



Regulatory Update- Questions without Answers

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What is an inpatient?

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.

42 CFR 412.3

A: Inpatient admission requires an inpatient admission order. Admission orders are never retroactive.

2016 OPPS Proposed Rule

- New C-APC for Obs- 8011- $2,111- comprehensive
- 7 deletions from Inpatient Only List- no joints removed
- 2 MN rule stays, adds physician judgement that a patient with < 2MN expectation warrants inpatient admission (whatever that means)
- QIO to do short stay reviews, refer outliers to RAC

But what time does an inpatient admission begin?

Dr. Dan Duvall of CMS stated during 9-26-13 ODF, "The physician may write the order and let's say the physician writes the order at 10:00, the patient is formally admitted at 11:00 so the patient becomes an inpatient on 11:00 and then the following morning, the physician authenticates the order, that's fine. It's the formal admission following the documentation of the order."

A: We don't know what made 11 the time of admission. We don't know when CMS thinks an admission begins.

Who can admit patients?

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…The ordering practitioner is not required to write the order but must sign the order reflecting that he or she has made the decision to admit the patient for inpatient services. CMS Q&A 1-30-14

A: The admit order must be from a practitioner who is permitted to admit patients

So can NPPs and residents admit patients?

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 counter-signing the order prior to discharge.

CMS Q&A 1-30-14

A: Prior to 1-1-15, no. As of 1-1-15, we don't know if NPPs with privileges can independently admit patients.

Can ED doctors write an admission order?

If ED doctors have admitting privileges, they can independently admit and their order is valid and does not require cosignature.

If ED doctors do not have admitting privileges, they are writing the order on behalf of the admitting doctor and that order requires cosignature.

A: It depends on their privileges.

Is authentication of the admission order required before discharge?

Therefore, we do not believe it is appropriate to change our existing policy which requires that inpatient orders be signed prior to discharge by a practitioner familiar with the case and authorized by the hospital to admit inpatients. FR 79, 6699, 2015 OPPS Final Rule

A: If the order was written by a practitioner without admitting privileges on behalf of another practitioner or by a hospital employee (TORB), it must be authenticated before discharge…if you want to get paid for the admission.

What if the order is not authenticated?

Inpatient status begins at the time of formal admission by the hospital pursuant to the physician order, including an initial order or a verbal order that is countersigned timely, by authorized individuals, as required in this section. If the physician or other practitioner responsible for 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 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.

CMS Q&A 1-30-14

A: No authentication at all, no inpatient admission

But what about the patient?

Hospitals are required to present all inpatients with a copy of the Important Message from Medicare (IMM) within 2 days of admission. Most give it when registration "admits" the patient pursuant to an admission order. That notifies them of their inpatient status and appeal rights.

42 CFR 405.1205(b)

A: For CMS to say that an unauthenticated admission order voids the whole admission totally disregards beneficiary rights to be informed of their status and financial liability and makes no sense at all.

What about…

Order is authenticated after discharge?

A: Inpatient admission valid, bill provider liable then rebill.

Order is written by ED doc (w/o privileges), attending orders obs?

A: If ED order not cosigned, can ignore. If cosigned, must do CC44. If cosigned after discharge, must do self-audit and denial. If going to "ignore" an admission order, ensure it is never cosigned.

Order is written by ED doc (w/o privileges), not cosigned, then attending writes new admission order?

A: Admission begins at time of attending admission order.

What is an order?

In very rare circumstances, the order to admit may be missing or defective (that is, illegible or incomplete), yet the intent,

decision, and recommendation of the physician (or other practitioner who can order inpatient services) to admit the

beneficiary as an inpatient can clearly be derived from the medical record. In these rare situations, we have provided

contractors with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. FR 78 50941

A: If order is missing or unsigned but signed H&P says "admit as inpatient," we don't know if that is a valid admission order or is just an indicator of "intent."

Is a discharge order required?

A hospital inpatient is considered discharged from a hospital paid under the prospective payment system when the patient is formally released from the hospital or the patient dies in the hospital. 42CFR 412.4

A: There is no regulatory requirement for a discharge order but discharging a patient should be done under the direction of a practitioner and that should be documented.

When is a patient considered discharged?

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 physician as having to occur prior to discharge (e.g., “discharge after supper” or “discharge after voids”). So discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the physician’s order for discharge is effectuated. CMS Q&A 1-30-14

Who cares about discharge time?

CC44: 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. MLN SE0622

Observation hour counting: Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. MCPM Ch 4, 290.2.2

A: Utilization review and finance care about discharge time.

Northwestern Medical Center cares about discharge time

For 22 of the 73 sampled claims, the Hospital incorrectly billed Medicare for observation hours resulting in incorrect outlier payments. Specifically, the Hospital included observation time for services that were part of another Part B service including postoperative monitoring or standard recovery care (10 errors), for time the patients remained in the hospital after treatment was finished (3 errors), or the medical record did not contain an order for the observation services (1 error). On the basis of our sample results, we estimated that the Hospital received net overpayments totaling at least $6,389,095 for the audit period.

OIG audit March, 2015, A-05-13-00051

Does CMS give any help?

…So discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the physician's order for discharge is effectuated. CMS Q&A 1-30-14

CAH CoP: Observation services **BEGIN** and **END** with an order by a physician or other qualified licensed practitioner of the CAH.

A: We don't know when CMS considers a patient discharged.

I recommend using the time when services end (iv out time) or time the patient gets discharge paperwork, whichever is earlier.

Do all hospital days count to the part A SNF benefit?

"The beneficiary must have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge." 42 CFR 409.30

A: Only inpatient days count. Days in observation do not count. Also note it is 3 days and not 3 midnights (even though it's the same).

Must all three days be medically necessary?

The beneficiary must have been hospitalized in a participating or qualified hospital or participating CAH, for medically necessary inpatient hospital or inpatient CAH care, for at least 3 consecutive calendar days, not counting the date of discharge."

When reviewing eligibility for the SNF benefit, reviewers should apply the "broad definition" of medical necessity, …denials should occur only if there is "substantial departure from normal practice."

MBPM, Ch 8, 20.1

A: The inpatient admission must be medically necessary (2 MN) but the third day can be "less necessary."

What is medical necessity for hospital care?

The crux of the medical decision is the choice to keep the beneficiary at the hospital in order to receive services or reduce risk, or discharge the beneficiary home because they may be safely treated through intermittent outpatient visits or some other care."

FR 78, 50945

A: If the patient passes observation criteria, passes inpatient criteria or fails discharge screening, they require hospital care. If those are not met, the case should be reviewed by the physician advisor.

Once you determine they need hospital care, then you apply the two midnight expectation.

CMS Response to Questions

I had expected that one consequence of the 2 midnight rule was that we would significantly increase our definitive guidance. I believe that any question deserves a prompt clear definitive official answer…but I guess it is called a bureaucracy for a reason.

Day says, “No questions now” and she is definitely in charge

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