Relevant sections of the proposed CMS rule changes on Observation Beds
May 12, 2013 Info provided by Evan Pollack, MD, FACP -

Medicare's proposed rule would better define an inpatient admission. Our resolution requested better transparency in defining an inpatient admission and CMS responded with this. They basically will define an inpatient stay as two midnights in the hospital. Dr. Pollack discussed this at our May, 2013 HPCC meeting and Chairman Arnie Eiser requested some reading material. The full document is 1400 pages. The portions below are relevant to us.

Under our proposal, Medicare's external review contractors would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 "midnights") in the hospital receiving medically necessary services.

- Similarly, we would presume that hospital services spanning less than 2 midnights should have been provided on an outpatient basis, unless there is clear documentation in the medical record supporting the physician's order and expectation that the beneficiary would require care spanning more than 2 midnights or the beneficiary is receiving a service or procedure designated by CMS as inpatient-only.

- We note that our current manual instructions referenced above, indicating that physicians should use a 24-hour period and the expectation of a beneficiary's need for an overnight stay in the hospital as inpatient admission benchmarks, remain in effect until we have finalized a new policy, at which time we will consider whether and how the existing instructions should be updated.

- Therefore, while the COPs do not preclude a doctor of medicine or osteopathy from delegating authority to other individuals, we are specifically clarifying in regulation that, for payment purposes, the authority to admit cannot be delegated to an individual who lacks that authority in his or her own right.

- While the requirement for the physician admission order has long been clear in the CoPs, we are proposing to state explicitly in our payment regulations that admission pursuant to this order is the means whereby a beneficiary becomes a hospital inpatient and, therefore, is required for payment of hospital inpatient services under Medicare Part A. Accordingly, we are proposing to add a new § 412.3 titled "Admissions," that would define a hospital inpatient admission as follows: "(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 paragraph (b) of this section [discussed below] 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.

- Inpatient hospital short-stay claim errors are frequently related to minor surgical procedures or diagnostic tests. In such situations, the beneficiary is typically admitted as a hospital inpatient after the procedure is completed on an outpatient basis, monitored overnight as an inpatient, and discharged from the hospital in the morning. Medicare review contractors typically find that while the underlying services provided were reasonable and necessary, the inpatient hospitalization following the procedure was not (that is, the services following the procedure should have been provided on an outpatient basis).

- (3) Inpatient Hospital Admission Guidelines - In this proposed rule, we are proposing inpatient hospital admission guidance under which a physician or other practitioner should order admission if he or she expects that the beneficiary's length of stay will exceed a 2-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only under 42 CFR 419.22. We are proposing that the starting point for this time-based instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided. However, we are soliciting public comments on this proposed method of calculating the length of stay for purposes of this 2-midnight threshold proposal.

- Conversely, when a patient enters a hospital for a surgical procedure not specified by Medicare as inpatient only under § 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the patient in the hospital for only a limited period of time that does not cross 2 midnights, the services would be generally inappropriate for payment under Medicare Part A. This would be the case regardless of the hour that the patient came to the hospital or whether the patient used a bed.

- Under our proposed medical review policy, Medicare's external review contractors would presume that hospital inpatient status is reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined as encounters crossing 2 midnights) after admission. Medical review efforts for inpatient hospital admissions greater than 2 midnights would focus on undue delays in the provision of care in an attempt to meet the 2-midnight threshold (that is, inpatient hospital admissions where medically necessary treatment was not provided on a continuous basis throughout the hospital stay and the services could have been furnished in a shorter timeframe). Beneficiaries should not be held in the hospital absent medically necessary care for the purpose of meeting the 2-midnight presumption.

- If the physician admits the beneficiary as an inpatient but the beneficiary is in the hospital for less than 2 midnights after admission, we are proposing that CMS and its medical review contractors would review the inpatient admission in accordance with current policy for Part A payment, as clarified below, and would not presume that the inpatient hospital admission was reasonable and necessary for payment purposes.

- In other words, if it was reasonable for the physician to expect the beneficiary to require a stay lasting 2 midnights, even though that did not transpire, payment would be made under Medicare Part A if the documentation in the medical record reflected such complex medical factors (and the physician's order and certification requirements also are met). As discussed above, payment may be made in the case of services on Medicare's inpatient only list and in exceptional cases such as beneficiary death or transfer.