

## **FY 2014 IPPS Rule Outreach ( CMS 1599-F) – 8-12-13**

### **Physician Order and Physician Certification**

In the final rule, CMS clarified that for purposes of payment under Medicare Part A, a beneficiary is considered an inpatient of a hospital (and a critical access hospital or CAH), if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner provided in the regulations. The order is a component of the statutorily required physician certification of the medical necessity of hospital inpatient services for Part A payment; therefore it must be documented in the medical record as a condition of payment.

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 admission decision (order) cannot be delegated to an individual who does not have this authority in his or her own right.

To improve clarity regarding the relationship between the order and the physician certification, CMS amended the regulations governing the physician certification, specifying that the certification begins with the order for inpatient admission. For each inpatient admission, the certification must be completed, signed and documented in the medical record prior to discharge (except for outlier extended stay cases, which require earlier certification and recertification).

In the final rule, CMS specified that inpatient rehabilitation facilities must also continue adhering to their existing admission requirements in the regulations.

### **Admission and Medical Review Criteria for Hospital Inpatient Services:**

Under this final rule—in addition to services designated as inpatient-only—surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (1) expects the beneficiary to require a stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation.

The final rule clarifies that the benchmark used in determining the expectation of a stay of at least two midnights begins when the beneficiary starts receiving services in the hospital. This would include outpatient care received while the beneficiary is in observation or is receiving services in the emergency department, operating room, or other treatment area.

The time a beneficiary spends as an outpatient before the formal inpatient admission order is not inpatient time, but may be considered by the physician—and subsequently the Medicare review contractor—when determining if the expectation of a stay lasting at least two midnights in the hospital is reasonable and was generally appropriate for inpatient admission. Documentation in the medical record must support a reasonable expectation of the need for the beneficiary to

require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance, this must also be clearly documented in the medical record.

Inpatient hospital claims with lengths of stay greater than two midnights after the formal inpatient order and admission will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts, absent evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the two-midnight presumption.

These provisions apply to all types of hospitals and CAHs, except inpatient rehabilitation facilities.

### **Payment of Hospital Services under Part B following Reasonable and Necessary Part A Inpatient Denials**

In the final rule, we provided that when a Medicare Part A claim for hospital inpatient services is denied because the inpatient admission was determined not reasonable and necessary, or if a hospital determines through utilization review after a beneficiary is discharged that his or her inpatient admission was not reasonable and necessary, the hospital may be paid for the Part B 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. Hospitals may bill services furnished after the time of the inpatient admission (the order) on a Part B inpatient claim, except observation services, hospital outpatient visits and outpatient diabetes self-management training services as these services require an outpatient status. The policy for payment of services furnished prior to the inpatient admission in the 3-day (1-day for non-IPPS hospitals) payment window in the regulations remains unchanged: the hospital may submit a Part B outpatient claim for payment of these services under Part B (including those requiring an outpatient status) as the outpatient services that they were. Part B coverage and payment rules must be met.

We finalized our proposal to continue applying the timely filing restriction to the billing of all Part B inpatient services, under which claims for Part B services must be filed within 1 year from the date of service. However, we will permit hospitals to follow the Part B billing timeframes established in CMS Ruling-1455-R after the effective date of the final rule (October 1, 2013), provided (1) the Part A claim denial was one to which the Ruling originally applied; or (2) the Part A inpatient claims has a date of admission before October 1, 2013, and is denied after September 30, 2013 on the grounds that although hospital outpatient services would have been reasonable and necessary, the inpatient admission was not. In the final rule, we also discussed appeals, beneficiary liability and other impacts of our final policies.

CMS plans to host an Open Door Forum (ODF), specific to the policies described above, on Thursday, August 15th from 3:00 to 4:00 PM ET. This call will provide introductory information on the physician order and physician certification, the admission and medical review criteria for inpatient hospital services, and the payment of hospitals services under Part B following

reasonable and necessary Part A denials, as defined in the final rule. ([Link to 1599-F; the 2014 IPPS Rule](#)). This introductory call will be a lecture-only conference, but we will provide additional forums for interactive discussion once stakeholders have had the opportunity to further review the final rule. The ODF telephone number and conference information is posted at: <http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/081513AdmissionsPolicySODFAnnouncement.pdf>.

Providers or associations are encouraged to submit any questions or concerns to the **IPPSadmissions@cms.hhs.gov** mailbox we have established for questions related to the two midnight provision for admission and medical review. Questions on Part B inpatient billing and the clarifications regarding the physician order and certification should be sent to the subject matter staff listed in the final rule. CMS will review stakeholder feedback as quickly as possible and provide responses and clarification as needed.