Audio Title: Guidance on Hospital Inpatient Admission Decisions

Audio Date: December 11, 2013
Run Time: 7 minutes
ICN: 908996

Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or "CMS". These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information that health care professionals can trust.

Are you an Inpatient Acute Care hospital that bills Medicare Administrative Contractors or (MACs) for services to Medicare beneficiaries? If so, you will benefit from this podcast!

It is important that any staff involved with the clinical decision to admit the beneficiary, stay abreast of all CMS national inpatient hospital policy and National and Local Coverage Determinations.

Additionally, make sure submitted medical documentation demonstrates evidence of the clinical need for the beneficiary to be admitted to the inpatient facility and accurately identifies any subsequent care that was provided during the inpatient stay.

Let's begin our discussion today with Background information on Hospitals' Inpatient Admission Decisions

Some hospitals have recently expressed concern about how CMS Recovery Audit Contractors or (RACs), MACs and the Comprehensive Error Rate Testing Contractor or (CERT) are utilizing screening criteria to analyze medical documentation and make a medical necessity determination on inpatient hospital claims.

There are several commercially available screening tools that can be used **to assist in the review of medical documentation to determine if a hospital admission is medically necessary:**

- First, Interqual
- Second, Milliman and
- Third, Other proprietary systems

Let's now discuss the CMS Policy Guidance

To assist hospitals regarding inpatient admission decisions, CMS would refer hospitals to the following:

Program Integrity Manual Guidance

Chapter 6, Section 6.5.1, of the Medicare Program Integrity Manual requires that contractors review the screening tool used by the staff as part of their medical review process for inpatient hospital claims. CMS does not require that the contractor use specific criteria nor endorse any particular brand of screening guidelines. CMS contractors are not required to pay a claim even if screening criteria indicate inpatient admission is appropriate Conversely, CMS contractors are not

required to automatically deny a claim that does not meet the admission guidelines of a screening tool. In all cases, in addition to screening instruments, the reviewer shall apply his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.

For each case, the staff review will utilize the following five (5) areas when making a medical necessity determination

- First, Admission criteria;
- Second, Invasive procedure criteria;
- Third, CMS coverage guidelines;
- Fourth, Published CMS criteria; and
- Fifth, Other screens, criteria and guidelines (for example, practice guidelines that are well accepted by the medical community).

Please note that CMS considers the use of screening criteria as only **one** tool that should be utilized by contractors to assist them in making an inpatient hospital claim determination.

Chapter 6, Section 6.5.2, of the Medicare Program Integrity Manual states that the review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. Once again, the beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

The reviewer will consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission.

Next, we'll discuss the Medicare Benefit Policy Manual Guidance

Chapter 1, Section 10 also contains relevant information regarding what constitutes an appropriate inpatient admission. According to that manual section, an **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark; that is, they should order admission for beneficiaries who are expected to need hospital care for 24 hours or more, and treat other beneficiaries on an outpatient basis). However, the decision to admit a beneficiary is a complex medical judgment which can be made only after the physician has considered a number of factors, including the beneficiary's medical history and current medical needs; the types of facilities available to inpatients and to outpatients; the hospital's by-laws and admissions policies; and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include four (4) factors:

- One, The severity of the signs and symptoms exhibited by the beneficiary;
- Two, The medical predictability of something adverse happening to the beneficiary;
- Three, The need for diagnostic studies that appropriately are outpatient services to assist in assessing whether the patient should be admitted; and

- Four - The availability of diagnostic procedures at the time when, and at the location where, the beneficiary presents.

To learn more about the Guidance on Hospital Inpatient Admission Decisions

Download the MLN Matters® Article on this topic, go to the CMS website at www.cms.gov and click on "Outreach and Education" at the top of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Matters® Articles link. Follow the links to "2012 MLN Matters® Articles" and search for MM article number "SE1037."

Or by going to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1037.pdf .

To download the MLN Matters® Article on this topic, go to the CMS website at www.cms.gov and click on "Outreach and Education" at the top of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Matters® Articles link. Follow the links to "2012 MLN Matters® Articles" and search for MM article number "SE1037."

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Look out for future MLN podcasts on the latest Medicare updates for health care professionals.