CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 234	**Date: March 10, 2017**
	Change Request 9979

SUBJECT: Clarification of Admission Order and Medical Review Requirements

I. SUMMARY OF CHANGES: This Change Request clarifies CMS rulemaking language as it relates to Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A; Requirements for Physician Orders.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 12, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/10/Covered Inpatient Hospital Services Covered Under Part A
N	1/10/10.2/Hospital Inpatient Admission Order and Certification

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 234	Date: March 10, 2017	Change Request: 9979

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I. GENERAL INFORMATION

A. Background: In response to concerns about the provision of observation services for increasingly long periods of time and in response to stakeholders' concerns about the clarity and appropriateness of Medicare's hospital inpatient admission and medical review guidelines, CMS published several clarifications and changes in policy in the FY 2014 IPPS/LTCH PPS final rule and subsequent rulemaking. These clarifications and changes remain in the text of the final rules; however, the Benefit Policy Manual was not updated to reflect the same clarifications and changes. This intent of this Change Request is to resolve that issue.

B. Policy: In the FY 2014 IPPS/LTCH PPS final rule and subsequent rulemaking CMS clarified and specified in the regulations that an individual becomes an inpatient of a hospital, including a Critical Access Hospital, when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner described in the final regulations. The order is required for payment of hospital inpatient services under Medicare Part A. CMS specified that for those hospital stays in which the physician expects the beneficiary to require care that crosses two midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. Conversely, CMS specified that hospital stays in which the physician expects the patient to require care less than two midnights, payment under Medicare Part A is generally inappropriate. This revised CMS guidance to hospitals and physicians relating to when hospital inpatient admissions are determined reasonable and necessary for payment under Part A.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9979.1	Contractors shall be aware of the updates to the Medicare Benefit Policy Manual, chapter 1, sections 10 and 10.2.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9979.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Daniel Schroder, 410-786-7452 or daniel.schroder@cms.hhs.gov, Joseph Brooks, 410-786-0275 or joseph.brooks@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Benefit Policy Manual
Chapter 1 - Inpatient Hospital Services Covered Under Part A

Table of Contents
(Rev. 234, Issued: 03-10-17)

10 - Covered Inpatient Hospital Services Covered Under Part A

(Rev. 234, Issued: 03-10-17, Effective: 01-01-16, Implementation: 06-12-17)

Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. (Inpatient hospital services do not include extended care services provided by hospitals pursuant to swing bed approvals. See Pub. *100-02*, Chapter 8, §*10.3*, "Hospital Providers of Extended Care Services."). However, both inpatient hospital and inpatient SNF benefits are provided under Part A - Hospital Insurance Benefits for the Aged and Disabled, of Title XVIII).

Additional information concerning the following topics can be found in the following chapters *of this manual*:

- Benefit Period is found in Chapter 3
- *Counting Inpatient* Days is found in Chapter *3*
- Lifetime reserve days is found in Chapter 5
- Related payment information is housed in the Provider Reimbursement Manual

Blood must be furnished on a day which counts as a day of inpatient hospital services to be covered as a Part A service and to count toward the blood deductible. Thus, blood is not covered under Part A and does not count toward the Part A blood deductible when furnished to an inpatient after the inpatient has exhausted all benefit days in a benefit period, or where the individual has elected not to use lifetime reserve days. However, where the patient is discharged on their first day of entitlement or on the hospital's first day of participation, the hospital is permitted to submit a billing form with no accommodation charge, but with ancillary charges including blood.

The records for all Medicare hospital inpatient discharges are maintained in CMS for statistical analysis and use in determining future Prospective Payment System (PPS) Diagnosis Related Group (DRG) classifications and rates.

Non-PPS hospitals do not pay for noncovered services generally excluded from coverage in the Medicare Program. This may result in denial of a part of the billed charges or in denial of the entire admission, depending upon circumstance. In PPS hospitals, the following are also possible:

1. In appropriately admitted cases where a noncovered procedure was performed, denied services may result in payment of a different DRG (i.e., one which excludes payment for the noncovered procedure); or

2. In appropriately admitted cases that become cost outlier cases, denied services may lead to denial of some or all of an outlier payment.

The following examples illustrate this principle. If care is noncovered because a patient does not need to be hospitalized, the *A/B MAC Part A* denies the admission and makes no Part A (i.e., PPS) payment unless paid under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider **and** the beneficiary were **not** aware the services were not necessary and could not reasonably be expected to know that the services were not necessary. For detailed instructions, see *Pub. 100-04*, Medicare Claims Processing Manual, Chapter 30,"Limitation on Liability" *section 20*. If a patient is appropriately hospitalized but receives (beyond routine services) only noncovered care, the admission is denied.

NOTE: The *A/B MAC Part A* does not deny an admission that includes covered care, even if noncovered care was also rendered. Under PPS, Medicare assumes that it is paying for **only** the covered care rendered whenever covered services needed to treat and/or diagnose the illness were in fact provided.

If a noncovered procedure is provided along with covered nonroutine care, a DRG change rather than an admission denial might occur. If noncovered procedures are elevating costs into the cost outlier category, outlier payment is denied in whole or in part.

When the hospital is included in PPS, most of the subsequent discussion regarding coverage of inpatient hospital services is relevant only in the context of determining the appropriateness of admissions, which DRG, if any, to pay, and the appropriateness of payment for any outlier cases.

If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or for only the appropriate prospective payment amount. This provision applies not only to inpatient services, but also to all hospital services under Parts A and B of the program. If the items or services were requested by the patient, the hospital may charge him *or her* the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services *(see §10.2 below)*. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights 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 the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. However, the decision to admit a patient is a

complex medical judgment which can be made only after the physician has considered a number of factors, including the patient'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 such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered **outpatients** for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Renal Dialysis - Renal dialysis treatments are usually covered only as outpatient services but may under certain circumstances be covered as inpatient services depending on the patient's condition. Patients staying at home, who are ambulatory, whose conditions are stable and who come to the hospital for routine chronic dialysis treatments, and not for a diagnostic workup or a change in therapy, are considered outpatients. On the other hand, patients undergoing short-term dialysis until their kidneys recover from an acute illness (acute dialysis), or persons with borderline renal failure who develop acute renal failure every time they have an illness and require dialysis (episodic dialysis) are usually inpatients. A patient may begin dialysis as an inpatient and then progress to an outpatient status.

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do

not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

Refer to *chapters* 4 and 7 of *Pub. 100-10, Quality Improvement Organization* Manual with regard to initial determinations for these services. The QIO will review the swing bed services in these PPS hospitals as well.

NOTE: When patients requiring extended care services are admitted to beds in a hospital, they are considered inpatients of the hospital. In such cases, the services furnished in the hospital will not be considered extended care services, and payment may not be made under the program for such services unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of Health and Human Services.

10.2 – Hospital Inpatient Admission Order and Certification

(Rev. 234, Issued: 03-10-17, Effective: 01-01-16, Implementation: 06-12-17)

The order to admit as an inpatient ("practitioner order") is a critical element in clarifying when an individual is considered an inpatient of a hospital, including a critical access hospital (CAH), and is therefore required for all hospital inpatient cases for hospital inpatient coverage and payment under Part A. As a condition of payment for hospital inpatient services under Medicare Part A, according to section 1814(a) of the Social Security Act, CMS is requiring, only for long-stay cases and outlier cases, separate physician certification of the medical necessity that such services be provided on an inpatient basis. The signed physician certification is considered, along with other documentation in the medical record, as evidence that hospital inpatient service(s) were reasonable and necessary.

The following guidance applies to all inpatient hospital and CAH services unless otherwise specified. For the remainder of this guidance, references to hospitals includes CAHs. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B, and requirements for admission orders are found at 42 CFR 412.3.

- ***A. Physician Certification.*** *Physician certification of inpatient services is required for cases that are 20 inpatient days or more (long-stay cases), for outlier cases of hospitals other than inpatient psychiatric facilities and for cases of CAHs. (See CY 2015 Outpatient Prospective Payment System Final Rule, 79 FR 66997 and 42 CFR 412 Subpart F, 42 CFR 424.13 and 42 CFR 424.15):*

  - ***1. Content:*** *The physician certification includes the following information:*

    - ***a.*** *Reason for inpatient services: The physician certifies the reasons for either— (i) Continued hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for outlier cases under the applicable prospective*

payment system for inpatient services. For example, documentation of an admitting diagnosis could fulfill this part of the certification requirement.

b. *The estimated (or actual) time the beneficiary requires or required in the hospital: The physician certifies the estimated time in the hospital the beneficiary requires (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed at discharge). Estimated or actual length of stay is most commonly reflected in the progress notes where the practitioner discusses the assessment and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.*

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, the regulations at 42 CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

c. *The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.*

d. *For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.*

Time as an outpatient at the CAH does not count towards the 96 hour certification requirement. The clock for the 96 hour certification requirement only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour certification requirement.

The 96-hour certification requirement is based on an expectation at the time of admission. If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH, and something unforeseen occurs that causes the individual to stay longer at the CAH, the CAH would be paid for that unforeseen extended inpatient stay as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the

CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay. This would be determined based on a medical review of the case.

All certification requirements must be completed, signed, and documented in the medical record no later than 1 day before the date on which the claim for payment for the inpatient CAH service is submitted, as provided in the FY15 IPPS Final Rule and 42 CFR 424.11 and 42 CFR 424.15.

e. *Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.*

2. Timing: *Outlier cases must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. For all other long stay cases, the certification must be signed and documented no later than 20 days into the inpatient portion of the hospital stay.*

3. Authorization to sign the certification: *The certification or recertification may be signed only by one of the following:*

(1) A physician who is a doctor of medicine or osteopathy.
(2) A dentist in the circumstances specified in 42 CFR 424.13(d).
(3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.

Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff (or by the dentist as provided in 42 CFR 424.11 and 42 CFR 424.13). CMS considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician: the admitting physician of record ("attending") or a physician on call for him or her; a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her; a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that

specifically contains all of the content elements discussed above. The admitting physician of record may be an emergency department physician or hospitalist. CMS does not require the certifying physician to have inpatient admission privileges at the hospital.

4. ***Format:*** *As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.*

B. Inpatient Order: *A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by an ordering practitioner. As stated in the FY 2014 IPPS Final Rule, 78 FR 50908 and 50941, and as conveyed in 42 CFR 482.24, if the order is not properly documented in the medical record prior to discharge, the hospital should not submit a claim for Part A payment. Meeting the two midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A. Rather, as provided in Medicare regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by an ordering practitioner.*

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 ordering practitioner as having to occur prior to discharge (e.g., "discharge after supper" or "discharge after voids"). Thus, discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the ordering practitioner's order for discharge is effectuated.

1. ***Content:*** *The ordering practitioner's order contains the instruction that the beneficiary should be formally admitted for hospital inpatient care. The order must specify admission for inpatient services. Inpatient rehabilitation facilities (IRFs) must adhere to the admission requirements specified in 42 CFR 412.622. The two midnight benchmark does not apply in IRFs.*

2. ***Qualifications of the ordering/admitting practitioner:*** *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. See section (B)(3) for a discussion of the requirements to be knowledgeable about the patient's hospital course. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision. The ordering practitioner is not required to write the order but must authenticate (sign, or in the case of an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)), countersign) the order reflecting that he or she has made the decision to admit the patient for inpatient services.

The admission decision (order) may not be delegated to another individual who is not authorized by the state to admit patients, or has not been granted admitting privileges by the hospital's medical staff. However, a medical resident, physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner provided they are authorized under state law to admit patients and the requirements outlined below are met (FY 14 IPPS Final Rule and 42 CFR 412.3(b)).

a. ***Residents and non-physician practitioners authorized to make initial admission decisions -*** *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 authenticating (countersigning) the order prior to discharge. (See (A)(2) for guidance regarding the definition of discharge time and (B)(3) for more guidance regarding knowledge of a patient's hospital course). In authenticating (countersigning) the order, the ordering practitioner approves and accepts responsibility for the admission decision. This process may also be used for practitioners (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or "bridge" inpatient admission orders.*

b. ***Verbal orders-*** *At some hospitals, individuals who lack the authority to admit inpatients under state laws and hospital by-laws (such as a registered nurse) may nonetheless enter the inpatient admission order as a verbal order. In these cases, the ordering practitioner directly communicates the inpatient admission order to staff as a verbal (not standing) order, and the ordering practitioner need not separately record the order to admit. Following discussion with and at the direction of the ordering practitioner, a verbal order for inpatient admission may be documented by an individual who is not qualified to admit patients in his or her own right, as long as that documentation (transcription) of the order for inpatient admission is in accordance with state law including; scope-of-practice laws, hospital policies, and medical staff bylaws, rules,*

and regulations. In this case, the staff receiving the verbal order must document the verbal order in the medical record at the time it is received. The order must identify the ordering practitioner and must be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge. Example: "Admit to inpatient per Dr. Smith" would be considered an acceptable method of identifying the ordering practitioner and would meet the verbal order requirement if the verbal order (1) is appropriately documented in the medical record by the individual receiving the verbal order when the order is received; and (2) is authenticated (countersigned) by Dr. Smith promptly, prior to discharge.

c. ***Standing orders and protocols*** *- The inpatient admission order cannot be a standing order. While Medicare's rules do not prohibit use of a protocol or algorithm that is part of a protocol, only the ordering practitioner, or a resident or other practitioner acting on his or her behalf under section (B)(2)(a) can make and take responsibility for the inpatient admission decision.*

d. ***Commencement of inpatient status*** *- Inpatient status begins at the time of formal admission by the hospital pursuant to the order, including an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)) that is authenticated (countersigned) timely, by authorized individuals, as required in this section. If the practitioner responsible for authenticating (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 authenticate (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.*

3. ***Knowledge of the patient's hospital course:*** *CMS considers only the following practitioners to have sufficient knowledge about the beneficiary's hospital course, medical plan of care, and current condition to serve as the ordering practitioner: the admitting physician of record ("attending") or a physician on call for him or her, primary or covering hospitalists caring for the patient in the hospital, the beneficiary's primary care practitioner or a physician on call for the primary care practitioner, a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her, emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission, and other practitioners qualified to admit inpatients and actively treating the beneficiary at the point of the inpatient admission decision. A utilization review committee physician functioning in that role does not have direct responsibility for the care of the patient and is therefore not considered to be sufficiently knowledgeable to order the inpatient admission. The order must be written by one of the above practitioners directly involved with the care of the beneficiary, and a utilization committee*

physician may only write the order to admit if he or she is not acting in a utilization review capacity and fulfills one of the direct patient care roles, such as the attending physician. Utilization review may not be conducted by any individual who was professionally involved in the care of the patient whose case is being reviewed (42 CFR 482.30(d)(3)).

4. ***Timing:*** *The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (e.g., for a pre-scheduled surgery), but the inpatient admission does not occur until hospital care services are provided to the beneficiary. Conversely, in the unusual case in which a patient is admitted as an inpatient prior to an order to admit and there is no documented verbal order, the inpatient stay should not be considered to commence until the inpatient admission order is documented. CMS does not permit retroactive orders. Authentication by the ordering practitioner of the order (either by signature or, in the case of an initial order under (B)(2)(a) or a verbal order under (B)(2)(b), countersignature) is required prior to discharge for all inpatient cases.*

5. ***Specificity of the Order****: The regulations at 42 CFR 412.3 require that, as a condition of payment, an order for inpatient admission must be present in the medical record. The preamble of the FY 2014 IPPS Final Rule at 78 FR 50942 states, "the order must specify the admitting practitioner's recommendation to admit 'to inpatient,' 'as an inpatient,' 'for inpatient services,' or similar language specifying his or her recommendation for inpatient care. While CMS does not require specific language to be used on the inpatient admission order, it is in the interest of the hospital that the ordering practitioner use language that clearly expresses intent to admit the patient as inpatient that will be commonly understood by any individual who could potentially review documentation of the inpatient stay. CMS does not recommend using language that may have specific meaning only to individuals that work in a particular hospital (e.g., "admit to 7W") that will not be commonly understood by others outside of the hospital.*

   If admission order language used to specify inpatient or outpatient status is ambiguous, the best course of action would be to obtain and document clarification from the ordering practitioner before initial Medicare billing (ideally before the beneficiary is discharged). Under this policy, CMS will continue to treat orders that specify a typically outpatient or other limited service (e.g., admit "to ER," "to Observation," "to Recovery," "to Outpatient Surgery," "to Day Surgery," or "to Short Stay Surgery") as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.

   The admission order is evidence of the decision by the ordering practitioner to admit the beneficiary to inpatient status. In extremely rare circumstances, the order to admit may be missing or defective (that is, illegible, or incomplete,

for example "inpatient" is not specified), yet the intent, decision, and recommendation of the ordering practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these extremely rare situations, contractors have been provided with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the order, there can be no uncertainty regarding the intent, decision, and recommendation by the ordering practitioner to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.

This narrow and limited alternative method of satisfying the requirement for documentation of the inpatient admission order in the medical record should be extremely rare, and may only be applied at the discretion of the contractor.