

## **CMS PROPOSES TO ELIMINATE WRITTEN PHYSICIAN ORDER REQUIREMENT AS A CONDITION FOR PAYMENT FOR INPATIENT ADMISSIONS**

On April 24, 2018, the Centers for Medicare & Medicaid Services (“CMS”) issued its proposed rule for the CY 2019 Inpatient Prospective Payment System (“Proposed Rule”). Among many other changes, one very important change stands out in the Proposed Rule, specifically eliminating the requirement that providers record a written inpatient admission order in the medical record to receive Part A payment thereby significantly easing documentation requirements for providers. Hospital providers should consider submitting comments on the Proposed Rule to support CMS’s proposal to eliminate the written order requirement.

### **BACKGROUND**

Under 42 CFR § 412.3(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. The 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.

Currently, when an order for inpatient admission is not present in the medical record, CMS grants medical reviewers discretion to determine whether the admission order information derived from the medical record constructively satisfies the inpatient admission order requirement.

### **THE PROPOSED UPDATE**

In its Proposed Rule, CMS acknowledged that some otherwise medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation requirements of inpatient admission orders. Common technical discrepancies, often deemed deficiencies, include missing physician admission signatures, missing co-signatures or authentication signatures and signatures occurring after discharge. These discrepancies have occasionally been the primary reason for denying Medicare payment of an individual claim.

In CMS’s view, medical reviewers should primarily focus on whether the inpatient admission was medically reasonable and necessary rather than occasional inadvertent signature documentation issues unrelated to the medical necessity of the inpatient stay. CMS stated it was not their intent that admission order documentation should by themselves lead to the denial of payment for otherwise medically reasonable and necessary inpatient stay. Accordingly, in order to reduce unnecessary administrative burden on physicians and providers, CMS proposed to revise the regulations at 42 CFR § 412.3(a) to remove the language stating that a 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.

CMS noted that hospitals and physicians are already required to document relevant orders in the medical record to substantiate medical necessity requirements. If other available documentation, such as the physician certification statement when required, progress notes or the medical record as a whole, supports that all the coverage criteria (including medical necessity) are met, and the hospital is operating in accordance with the hospital conditions of participation, CMS stated it believes it is no longer necessary to also require specific documentation requirements of inpatient admission orders as a condition of Medicare Part A payment.

CMS reminded stakeholders that this proposal does not change the requirement that an individual is considered an inpatient if formally admitted as an inpatient under an order for inpatient admission and further noted that it is not proposing any changes with respect to the “2-midnight” payment policy.

### **PRACTICAL TAKEAWAYS**

Although this proposed change would reduce unnecessary administrative burden on physicians and providers, hospitals should still continue to ensure that there is sufficient documentation in the medical record to support medical necessity for the inpatient stay. Further, hospitals should continue to adhere to the 2-midnight payment policy for purposes of Medicare Part A payment. Under the 2-midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning two or more midnights and such reasonable expectation is supported by the medical record documentation.

Given the significant, positive impact this change could have on hospital providers, we encourage providers to submit comments to the Proposed Rule. Comments are due no later than 5:00 PM on June 25, 2018.

If you have questions or would like additional information about this topic, please contact:

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