PUBLICATION

CMS Proposes New Standard for Hospital Inpatient Admissions [Ober|Kaler]

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As part of its proposed inpatient prospective payment systems (IPPS) rule for FY 2014, CMS introduced a new standard for determining whether an inpatient admission to an acute care hospital is appropriate. Specifically, CMS proposed that instead of a physician using the expectation that a patient will stay overnight or at least 24 hours (the current standard), the new standard would be the expectation by the physician that the patient would require inpatient care spanning at least two midnights. *See* 27646 Fed. Reg. 27486, 27644-650 (May 10, 2013).

CMS also proposes that Medicare contractors use this new standard, or benchmark, when reviewing inpatient admissions. Under the new standard, Medicare's review contractors would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require at least two midnights in the hospital. CMS advises the contractors to be on the watch for providers found to be abusing this two-midnight presumption and making non-medically necessary inpatient hospital admissions, e.g., where hospitals are systematically delaying the provision of care in order to exceed the two-midnight timeframe.

Similarly, CMS also proposes a review presumption that hospital services spanning less than two 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 two midnights or the beneficiary is receiving a service or procedure designated by CMS as inpatient-only. New language in the proposed rules specifically states that “[n]o presumptive weight shall be assigned to the physician's order…or certification…in determining the medical necessity of inpatient hospital services.” Thus, although an order of admission from the treating physician is still required, the entire admission must be justified independently in the medical record. CMS, however, continues to assert that the judgment of the physician and the physician's order for inpatient care should be based on such complex medical factors as patient history and symptoms, current medical needs and the risk of an adverse event.

The new rule also allows for an exception. CMS affirms that if at the time of the admission decision, it was reasonable to expect that the patient would need inpatient care spanning at least two midnights, and that expectation is supported in the medical record, and there was a physician order and certification for the inpatient care, payment would be made under Part A even if the patient did not stay at least two midnights. However, the exception in the proposed rule seems to anticipate an exception only being necessary when a patient dies or is transferred, rather than discharged early to home: “If an unforeseen circumstance, such as a beneficiary death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least two midnights, the patient may be considered to be appropriately treated on an inpatient basis, and the hospital inpatient payment may be made under Medicare Part A.”

Lastly, CMS anticipates an increase of $220 million in Medicare costs due to the presumption that hospital inpatient stays are reasonable if they span at least two midnights. CMS proposes to reduce the standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount by 0.2 percent to offset the anticipated cost increase.

Comments

CMS's new rule is part of its bigger plan to address the inpatient admission versus outpatient observation problem, with its stated purpose being to create greater clarity with regard to this issue. CMS recently revised its Part B billing rules via a proposed rule and a ruling, which affect billing for Part B services when inpatient admissions are found to be medically unnecessary. For a discussion of the Part B proposed rule changes and the ruling, see “CMS Revises Part B Billing Policy for Unnecessary Inpatient Admissions” published in the March 21, 2013 *Payment Matters*.

It is hard to see how increasing the standard for an inpatient admission from one night or 24 hours, to two midnights, is going to add any greater clarity to the problem. What is easy to see, however, is that this new standard, along with the elimination of any presumption in favor of the treating physician's order for care, will lead to a decrease in hospital inpatient admissions and an increase in outpatient care, which results in lower payments generally to hospitals. Despite CMS's financial calculations, it is difficult to understand how creating a higher standard for inpatient admission will result in increased costs to the Medicare program, when inpatient care is generally more costly than outpatient care. Nevertheless, as a result, hospitals will also receive lower Medicare payments due to a decrease in the standardized amount to account for the anticipated increase in costs to Medicare. CMS has further financially squeezed hospitals through its revisions to the Part B billing rules which will eliminate the authority for ALJs to continue to allow that denied inpatient stays be paid as outpatient observation care and will effectively eliminate the ability for hospitals to timely file Part B outpatient claims when services for inpatient care are denied.

Hospitals have until **July 25, 2013** to comment on the proposed rules. Changes to the rules are proposed to be effective October 1, 2013.