denied as Not Reasonable and Necessary

Medicare covers and makes payment under Part B for inpatient services in three separate circumstances:

- *An inpatient admission denied as not reasonable and necessary by a contractor or through self-denial (UR determination)*
- *The patient has no entitlement to Part A or has exhausted their Part A benefits*
- *Preventative services only covered under Part B*

1. Inpatient Part B payment is available if:

- a. The inpatient admission is denied as not reasonable and necessary through contractor or self-denial; and
 - b. The services would have been reasonable and necessary as outpatient services; and
 - c. The services meet all applicable Part B coverage and payment conditions. <See 42 *CFR* 414.5, 78 *Fed. Reg.* 50914; see *Medicare Benefit Policy Manual*, Chapter 6 § 10.1>
2. Payment is available for the following services:
- a. Payment is available for services payable under OPPTS or an alternative payment methodology such as cost (i.e., CAH). <See 42 *CFR* 414.5(a)(1); 78 *Fed. Reg.* 50914; see *Medicare Benefit Policy Manual*, Chapter 6 § 10.1; *MLN Matters SE1333*>
 - i. *Medicare Benefit Policy Manual*, Chapter 6 § 10.1, attached, has a list of the ancillary services payable when the inpatient admission is denied as not reasonable and necessary.
 - ii. Exceptions
 - a) Services that by their nature are outpatient services (e.g., ED visits and observation services). <See *Medicare Benefit Policy Manual*, Chapter 6 § 10.1; *MLN Matters SE1333*>
- Tip: These services should be submitted on an outpatient claim (TOB 0851).*
- b) Inpatient nursing services (e.g., infusions, injections, transfusions and nebulizer treatments) that the hospital treats as routine (i.e., billed as part of their inpatient room rate). <See *Medicare Claims Processing Manual*, Chapter 4 § 240>
 - 1) Routine services are services included in the provider's daily room and board charges and the provider does not separately charge for them. <*Program Reimbursement Manual*, Chapter 22 § 2202.6>

- a. The provider must follow all instructions in the Provider Reimbursement Manual and the principles of cost apportionment for Medicare to “recognize” their treatment of the services as routine or ancillary. <Medicare Claims Processing Manual, Chapter 4 § 240>

Tip: Ancillary nursing services for which the provider customarily makes a separate charge to inpatients may be billed for inpatient Part B payment if all documentation and coverage requirements are met.

3. Billing requirements

a. Outpatient Part B claim

- i. CAHs are exempt from the 1- and 3-day payment windows. Outpatient services provided prior to the inpatient admission are billed separately on a TOB 085X. <MLN Matters SE1333; see Medicare Benefit Policy Manual, Chapter 6 § 10.1; Medicare Claims Processing Manual, Chapter 4 § 10.12; Medicare Claims Processing Manual, Chapter 3 § 30.1.1 and § 40.3>

b. Inpatient Part A non-covered claim

- i. In order to bill for inpatient Part B payment, the provider must relinquish its right to recover under Part A. <MLN Matters SE1333; see Medicare Claims Processing Manual, Chapter 4 § 240.6; Medicare Claims Processing Manual Transmittal 2877>
 - a) If a claim has not yet been submitted to the contractor, the hospital must submit a Part A “provider liable” claim on type of bill 110.
 - 1) The provider must report the Occurrence Span Code M1 to indicate the period of provider liability on the Part A claim.
 - 2) The “provider liable” claim must process and the remittance advice must be issued prior to billing for inpatient Part B payment.
 - b) If a Part A claim for the stay has already been denied by the contractor and an appeal has been filed, the provider must terminate the appeal before submitting an inpatient Part B claim

- c) In either case, the provider must refund any inpatient deductible or coinsurance to the patient.

c. Inpatient Part B claim

- i. Once the provider has a remittance advice for the denied Part A stay, the provider may submit a claim on type of bill 12X for payment of inpatient services under Part B. <See *Medicare Claims Processing Manual*, Chapter 4 § 240; *MLN Matters SE1333*>
 - a) The provider must submit the following on the 12X claim:
 - 1) A treatment authorization code "A/B Rebilling".
 - 2) Condition code W2 attesting that the claim is a rebill and no appeal is in process.
 - 3) A remark code with the document control number (DCN) of the denied inpatient Part A claim in the format ABREBILL followed by the DCN of the denied inpatient claim. <*Medicare Claims Processing Manual Transmittal 2877*>
 - b) *Medicare Claims Processing Manual*, Chapter 4 § 240.1, attached, contains a list of revenue codes that are not payable and may not be reported on a 12X claim for inpatient Part B services when the inpatient stay was denied as not reasonable and necessary.
 - c) A CAH must report the HCPCS codes it would usually report on an outpatient Part B claim (TOB 085X). <See *Medicare Claims Processing Manual*, Chapter 4 § 240.1, 240.3>
 - d) The claim for Part B inpatient payment must be submitted within one year of the date of service in compliance with normal timely filing requirements. <See 42 *CFR* 414.5 (c)>
- ii. The patient is liable for the normal Part B deductible and coinsurance for services billed on an inpatient Part B claim. <See *Medicare Claims Processing Manual*, Chapter 4 § 240.6>

Case Study 7

Facts: A patient presented to a CAH for a scheduled outpatient surgery at 8:00am on Monday. At 4:00 p.m. the physician ordered inpatient care and the patient stayed overnight and was discharged on Tuesday after a normal recovery period and routine course of care.

Upon utilization review, the CAH's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e., there was no reasonable expectation of a two midnight stay) and would not be covered under Part A.

- On what bill type should the CAH submit the surgical procedure?

B. No Part A Entitlement or Exhaustion of Part A Benefits

1. Limited inpatient Part B payment is available if:

- a. No Part A payment is made at all for the case because the patient had exhausted his or her benefit days *before* or during the admission; or,
- b. The patient was otherwise not eligible for or entitled to coverage under Part A. <See *Medicare Benefit Policy Manual*, Chapter 6 § 10.2>

2. Payment is available for:

- a. Certain limited ancillary services payable under OPPS or an alternative payment methodology such as cost for CAHs (e.g., diagnostic tests including lab, specified screening tests, and specified covered drugs). <See *Medicare Benefit Policy Manual*, Chapter 6 § 10.2>
 - i. *Medicare Benefit Policy Manual*, Chapter 6 § 10.2, attached, has a list of the services payable when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.

3. Billing requirements

a. Outpatient Part B claim

- i. CAHs are exempt from the 1- and 3-day payment windows. Outpatient services provided prior to the inpatient order for admission are billed separately on a TOB 085X for payment under Part B as noted above. <See *Medicare Claims Processing Manual*, Chapter 4 § 10.12>

b. Inpatient Part B claim

- i. The provider submits a claim with type of bill 012X for payment of inpatient services under Part B. <See *Medicare Claims Processing Manual*, Chapter 4 § 240>
 - a) *Medicare Claims Processing Manual*, Chapter 6 § 240.2, attached, contains a list of revenue codes that are not payable and may not be reported on a 12X claim for inpatient Part B services when the patient has exhausted their Part A benefits or is otherwise not entitled to Part A.
 - b) A CAH must report the HCPCS codes it would usually report on an outpatient Part B claim. <See *Medicare Claims Processing Manual*, Chapter 4 § 240.2>

C. Services Covered Only Under Part B

1. Payment is available for:

- a. A limited number of preventative services and vaccines only covered under Part B and not covered under Part A when provided to an inpatient directly or under arrangement by a CAH. <See *Medicare Benefit Policy Manual*, Chapter 6 § 10.3>
- b. *Medicare Benefit Policy Manual*, Chapter 15 § 250, attached, contains a list of the services only covered under Part B and not under Part A.

2. Billing requirements

- a. The CAH submits a 12X claim for these services. <See *Medicare Claims Processing Manual*, Chapter 4 § 240>

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 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.

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.

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 2:00 p.m. 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 7:00 p.m. 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.

Modified Facts: On Thursday afternoon at 1:00 p.m. following diagnostic testing, the hospitalist determines 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 3:00 p.m. 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 10:00 a.m. 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.

Version 02/27/2023
Check for Updates

Case Study 3

Facts: A Medicare patient is admitted to the hospital as an inpatient on Sunday evening. The First IM was given to the patient on Monday morning. The hospital staff explained to the patient their discharge appeal rights and the patient indicated they understood the information and signed the IM form. On Tuesday, the physician discusses with the patient her plans to discharge the patient the following afternoon. Is the hospital required to provide a follow-up IM?

Analysis: No, the same notice may function as the First IM and the follow-up IM as long as it falls within the required time frame, i.e., within 2 days of admission and at least 4 hours prior to discharge. <Medicare Claims Processing Manual, Chapter 30 § 200.3.4.2>

Version 02/27/2023
Check for Updates

Case Study 4

Facts: On Friday morning, hospital staff discuss with a patient the physician's plan to discharge the patient home that afternoon. The patient informs the hospital staff that her daughter, who is coming to care for her after her discharge, is not going to arrive until Monday morning. The patient explains to the hospital that she does not want to leave the hospital until her daughter arrives even though she understands that the hospital has determined her care is no longer medically necessary and her physician is planning to discharge her.

The patient elects to appeal her discharge to the QIO. The QIO notifies the hospital of the patient's appeal on Friday afternoon. How long does the hospital have to provide the Detailed Notice of Discharge?

Analysis: The hospital should provide the DND as soon as possible but not later than noon on Saturday. Note the QIO should complete their review by Sunday and the patient would become liable on Monday. <Medicare Claims Processing Manual, Chapter 30 §§ 200.4.4 and 200.4.5>

Case Study 5

Facts: A Medicare beneficiary is scheduled for a total knee arthroplasty (TKA) as an inpatient. The surgeon documents in the admission H&P that patient has osteoarthritis in the medial compartment of the knee only. The surgeon also documents that the patient has requested a TKA instead of a uni-compartmental joint replacement so that he can continue with his active lifestyle and not have to undergo another surgery in the future. The patient's medical record does not indicate that non-surgical medical management was attempted or that conservative therapy was not appropriate for this patient.

The LCD for TKA states that when conservative, non-surgical medical management is not appropriate, the medical record must clearly document why such approach is not reasonable. The LCD also states that a failed previous uni-compartmental joint replacement is an indication for performing a total knee arthroplasty.

- Is the CAH required to provide the patient with a notice?
- If so, which notice would apply in this scenario?

Analysis: Yes, the CAH should provide a Preadmission/Admission HINN to the patient informing him that his procedure is not covered by Medicare. If the CAH fails to inform the patient prior to his procedure that it is not covered by Medicare, the CAH, rather than the patient, will be liable for the procedure. The IM notice is not required in this case because the stay is not covered by Medicare.

Case Study 6

Facts: A Medicare patient presents to the emergency department and is admitted to the hospital as an inpatient on Friday evening. The patient is discharged to home on Saturday afternoon. On Monday during a routine review, a utilization review management nurse determined that the patient did not qualify for a covered level of inpatient care; however, they met an appropriate level of covered outpatient observation care. The case was referred to the hospital's Utilization Review Committee and a representative of the UR Committee determined the patient did not require inpatient care and the care should have been provided as observation or outpatient care.

- May the hospital change the patient's status to outpatient and bill with condition code 44?

Analysis: No, to bill with condition code 44, the UR committee determination must be made prior to the patient's discharge and notice provided to the patient. The stay may be billed to Medicare as a self-denial for inpatient Part B payment.

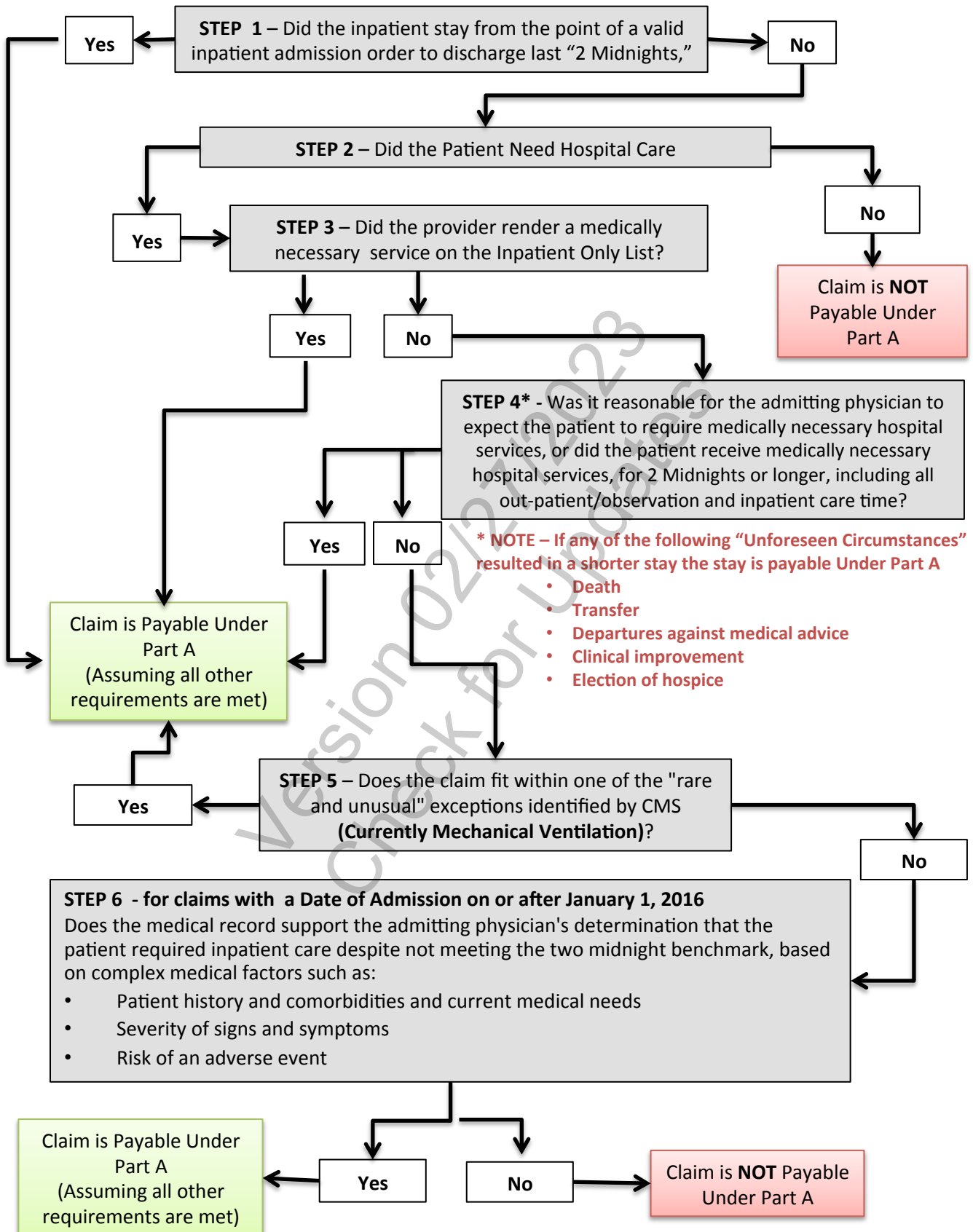
Case Study 7

Facts: A patient presented to a CAH for a scheduled surgery on Monday at 8:00 a.m. At 4:00 p.m. the physician ordered inpatient care and the patient stayed overnight and was discharged on Tuesday after a normal recovery period and routine course of care.

Upon utilization review, the CAH's utilization review committee determined that the inpatient admission was not reasonable and necessary (i.e., there was no reasonable expectation of a two midnight stay) and would not be covered under Part A.

- On what bill type should the CAH submit the surgical procedure?

Analysis: The CAH should submit the surgery on a TOB 085X because the surgery was an outpatient service provided prior to a non-covered inpatient stay. The three-day payment window is not applicable to a CAH. An inpatient Part B claim (TOB 0121) can be billed to report Part B services received during a non-covered Part A stay.



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]



Displaying title 42, up to date as of 1/20/2022. Title 42 was last amended 1/18/2022.

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

§ 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]



Displaying title 42, up to date as of 1/20/2022. Title 42 was last amended 1/18/2022.

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

§ 424.15 Requirements for inpatient CAH services.

- (a) Medicare Part A pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH, and that the services are provided in accordance with § 412.3 of this chapter.
- (b) Certification begins with the order for inpatient admission. 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.

[78 FR 50970, Aug. 19, 2013, as amended at 79 FR 50359, Aug. 22, 2014]

Version 02/27/2023
Check for Updates

ELECTRONIC CODE OF FEDERAL REGULATIONS

Title 42 → Chapter IV → Subchapter B → Part 424 → Subpart B → §424.11

Title 42: Public Health
PART 424—CONDITIONS FOR MEDICARE PAYMENT
Subpart B—Certification and Plan Requirements


§424.11 General procedures.

Added and deleted text represents amendment effective October 1, 2018

[Link to an amendment published at 83 FR 41706, August 17, 2018.](#)

(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. ~~If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found.~~

(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]

Version 02/27/2023
Check for Updates



Displaying title 42, up to date as of 1/20/2022. Title 42 was last amended 1/18/2022.

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

§ 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]

Version 02/27/2023
Check for Updates

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

Medicare Benefit Policy Manual, Chapter 1 - Caution: Some portions of Section 10.2 have been superseded by 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;

For the guidance prior to January 1, 2016, please see <http://qioprogram.org/sites/default/files/20151109-ReviewingHospitalClaimsforAdmissionMemo%20Final.pdf>.

For the guidance on or after January 1, 2016, please see <http://qioprogram.org/announcements>

cms.gov <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/inpatienthospitalreviews.html>



Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016

(Last Updated: 1/5/2015)

Medical Review of Inpatient Hospital Claims

On October 1, 2015, the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIOs) began conducting initial patient status reviews of acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims. The claims are being reviewed in accordance with the FY 2014 Hospital IPPS Final Rule CMS-1599-F, which provided two distinct, although related, medical review policies: a 2 midnight presumption and a 2 midnight **benchmark**. Under the 2-midnight presumption, inpatient hospital claims with lengths of stay 2 midnights or greater after the formal admission following the order are presumed to be appropriate for Medicare Part A payment and are not the focus of medical review efforts, absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. CMS finalized proposed refinements to the 2-midnight policy in the FY 2016 OPPS Final Rule, CMS-1633-F, effective January 1, 2016.

Beginning in January 2016, Recovery Auditors may conduct patient status reviews for those providers that have been referred by the QIO as exhibiting persistent noncompliance with Medicare payment policies, including, but not limited to:

- consistently failing to adhere to the Two Midnight rule, or
- failing to improve their performance after QIO educational intervention.

Patient Status Reviews

Throughout this document, the term “patient status reviews” will be used to refer to medical record reviews conducted by the QIOs to determine the appropriateness of Part A payment for short stay inpatient hospital claims (i.e., assessing whether Part A (inpatient) or Part B (outpatient) payment is most appropriate).

On October 1, 2015, QIOs began applying CMS-1599-F when conducting patient status reviews for adjudicated claims that were submitted by acute care inpatient hospital facilities and Long Term Care Hospitals (LTCHs) for dates of admission within the previous 6 months. QIOs will NOT apply these instructions to admissions at Inpatient Rehabilitation Facilities (IRFs) and Critical Access Hospitals (CAHs). IRF patient status reviews are specifically excluded from the 2-midnight inpatient admission and medical review guidelines per CMS-1599-F.

When conducting a patient status review, QIOs will review the medical record to assess the hospital’s compliance with:

- a) the admission order requirements, and
- b) the 2-midnight benchmark

I. Reviewing Hospital Claims for Inpatient Status: Inpatient Admission Order Requirements

When conducting patient status reviews, QIOs will assess whether the inpatient admission order requirements were met. While the inpatient admission order continues to be required for all admissions, effective January 1, 2015, the physician certification is only required for outlier cases and long stay cases of 20 days or more under the Inpatient Prospective Payment System.

A. Claims Eligible for Review

A.1. BFCC-QIOs will conduct patient status reviews on a sample of inpatient hospital Part A claims for appropriateness of inpatient admission under the 2 midnight rule for acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities impacted by CMS-1599-F.

A.2. Twice a calendar year, the BFCC-QIOs will conduct patient status reviews using a provider sample from claims paid within the previous 6 months.

B. Medical Records

B.1. BFCC-QIOs will request a minimum of 10 records in a 30-45-day time period from hospitals. The maximum number of record requests per 30 days will be 30 records.

B.2. A hospital's failure to provide the requested medical record for the identified claim(s) to the BFCC-QIO within 30-45 days of the request may result in the BFCC-QIO reopening the initial determination on the claim and a subsequent denial of payment on the claim(s) selected for review.

C. Provider Education

BFCC-QIOs shall rate and stratify providers for education and corrective action based upon the results of the completed initial patient status claim review.

1. C.1. Provider Results Letters

- a. The BFCC-QIO shall develop a detailed results letter for all providers after the completion of the initial patient status claim review.
- b. CMS minimally expects detailed results letters to include individualized, claim-by-claim denial rationales and encourages the BFCC-QIO to include the written clinical details that are to be discussed during any 1:1 telephonic education.
- c. The letter shall include a specific phone number and/or point of contact, clearly indicated on the face of the letter for providers to request or schedule a provider education teleconference.
- d. CMS will approve a letter template for the BFCC-QIOs to use to share the provider's results.

2. 1 on 1 Provider Education

- a. The 1 on 1 (1:1) provider education is to be done within 90 days after BFCC-QIO's completion of the initial patient status claim review.

- b. The BFCC-QIO conducting 1:1 telephonic education for providers will use or facilitate the educational session with a clinician who is knowledgeable of the denied claim(s). **NOTE:** This knowledge may be the result of serving as the primary or secondary clinical reviewer for the identified claim(s).
 - c. The 1:1 provider education session is designed to be provider-specific and interactive giving the provider the opportunity to review the BFCC-QIO claim(s) decisions, ask questions and receive meaningful feedback conducive to behavioral change to increase provider compliance. The provider determines the appropriate personnel to receive the education.
 - d. The BFCC-QIO is to notify providers at the start of every teleconference that the discussion may be monitored by CMS as a third party for quality assurance purposes.
3. QIO Referral to the Review Auditors
- a. At the direction of CMS, the BFCC-QIO will refer providers with inpatient status claims identified as having ‘Major Concerns’ to the Recovery Audit Contractor (RACs) to implement provider specific audits.

II. Reviewing Hospital Claims for Inpatient Status: The 2-Midnight Benchmark

The 2-midnight benchmark represents guidance to Medicare review contractors to identify when an inpatient admission is generally appropriate for Medicare Part A payment under CMS-1599-F, as revised by CMS-1633-F.

A. General Rule for Expected 0-1 Midnight Stays

A.1. General Rule for Services on Medicare’s Inpatient Only List: Medicare’s “Inpatient-Only” list, as authorized by 42 C.F.R. § 419.22(n), defines services that support an inpatient admission and Part A payment as appropriate, regardless of the expected length of stay. The QIOs will approve these cases so long as other requirements are met.

Providers are reminded that the list of procedural codes defined as “inpatient-only” are accessible at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html>. Providers trying to determine if a procedure is classified as inpatient-only for the year in which the procedure is being performed shall access the final rule for the year in question, click on the “OPPS Addenda” under the related links, and review the file containing addendum E.

A.2 When the Expected Length of Stay was Less Than 2 Midnights:

Pursuant to the 2 Midnight Rule [or CMS-1599-F], except for cases involving services on the “Inpatient-Only” list, Part A payment is generally not appropriate for admissions where the expected length of stay is less than two midnights. Under the revised exceptions policy pursuant to CMS-1633-F, for admissions not meeting the two midnight benchmark, Part A payment is appropriate on a case-by-case basis where the medical record supports the admitting physician’s determination that the patient requires inpatient care, despite the lack of a 2 midnight expectation. The QIOs will consider complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event to determine whether the medical record supports the need for inpatient hospital care. These cases will be approved by the QIOs when the other requirements are met.

B. General Rule for Expected 2 or More Midnight Stays

When a patient enters a hospital for a surgical procedure, a diagnostic test, or any other treatment and the physician expects the beneficiary will require medically necessary hospital services for 2 or more midnights (including inpatient and pre-admission outpatient time), and orders admission based upon that expectation, the services are generally appropriate for inpatient payment under Medicare Part A. QIOs will approve these cases so long as other requirements are met.

B.1. Unforeseen Circumstances: If an **unforeseen** circumstance results in a shorter beneficiary stay than the physician's reasonable expectation of at least 2 midnights, hospital inpatient payment may still be made under Medicare Part A despite the actual length of stay being less than 2 midnights. Such circumstances must be documented in the medical record in order to be considered upon medical review. Examples include unforeseen: death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice care in lieu of continued treatment in the hospital.

B.2 Documentation Requirements: The 2-midnight benchmark is based upon the physician's expectation of the required duration of medically necessary hospital services at the time the inpatient order is written and the formal admission begins. QIOs will, when conducting patient status reviews, consider complex medical factors that support a reasonable expectation of the needed duration of the stay relative to the 2-midnight benchmark. Both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are based on such complex medical factors as beneficiary 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. In other words, if the reviewer determines, based on documentation in the medical record, that it was reasonable for the admitting physician to expect the beneficiary to require medically necessary hospital care lasting 2 midnights, the inpatient admission is generally appropriate for payment under Medicare Part A; this is regardless of whether the anticipated length of stay did not transpire due to unforeseen circumstances (See section B1.)

QIOs will continue to follow longstanding guidance to review the reasonableness of the inpatient admission for purposes of Part A payment based on the information known to the physician at the time of admission. The expectation for sufficient documentation is well rooted in good medical practice "supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities," according to § 1156 of the Social Security Act. Physicians need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. QIOs will expect such factors to be documented in the physician assessment and plan of care. The entire medical record may be reviewed to support or refute the reasonableness of the physician's expectation, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission.

B.3. The 2 Midnight Benchmark and Outpatient Time:

1. General

For purposes of determining whether the 2-midnight benchmark was met the QIOs will review the claim to determine if either the benchmark is met or the medical record supports the determination that the

patient required inpatient care. Upon review, QIOs will consider time the beneficiary spent receiving outpatient services within the hospital prior to inpatient admission, in addition to the post-admission duration of care. 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.

2. 2-Midnight Benchmark Reviews

Whether the beneficiary receives services in the ED as an outpatient prior to inpatient admission (for example, receives observation services in the ED) or is formally admitted as an inpatient upon arrival at the hospital (for example, inpatient admission order written prior to an elective inpatient procedure), the starting point for the 2 midnight timeframe for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital.

For the purpose of determining whether the 2-midnight benchmark was met, QIOs will exclude triaging activities (such as vital signs) and wait times prior to the initiation of medically necessary services responsive to the beneficiary's clinical presentation. If the triaging activities immediately precede the initiation of medically necessary and responsive services, it is the initiation of diagnostic or therapeutic services responsive to the beneficiary's condition that QIOs will consider to "start the clock" for purposes of the 2 midnight benchmark. QIOs will not count the time a beneficiary spent in the ED waiting room while awaiting the start of treatment.

In other words, a beneficiary sitting in the ED waiting room at midnight while awaiting the start of treatment would not be considered to have passed the first midnight, but a beneficiary receiving services in the ED at midnight would meet the first midnight of the benchmark.

B.4. The 2 Midnight Benchmark and Transfers: For the purpose of determining whether the 2-midnight benchmark was met, the QIO shall take into account the pre-transfer time and care provided to the beneficiary at the initial hospital. That is, the "clock" for transfers begins when the care begins in the initial hospital. Any excessive wait times or time spent in the hospital for non-medically necessary services shall be excluded.

The QIOs may request records from the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving care to ensure compliance and deter gaming or abuse. The initial hospital should continue to apply the 2-midnight benchmark based on the expected length of stay of the beneficiary for hospital care within their facility.

B.5. Delays in the Provision of Care: 1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of reasonable and necessary medical treatment. As such, CMS expects Medicare review contractors will continue to follow CMS' longstanding instruction that Medicare payment is prohibited for care rendered for social purposes or reasons of convenience. Therefore, QIOs will exclude extensive delays in the provision of medically necessary care from the 2 midnight benchmark calculation. QIOs will only count the time in which the beneficiary received medically necessary hospital treatment. Factors that may result in an inconvenience to a beneficiary, family, physician or hospital do not, by themselves, justify Part A payment. When such factors affect the beneficiary's health, QIOs will consider them in determining whether inpatient hospitalization was reasonable and necessary for purposes of Part A payment. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify Part A payment for a continued hospital stay.

B.6. The Two Midnight Benchmark and Cancelled Surgical Procedures: QIOs will review the initial determination on paid Part A inpatient claims in which a surgical procedure was cancelled based on the general 2-Midnight benchmark instruction. In other words, if the physician reasonably expects the beneficiary to require a hospital stay for 2 or more midnights at the time of the inpatient order and formal admission, and this expectation is documented in the medical record, the inpatient admission is generally appropriate for Medicare Part A payment.

C. Monitoring Hospital Billing Behaviors for Gaming

CMS may monitor inpatient hospital claims spanning 2 or more midnights after admission for evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. CMS may identify such trends through probe reviews and through its data sources, such as those provided by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and Program for Evaluating Payment Patterns Electronic Report (PEPPER).

Version 02/27/2013
Check for Updates

Medicare Program Integrity Manual, Chapter 6

- Published CMS criteria
- DRG validation guidelines;
- Coding guidelines; and
- Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community)

Contractors shall consult with physician or other specialists if necessary to make an informed medical review determination.



6.5.2 - Conducting Patient Status Reviews of Claims for Medicare Part A Payment for Inpatient Hospital Admissions (Rev. 716, Issued: 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

This section applies to 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.

B. 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.

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

MLN Matters Number: SE19002 **Reissued**

Related Change Request (CR) Number: N/A

Article Release Date: January 24, 2019

Effective Date: January 1, 2018

Related CR Transmittal Number: N/A

Implementation Date: N/A

Note: This article was reissued on January 24, 2019, to clarify information.

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 OPPTS final rule. In the CY 2018 OPPTS 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.

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2017 American Medical Association. All rights reserved.

Copyright © 2018, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.

ELECTRONIC CODE OF FEDERAL REGULATIONS

[Title 42](#) → [Chapter IV](#) → [Subchapter B](#) → [Part 414](#) → [Subpart A](#) → [§414.5](#)

Title 42: Public Health

[PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES](#)

[Subpart A—General Provisions](#)

§414.5 Hospital services paid under Medicare Part B when a Part A hospital inpatient claim is denied because the inpatient admission was not reasonable and necessary, but hospital outpatient services would have been reasonable and necessary in treating the beneficiary.

(a) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under §482.30(d) of this chapter or §485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for any of the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

- (1) Services described in §419.21(a) of this chapter that do not require an outpatient status.
- (2) Physical therapy services, speech-language pathology services, and occupational therapy services.
- (3) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l) of Act.
- (4) Except as provided in §419.2(b)(11) of this chapter, prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.
- (5) Except as provided in §419.2(b)(10) of this chapter, durable medical equipment supplied by the hospital for the patient to take home.
- (6) Clinical diagnostic laboratory services.
- (7)(i) Effective December 8, 2003, screening mammography services; and
(ii) Effective January 1, 2005, diagnostic mammography services.
- (8) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in §410.15 of this chapter.

(b) If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under §482.30(d) of this chapter or §485.641 of this chapter after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, the hospital may be paid for hospital outpatient services described in §412.2(c)(5), §412.405, §412.540, or §412.604(f) of this chapter or §413.40(c)(2) of this chapter that are furnished to the beneficiary prior to the point of inpatient admission (that is, the inpatient admission order).

(c) The claims for the Part B services filed under the circumstances described in this section must be filed in accordance with the time limits for filing claims specified in §424.44(a) of this chapter.

[78 FR 50968, Aug. 19, 2013]

10 - Medical and Other Health Services Furnished to Inpatients of Participating Hospitals *(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)*

Payment may be made under Part B for physician services and for the nonphysician medical and other health services *as provided in this section* when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. *This policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospital services furnished by nonparticipating hospitals. In this section, the term "hospital" includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.*

For services to be covered under Part A or Part B, a hospital must furnish nonphysician services to its inpatients directly or under arrangements (*see chapter 16, §170 of this manual, "Inpatient Hospital or SNF Services Not Delivered Directly or Under Arrangement by the Provider"*). A nonphysician service is one which does not meet the criteria defining physicians' services specifically provided for in regulation at 42 CFR 415.102. Services "incident to" physicians' services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision.

10.1 - Reasonable and Necessary Part A Hospital Inpatient Claim Denials *(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)*

If a Medicare Part A claim for inpatient hospital services is denied because the inpatient admission was not reasonable and necessary, or if a hospital determines under 42 CFR §482.30(d) or §485.641 after a beneficiary is discharged that the beneficiary's inpatient admission was not reasonable and necessary, and if waiver of liability payment is not made, the hospital may be paid for the following Part B inpatient services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as an inpatient, provided the beneficiary is enrolled in Medicare Part B:

- 1) Part B services paid under the outpatient prospective payment system (OPPS), excluding observation services and hospital outpatient visits that require an outpatient status. Hospitals that are excluded from payment under the OPPS are instead paid under their alternative payment methodology (e.g., reasonable cost, all inclusive rate, or Maryland waiver) for the services that are otherwise payable under the OPPS.*
- 2) The following services excluded from OPPS payment, that are instead paid under the respective Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients:*
 - a. Physical therapy services, speech-language pathology services, and occupational therapy services (see chapter 15, §§220 and 230 of this manual, "Covered Medical and Other Health Services,").*
 - b. Ambulance services.*
 - c. Prosthetic devices, prosthetic supplies, and orthotic devices paid under the DMEPOS fee schedule (excludes implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) and replacement of such devices).*
 - d. Durable medical equipment supplied by the hospital for the patient to take home, except durable medical equipment that is implantable.*

- e. *Certain clinical diagnostic laboratory services.*
- f. *Screening and diagnostic mammography services.*
- g. *Annual wellness visit providing personalized prevention plan services.*

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician’s office), may not be billed by the hospital to Part B. Reference labs may be billed only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for Part B services submitted following a reasonable and necessary Part A claim denial or hospital utilization review determination must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70 “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.2 - Other Circumstances in Which Payment Cannot Be Made Under Part A ***(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)***

Part B payment could be made to a hospital for the medical and other health services listed in this section for inpatients enrolled in Part B if:

- *No Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before or during the admission; or*
- *The patient was not otherwise eligible for or entitled to coverage under Part A (see chapter 16, §180 of this manual for services received as a result of non-covered services).*

Beginning in 2014, for hospitals paid under the OPPS these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

The following inpatient services are payable under the OPPS:

- *Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;*
- *X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;*
- *Acute dialysis of a hospital inpatient with or without end stage renal disease (ESRD). The charge for hemodialysis is a charge for the use of a prosthetic device, billed in accordance with Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §200.2, “Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD).”*
- *Screening pap smears;*

- *Influenza, pneumococcal pneumonia, and hepatitis B vaccines;*
- *Colorectal screening;*
- *Bone mass measurements;*
- *Prostate screening;*
- *Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;*
- *Immunosuppressive drugs;*
- *Oral anti-cancer drugs;*
- *Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and*
- *Epoetin Alfa (EPO) that is not covered under the ESRD benefit.*

The following inpatient services are payable under the non-OPPS Part B fee schedules or prospectively determined rates listed:

- *Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations (DMEPOS fee schedule);*
- *Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of intraocular lens (DMEPOS fee schedule, except for implantable prosthetic devices paid at the applicable rate under Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §240.3, “Inpatient Part B Hospital Services - Implantable Prosthetic Devices”);*
- *Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including replacements if required because of a change in the patient’s physical condition (DMEPOS fee schedule);*
- *Physical therapy services, speech-language pathology services, and occupational therapy services (see Chapter 15, §§220 and 230 of this manual, “Covered Medical and Other Health Services”) (applicable rate based on the Medicare Physician Fee Schedule);*
- *Ambulance services (ambulance fee schedule); and*
- *Screening mammography services (Medicare Physician Fee Schedule).*

Hospitals may also be paid under Part B for services included in the payment window prior to the point of inpatient admission for outpatient services treated as inpatient services (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12, “Payment Window for Outpatient Services Treated as Inpatient Services”), including services requiring an outpatient status. The hospital can only bill for services that it provided directly or under arrangement in accordance with Part B payment rules. Outpatient therapeutic services furnished at an entity that is wholly owned or wholly operated by the hospital and is not part of the hospital (such as a physician’s office), may not be billed by the hospital to Part B. Reference labs may be billed

only if the referring laboratory does not bill for the laboratory test (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §40.1, “Laboratories Billing for Referred Tests”).

The services billed to Part B must be reasonable and necessary and must meet all applicable Part B coverage and payment conditions. Claims for these services must be filed no later than the close of the period ending 12 months or 1 calendar year after the date of service (see Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70, “Time Limitations for Filing Part A and Part B Claims”). See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §240 for required bill types.

10.3 - Hospital Inpatient Services Paid Only Under Part B **(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)**

The services listed in Chapter 15, §250 of this manual, “Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities,” when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. This is because these services are covered under Part B and are not covered under Part A.

In all hospitals, all other services provided to a hospital inpatient must be treated as an inpatient hospital service to be paid for under Part A, if Part A coverage is available and the beneficiary is entitled to Part A. This is because every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

However, note that in order to have any Medicare coverage at all (Part A or Part B), any nonphysician service rendered to a hospital inpatient must be provided directly or arranged for by the hospital.

Version 02/27/2023
Check for Updates

Medicare Benefit Policy Manual

Chapter 15 - Covered Medical and Other Health Services

250 - Medical and Other Health Services Furnished to Inpatients of Hospitals and Skilled Nursing Facilities

(Rev. 182, Issued: 03-21-14, Effective: 10-01-13, Implementation: 04-21-14)

There are several services which, when provided to a hospital or SNF inpatient, are covered under Part B, even though the patient has Part A coverage for the hospital or SNF stay. Those services are:

Physicians' services (including the services of residents and interns in unapproved teaching programs);

Physician assistant services, furnished after December 31, 1990;

Certified nurse-midwife services, as described in §180, furnished after December 31, 1990; and

Qualified clinical psychologist services, as defined in §160, furnished after December 31, 1990;

Screening mammography services;

Screening pap smears and pelvic exams;

Screening glaucoma services;

Influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administrations;

Colorectal screening;

Bone mass measurements; and

Prostate screening;

Pneumococcal and hepatitis B vaccine services must be provided directly or arranged for by the hospital in order to be covered when furnished to a hospital inpatient. The other services listed are not subject to bundling but, because they are excluded from the statutory definition of inpatient hospital services, may be covered only under Part B.

Payment may be made under Part B *to a hospital (or critical access hospital) for certain medical and other health services furnished to its inpatients as provided in Chapter 6, §10 of this manual, "Medical and Other Health Services Furnished to Inpatients of Participating Hospitals."*

Payment may be made under Part B for *certain medical and other health services if the beneficiary is an inpatient of a skilled nursing facility (SNF) as provided in chapter 8, §§ 70ff of this manual.*

Medicare Claims Processing Manual, Chapter 4

recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

231.12 - Correct Coding Initiative (CCI) Edits

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The OPPS providers should be aware that certain CCI edits may apply when billing for blood and blood product services. The OPPS providers should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by A/B MACs (A) under the OPPS is available at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp>



240 - Inpatient Part B Hospital Services

(Rev. 3106, Issued: 11-06-14, Effective: 10-01-13, Implementation: 02-10-15)

Medicare pays for hospital (including CAH) inpatient Part B services in the circumstances provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, § 10 (“Medical and Other Health Services Furnished to Inpatients of Participating Hospitals”). Hospitals must bill Part B inpatient services on a 12x Type of Bill. This Part B inpatient claim is subject to the statutory time limit for filing Part B claims described in chapter 1, §70 of this manual.

Inpatient Part B services include inpatient ancillary services that do not require an outpatient status and are not strictly provided in an outpatient setting. Services that require an outpatient status and are provided only in an outpatient setting are not payable inpatient Part B services, including Clinic Visits, Emergency Department Visits, and Observation Services (this is not a complete listing).

Inpatient routine services in a hospital generally are those services included by the provider in a daily service charge--sometimes referred to as the "Room and Board" charge. They include the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made to Medicare Part A. Many nursing services provided by the floor nurse (such as IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State. Some provider's customary charging practice has established separate charges for these services

following the PRM-1 instructions, however, in order for a provider's customary charging practice to be recognized it must be consistently followed for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM-1 instructions have not been followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for service rendered and documentation meet the definition of the HCPCS in order to separately bill.

240.1 - Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials

(Rev. 4394, Issued: 09-13-19, Effective: 10-01-13, Implementation: 10-15-19)

When inpatient services are denied as not medically necessary or a provider submitted medical necessity denial utilizing occurrence span code "M1", and the services are furnished by a participating hospital, Medicare pays under Part B for physician services and the non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10.1, "Reasonable and Necessary Part A Hospital Inpatient Claim Denials."

A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital would be required to adjust its Part A claim (to make the provider liable) prior to submitting a claim for payment of Part B inpatient services. Whether or not the hospital had submitted a claim to Part A for payment, we require the hospital to submit a Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. The hospital could then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

A hospital part B inpatient services claim billed when a reasonable and necessary part A hospital inpatient was denied must be billed with:

- *A condition code "W2" attesting that this is a rebilling and no appeal is in process,*
- *"A/B REBILLING" in the treatment authorization field, and*
- *The original, denied inpatient claim (CCN/DCN/ICN) number.*

NOTE: *Providers submitting an 837I are instructed to place the appropriate Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:*

*REF*G1*A/B REBILLING~ For DDE or paper Claims, "A/B Rebilling" will be added in FL 63.*

NOTE: *Providers submitting an 837I are instructed to place the DCN in the Billing Notes loop 2300/NTE in the format: NTE*ADD*ABREBILL12345678901234~ For DDE*

or paper Claims, Providers are instructed to use the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN shall be added to the Remarks Field (form locator #80) on the claim using the following format: "ABREBILL12345678901234". (The numeric string (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.)

Not Allowed Revenue Codes

The claims processing system shall set edits to prevent payment on Type of Bill 012x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	029x	0390
0399	045x	050x	051x	052x	054x	055x	056x
057x	058x	059x	060x	0630	0631	0632	0633
0637	064x	065x	066x	067x	068x	072x	0762
082x	083x	084x	085x	088x	089x	0905	0906
0907	0912	0913	093x	0941	0943	0944	0945
0946	0947	0948	095x	0960	0961	0962	0963
0964*	0969	097x	098x	099x	100x	210x	310x

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: M28
MSN: 21.21

CWF shall edit to ensure that DSMT services are not billed on a 012x claim.

Hospitals are required to report HCPCS codes that identify the services rendered.

240.2 - Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A *(Rev. 4394, Issued: 09-13-19, Effective: 10-01-13, Implementation: 10-15-19)*

When Medicare pays under Part B for the limited set of non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (that is, when furnished by a participating hospital to an inpatient of the hospital who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or

receives services not covered under Part A), the contractor shall set revenue code edits to prevent payment on Type of Bill 012x for claims containing the revenue codes listed in the table below *with exceptions as noted. For the exceptions noted, contractors shall ensure that only the exceptions identified are allowed to process with the revenue code.*

Not Allowed Revenue Codes

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	0250	0251
0252	0253	0256	0257	0258	0259	0261	0269
0270	0273	0277	0279	028x	029x	0360	0362
0367	0369	0370	0374	0379	038x	039x	041x
045x	0470	0472	0479	049x	050x	051x	052x
053x	0541	0542	0543	0544	0546	0547	0548
0549	055x	056x	057x	058x	059x	060x	0620
0623	0624	0630	0631	0632	0633	0637	064x
065x	066x	067x	068x	069x	072x	0760	0762
079X	081x	082x	083x	084x	085x	088x	090x
091x	093x	0940	0941	0942*	0943	0944	0945
0946	0947	0948	0949	095x	0960	0961	0962
0964*	0969	097x	098x	099x	100x	210x	310x

* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

** In the case of Revenue Code 0942, this is used by rural hospitals for kidney disease education (KDE) services. The actual geographic location, core based statistical area (CBSA) is used to identify facilities located in rural areas. In addition, KDE services are covered when claims are received from section 401 hospitals. Additionally, models may allow this Revenue Code.*

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR

CARC: 96

RARC: M28

MSN: 21.21

Hospitals are required to report HCPCS codes that identify the services rendered.

Excerpt from Medicare Claims Processing Manual, Chapter 4

240.3 – Implantable Prosthetic Devices

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

Under 42 CFR 419.2(b)(11), implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices, are paid under the OPPTS, and are therefore packaged with the surgical implantation procedure unless the device has pass-through payment status. This payment provision applies when such a device is billed as a Part B outpatient service, or as a Part B inpatient service when the inpatient admission is determined not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.1). In these circumstances, hospitals should submit the usual HCPCS code for Part B payment of the device.

In the other circumstances in which a beneficiary does not have Part A coverage of inpatient services on the date that such a device is implanted (that is, when furnished by a participating hospital to an inpatient who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or receives services not covered under Part A), hospitals paid under the OPPTS should report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, that is effective for services furnished on or after January 1, 2009. This code allows an alternative Part B inpatient payment methodology for the device as discussed in this section, and may be reported only on claims with TOB 12X when the prosthetic device is implanted on a day on which the beneficiary does not have coverage under Part A because he or she is not entitled to Part A benefits, has exhausted his or her Part A benefits, or receives services not covered under Part A. The line containing this new code will be rejected if it is reported on a claim that is not a TOB 12X or if it is reported with a line item date of service on which the beneficiary has coverage of inpatient hospital services. By reporting C9899, the hospital is reporting that the item is eligible for separate OPPTS payment because the primary procedure is not a payable Part B inpatient service under Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10.2 (“Other Circumstances in Which Payment Cannot Be Made under Part A”).

If C9899 is a separately payable Part B inpatient service, the contractor shall determine the payment amount as follows. If the device has pass through status under the OPPS, the contractor shall establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio. Where the device does not have pass through status under the OPPS, the contractor shall establish the payment amount for the device at the amount for a comparable device in the DMEPOS fee schedule where there is such an amount. Payment under the DMEPOS fee schedule is made at the lesser of charges or the fee schedule amount and therefore if there is a fee for the specific item on the DMEPOS fee schedule, the payment amount for the item will be set at the lesser of the actual charges or the DMEPOS fee schedule amount. Where the item does not have pass through payment status and where there is no amount for a comparable device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. This amount (less applicable unpaid deductible and coinsurance) will be paid for that specific device for services furnished in the applicable calendar year unless the actual charge for the item is less than the established amount). Where the actual charge is less than the established amount, the contractor will pay the actual charge for the item (less applicable unpaid deductible and coinsurance).

In setting a contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

If the contractor chooses to use this amount, see www.cms.hhs.gov/HospitalOutpatientPPS/ for the amount of reduction to the APC payment that would apply in these cases. From the OPPS webpage, select “Device, Radiolabeled Product, and Procedure Edits” from the list on the left side of the page. Open the file “Procedure to Device edits” to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS webpage and open the file “FB/FC Modifier Procedures and Devices”. Select the applicable year’s file of APCs subject to full and partial credit reductions (for example: CY 2008 APCs Subject to Full and Partial Credit Reduction Policy”). Select the “Full offset reduction amount” that pertains to the APC that is most applicable to the device described by C9899. It would be reasonable to set this amount as payment for the device.

For example, if C9899 is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in “remarks”) the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is \$4881.77. It would therefore be reasonable for the contractor/MAC to set the payment rate for a single

chamber pacemaker to \$4881.77. In this case the coinsurance would be \$936.75 (20 percent of \$4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount, the contractor established amount, or the actual charge if less than the DMEPOS fee schedule amount or the contractor established amount for the specific device), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

When a hospital that is not paid under the OPPIPS furnishes an implantable prosthetic device other than dental), which replaces all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such a device, to an inpatient who has coverage under Part B but does not have Part A coverage, and the primary procedure is not a payable Part B inpatient service under Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (“Other Circumstances in Which Payment Cannot Be Made under Part A”), payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

240.4 – Indian Health Service/Tribal Hospital Inpatient Social Admissions

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

There may be situations when an American Indian/Alaskan Native (AI/AN) beneficiary is admitted to an IHS/Tribal facility for social reasons. These social admissions are for patient and family convenience and are not billable to Medicare. There are also occasions where IHS/Tribal hospitals elect to admit patients prior to a scheduled day of surgery, or place a patient in a room after an inpatient discharge. These services are also considered to be social admissions as well.

For patients in a social admission status requiring outpatient services at another facility, Medicare disallows payment for inpatient Part B ancillary services, Type of Bill (TOB) 12X during a social admission stay when there is another bill from a different facility for an outpatient service, TOB 13X or 72X. The Common Working File (CWF) returns an A/B crossover edit and creates an unsolicited response (IUR) in this situation.

The CWF also creates an IUR when a line item date of service on TOB 12X is equal to or one day following the discharge date on TOB 11X for the same provider.

The CWF bypasses both of these edits when the beneficiary is not entitled to Medicare Part A at the time the services on TOB 12X are rendered.

240.5 – Payment of Part B Services in the Payment Window for Outpatient Services Treated as Inpatient Services When Payment Cannot Be Made Under Part A

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10 (“Medical and Other Health Services Furnished to Inpatients of Participating Hospitals”) and Pub 100-04, Medicare Claims Processing Manual, Chapter 4, §10.12 (“Payment Window for Outpatient Services Treated as Inpatient Services”) regarding services bundled into the original Part A claim under the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission, that may be billed to Part B when Part A payment cannot be made. Hospitals should use the following type of bill to report these services:

- 13X TOB (85X for a CAH)- Hospital outpatient services included in the payment window for outpatient services treated as inpatient services
- 14X TOB- Laboratory tests that are paid under the clinical laboratory fee schedule (see chapter 16, §40.3 of this manual), and included in the payment window for outpatient services treated as inpatient services

240.6 – Submitting Provider-Liable “No-Pay” Part A Claims and Beneficiary Liability

(Rev. 2877, Issued: 02-07-14, Effective: 10-01-13, Implementation: 04-07-14)

When Part A payment cannot be made for a hospital inpatient admission and the hospital, not the beneficiary, is liable under section 1879 of the Act for the cost of the Part A items and services, the hospital must submit a provider-liable “no pay” Part A claim (110 TOB) (see chapter 3 §40.2.2, “Charges to Beneficiaries for Part A Services” of this manual). Submission of this claim cancels any claim that may have already been submitted by the hospital for payment under Part A. When a Medicare review contractor denies a Part A claim for medical necessity, the claims system converts the originally submitted 11X claim to a 110 TOB on behalf of the hospital.

When the hospital and not the beneficiary is liable for the cost of the Part A services (pursuant to the limitation on liability provision in Section 1879 of the Social Security Act), the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied Part A claim and the beneficiary’s Medicare utilization record is not charged for the services and items furnished. The hospital must refund any payments (including coinsurance and deductible) made by the beneficiary or third party for a denied Part A claim when the provider is held financially liable for that denial (see section 1879(b) of the Act; 42 CFR § 411.402; and chapter 30 §§ 30.1.2, “Beneficiary Determined to Be Without Liability” and 30.2.2, “Provider/Practitioner/Supplier is Determined to Be Liable” of this manual).

Medicare beneficiaries are liable for their usual Part B financial liability for services covered under Part B when Part A payment cannot be made, including Part B copayments for each payable Part B inpatient or Part B outpatient service. The beneficiary is also liable for the cost of services not covered under Part B.

furnished to a patient, up to certain specified maximum amounts, may be paid for by the hospital insurance plan. This situation occurs most often when long-term care hospitals are involved. For hospice claims, out of sequence processed claims must be reprocessed to maintain the integrity of hospice election periods. If an FI is contacted by another FI or any regional office (RO), they cancel all affected claims and reprocess in accordance with the instructions from the lead FI or RO.

The lead FI is the one contacted by a provider, beneficiary, or other insurer complaining of improper payment as result of out-of-sequence billing. The lead FI will coordinate actions with any other FIs involved to cancel and reprocess the bills, as necessary. For inpatient stays, the lead FI verifies that the provider, beneficiary, or other insurer was adversely affected and coordinates these actions directly with any other affected FI to cancel any out-of-sequence bills they processed and posted. For hospice claims, the lead FI verifies an out-of-sequence claim(s) impacted the hospice election period. The lead FI coordinates actions to cancel any bills posted out-of-sequence directly with any other affected FI. All FIs must reprocess all bills based on the actual sequence of the beneficiary's stays at the various providers or on the actual sequence of hospice services. The lead FI controls the sequence in which the bills are processed and posted to CWF.

If the lead FI experiences any difficulty with another FI, they contact their RO to coordinate with any necessary ROs for other affected FIs' bills.

This approach is to be used only when the beneficiary, provider, or other insurer has increased liability as a result of out-of-sequence processing or when the hospice election periods are incorrect. It is not to be used if the liability stays the same, e.g., if deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.

50.3 - When an Inpatient Admission May Be Changed to Outpatient Status


(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

50.3.1 - Background

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Payment is made under the hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under the applicable other payment methodologies for hospitals not subject to the OPPS.

“Outpatient” means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

 Under the hospital Condition of Participation (CoP) at 42 C.F.R. §482.12(c), patients are admitted to the hospital or CAH as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. In addition,

every Medicare patient must be under the care of a physician or other type of practitioner listed in the regulation (“the practitioner responsible for care of the patient”). In some instances, a practitioner may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital’s utilization review (UR) committee determines that an inpatient level of care is not medically necessary.

Taking this into consideration, CMS obtained a condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004, that specifies:

Condition Code 44--Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.



The utilization review requirements for hospitals and CAH are found in their respective CoPs at §482.30 or §485.641. The hospital must ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stays required by §482.30(d), are fulfilled as described in the regulation. Section 482.30(d) delineates requirements that hospitals must follow when making the determination as to whether an admission or discharge of a patient is or was medically necessary. Review of admissions may be performed before, at, or after hospital admission. More information about the hospital CoP may be found in Pub.100-07, State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Section 485.641 requires CAHs to have a similar program for the evaluation of all services they furnish, including the quality and appropriateness of diagnoses and treatments furnished by their staff physician and non-physician practitioners. If in addition to making a medical necessity determination (or evaluating the appropriateness of diagnosis and treatment in a CAH) a hospital or CAH wishes to change a patient’s status from inpatient to outpatient, the following requirements apply.

CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. The State Operations Manual states that in no case may a non-physician make a final determination that a patient’s stay is not medically necessary or appropriate (see Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals). However, CMS encourages and expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or Quality Improvement Organization (QIO), and to assist the UR committee in the decision-making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital’s existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report Condition Code 44 should become increasingly rare.

50.3.2 - Policy and Billing Instructions for Condition Code 44

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)



In cases where a hospital or a CAH's UR committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital or CAH may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and
4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.

While typically the full UR committee makes the decision for the committee that a change in patient status under Condition Code 44 is warranted, in accordance with §482.30(d)(1) one physician member of the UR committee may make the decision for the committee, provided he or she is a different person from the concurring practitioner who is responsible for the care of the patient.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x or 85x bill type and outpatient services that were ordered and furnished should be billed as appropriate.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the ASC X12 837 institutional claim format in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs to track and monitor these occurrences. The reporting of Condition

Code 44 on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is concurrence by the practitioner who is responsible for the care of the patient with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services. See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.12 for a discussion of the billing and payment rules regarding services furnished within the payment window for outpatient services treated as inpatient services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.



When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order.

While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see chapter 4, section 290 of this manual, and Pub.100-02, Medicare Benefit Policy Manual, chapter 6, Section 20.6.

Version 02/27/2019
Check for Updates



MLN Matters Number: SE0622

Related Change Request (CR) #: 3444

Related CR Release Date: September 10, 2004

Effective Date: N/A

Related CR Transmittal #: R299CP

Implementation Date: N/A

Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient"

Introduction

Following issuance of Transmittal 299 (Change Request 3444) on September 10, 2004, the Centers for Medicare & Medicaid Services (CMS) received numerous questions and requests for clarification. This Special Edition article and the Q&As that follow are intended to address those questions and provide clarification of Medicare policy related to inpatient admissions that are determined not to be medically necessary, as well as Medicare policy related to changing a beneficiary status from inpatient to outpatient, and how the two policies interface.

Provider Types Affected

Hospitals, including those for which payment for Medicare Part B services is made under the hospital Outpatient Prospective Payment System (OPPS), as well as hospitals that are not subject to the OPPS for which payment for outpatient services is made under other payment methodologies

Provider Action Needed

Be sure to understand Medicare rules and policy when utilization review (UR) determines that an inpatient admission is not medically necessary or when a hospital should report Condition Code 44 in Form Locator (FL) 24-30, or its electronic equivalent, on outpatient claims (type of bill 13X, 85X) to signal a change in patient status from inpatient to outpatient.

Background

Hospital Conditions of Participation

The hospital Conditions of Participation (CoPs) require all hospitals to have a utilization review (UR) plan. A hospital must ensure that all the UR requirements

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

of 42 CFR 482.30 are fulfilled. These requirements can be fulfilled by the hospital directly through its policies, procedures, and UR committee. Alternatively, the hospital may fulfill these UR requirements (including the UR committee's functions and responsibilities) through a quality improvement organization (QIO) that has assumed binding review. However, in either case the hospital is responsible to ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stay are fulfilled as described in 42 CFR 482.30. Specifically:



- A UR committee consisting of two or more practitioners must carry out the UR function. At least two members of a hospital's UR committee must be doctors of medicine or osteopathy, and the other members may be any of the other types of practitioners specified in regulation.



- The determination that an admission or continued stay is not medically necessary must either be made by (i) one member of the UR committee if the practitioner(s) responsible for the care of the patient either concurs with the determination or fails to present their views when afforded the opportunity, or (ii) two members of the UR committee in all other cases.
- The UR committee must consult with the practitioner(s) responsible for the care of the patient and allow them to present their views **before** making the determination.
- If the UR committee determines that the admission is not medically necessary, the committee must give written notification, no later than 2 days after the determination, to the hospital, the patient, and the practitioner responsible for the care of the patient.

Review of admissions may be performed before, at, or after hospital admission.

Note: Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. "Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital records as an outpatient and receives services (rather than supplies alone) directly from the hospital.

The Use of Condition Code 44

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon subsequent review, it is determined that an inpatient level of care does not meet the hospital's admission criteria. The National Uniform Billing Committee (NUBC) issued Condition Code 44, effective April 1, 2004, to identify cases when this occurs. The definition of Condition Code 44 is as follows:

- Condition Code 44 Inpatient admission changed to outpatient
 - For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

was initially submitted, the hospital determined the services did not meet its inpatient criteria.

CMS issued Transmittal 299 (Change Request 3444) on September 10, 2004, to implement new section 50.3 in Chapter 1 of the *Medicare Claims Processing Manual*. Section 50.3 describes when and how a hospital may change a patient's status from inpatient to outpatient as well as the appropriate use of Condition Code 44.

In cases where a beneficiary's status is changed from inpatient to outpatient subsequent to UR determination that the inpatient admission does not meet the hospital's inpatient criteria, the hospital may submit an outpatient claim (Type of Bills 13x, 85x) to receive payment for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
- The hospital has not submitted a claim to Medicare for the inpatient admission;
- A physician concurs with the utilization review committee's decision; and
- The physician's concurrence is documented in the patient's medical record.

Questions and Answers (Q&As)

Q1. Isn't there a conflict between the Condition Code 44 policy and the standards included in the hospital Condition of Participation related to review of admissions for medical necessity?

A1. No. The CoP standards in section 482.30 of the regulations are comprehensive and broadly applicable with regard to the medical necessity of admissions to the hospital. CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. For such cases, prior to implementation of Condition Code 44, a hospital could only receive payment for certain nonphysician medical and other health services payable under Part B that were furnished either directly or indirectly to an inpatient for which payment could not be made under Part A. Condition Code 44 allows hospitals to treat the entire episode of care as an outpatient encounter, to report as outpatient services whatever services are furnished, and to receive payment under the outpatient prospective payment system as though the patient had been registered as an outpatient.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Q2. If the hospital complies with the requirement for written notification within two days of the determination, can it still bill for the encounter as an outpatient episode of care and use Condition Code 44?

A2. Yes, as long as the patient has not yet been released from the hospital, and provided that the other prerequisites for use of Condition Code 44 are met.

Q3. Can a case manager or utilization management staff member change a patient's status from inpatient to outpatient after determining that the hospital's admission criteria were not met?



A3. CMS has received many questions regarding who may make the status change, and requests for clarification as to whether utilization management staff or a case manager may implement the change. The CoP in §482.30 of the regulations requires that the utilization review committee be comprised of at least two doctors of medicine or doctors of osteopathy, although it may include other specified practitioners. The CoP provides that the determination concerning the medical necessity of an admission or continued stay must be made by members of the UR committee (or QIO) in consultation with the practitioner(s) responsible for the care of the patient. The CoP in §482.12(c) provides that patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in Medicare regulations, the patient must be under the care of a doctor of medicine or osteopathy. Therefore, a case manager or other utilization management staff person who is not a licensed practitioner permitted by the state to admit patients to a hospital or a doctor of medicine or osteopathy would not have the authority to change a patient's status from inpatient to outpatient. However, we encourage and expect hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or QIO, and to assist the UR committee in the decision making process.



Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

Q4. Is the concurrence of any physician or practitioner acceptable when a hospital has determined that a patient's status should be changed from inpatient to outpatient?

A4. One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

an outpatient. The practitioner(s) responsible for the care of the patient must concur with the hospital's finding that inpatient admission criteria are not met. This prerequisite for use of condition code 44 is consistent with the requirements in the CoP at §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

Q5. How does a hospital bill using Condition Code 44?

A5. When the hospital has determined that it may submit an outpatient claim according to the conditions applicable to the use of Condition Code 44, the hospital should report the entire episode of care as an outpatient encounter, as though the inpatient admission never occurred

When a hospital submits a 13X or 85X type of bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital must report Condition Code 44 in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Condition Code 44 will be used by CMS and QIOs to track and monitor these occurrences.

Q6. How should the hospital bill Medicare if the criteria for using Condition Code 44 are not met, but all requirements in the condition of participation in §482.30 have been complied with?



A6. If the conditions for use of Condition Code 44 are not met, the hospital should submit a bill using Type of Bill 12x for covered Part B Only services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about Part B only services is located in the *Medicare Benefit Policy Manual* (Chapter 6, Section 10). Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and other services. The *Medicare Benefit Policy Manual* includes a complete list of the payable Part B Only services.

Q7. How should the change in patient status from inpatient to outpatient be reported in the patient's medical record? Can the hospital just discard the inpatient record?

A7. Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

Q8. Why has CMS required that the patient still be in the hospital when his or her status is changed from that of an inpatient to outpatient? Most hospitals have agreements with QIOs for UR, and determinations about medically unnecessary admissions can be decided days or weeks after the patient leaves the hospital.

A8. The patient rights CoP in §482.13 of the regulations require a hospital to protect and promote each patient's rights. Medicare beneficiaries have the right to participate in treatment decisions and to know their treatment choices. Beneficiaries are also entitled to receive information about co-insurance and deductibles. CMS has a duty to protect these rights. Requiring that the decision resulting in a change in patient status be made before the beneficiary is discharged is intended to ensure that the patient is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible. For example, if a patient has already met her Part A deductible, informing the beneficiary a month after discharge that that she will now be responsible for additional coinsurance as an outpatient could impose a financial hardship.

Additionally, the hospital is responsible to ensure that when there is a question regarding the medical necessity of an inpatient admission that the required UR review of that patient's status is conducted as stated in 42 CFR 482.30. The UR committee's responsibilities and functions may be conducted by the hospital's QIO that has assumed binding UR review. However, the hospital is responsible to have either a UR committee or have a QIO that carries out the UR activities as described in 42 CFR 482.30, including the review for medical necessity of an inpatient admission and continued stay.

Q9: HIPAA establishes NUBC as the keeper of the UB-92 condition codes. How can CMS place extra requirements on the use of the code? Doesn't this violate HIPAA?

A9. No, this does not violate HIPAA. CMS has established conditions when this code may be used for payment purposes under Medicare. The CMS policy neither modifies nor contradicts the code descriptor published by NUBC. Instead, it sets additional payment conditions under Medicare. The HIPAA implementation guide is unaffected by payment policy decisions and the other insurers who use the UB-92 codes may continue to rely on the code as they otherwise would.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

In another example, CMS and its contractors set payment policy related to CPT and HCPCS codes through national and local coverage determinations (NCDs and LCDs). These determinations include payment policy standards such as when, how, and by whom CPT and HCPCS codes may be used for a particular diagnosis or procedure. CMS pays only for services that meet the requirements of these coverage determinations.

Additional Information

The instructions provided in CR3444 and the information in this article should be followed within the framework of an individual hospital's existing policies and procedures and do not override or supersede other CMS policies or procedures on observation services, beneficiary financial liability protections, or other related policies.

If you have questions regarding this issuance, please contact your fiscal intermediary (FI) for additional guidance with regard to CR3444.

For complete details, please see the official instruction issued to your FI regarding this change. That instruction for Condition Code 44 that affects the Medicare Claims Processing Manual may be found at <http://www.cms.hhs.gov/transmittals/downloads/R299CP.pdf> on the CMS web site.

For details concerning the "Part B Only" rule, see the Medicare Benefit Policy Manual, Chapter 6, Section 10, at <http://www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf> on the CMS web site.

For a link to the Code of Federal Regulations, go to http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr482_04.html

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.