CMS Softens Physician Inpatient Order Documentation Requirement

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CMS Softens Physician Inpatient Order Documentation Requirement

Written by Leslie Demaree Goldsmith – 9/14/18

Effective for hospital inpatient admissions on or after October 1, 2018, CMS has removed the requirement that a signed physician order must be present in the medical record to establish inpatient coverage. While this guidance would appear to remove one technical basis for denials, it does not remove the need for evidence that a physician judged a patient in need of inpatient services. CMS continues to require that an inpatient be *formally admitted* as an inpatient to qualify for inpatient benefits covered under Part A.

In the final FY 2019 Hospital Inpatient Prospective Payment rule, the agency explained that it was not its intent when it adopted the inpatient order documentation requirements related to the Two Midnight rule in 2013 that the documentation requirements "should by themselves lead to the denial of payment for medically reasonable and necessary inpatient stays." 83 Fed. Reg. 41144, 41507 (Aug. 7, 2018). The agency further observed that since the promulgation of that rule, medically necessary inpatient admissions were being denied coverage due to technical discrepancies with documentation, such as missing practitioner admission signatures, missing co-signatures and authentication signatures, and signatures occurring after discharge. CMS stated that the focus of the medical review process should be to determine if an inpatient stay was medically reasonable and necessary

and intended by the admitting physician, rather than towards occasional inadvertent signature or documentation issues unrelated to the medical necessity of the stay or intent of the physician.

Accordingly, CMS removed the following sentence from 42 C.F.R. § 412.3(a): "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."

Despite the removal of that provision, 42 C.F.R. § 412.3 still requires, for purposes of payment, that an inpatient be "formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner." However, CMS will now consider that requirement met if the totality of available documentation, such as the physician certification statement, progress notes, or medical record as a whole, supports that all the coverage criteria, including medical necessity are met, and the hospital meets the hospital conditions of participation (CoPs). In particular, the CoPs require that Medicare inpatients receive written information about their hospital discharge appeal rights.

Implications for Providers

Despite the removal of the inpatient order in the medical record, such an order remains a provider's best documentation of a physician's intent for an inpatient stay and thus requiring physicians to continue to comply with such a rule would be a best practice from a compliance and reimbursement perspective.

CMS clearly states that it was never its intention in adopting the original inpatient order rule that inpatient stays be denied payment

based solely on the absence of an inpatient order in the medical record. However, it is making the change to the rule *prospective* only. Usually when CMS clarifies its original intent, it is to the detriment of the provider, and the application of the original intent reaches back to the original passage of the regulation or policy. It seems incongruous and perhaps disingenuous that in this situation, when the clarification of original intent would benefit providers, it is not being expressly adopted retrospectively as a clarification. We are hopeful that the instructions to Medicare Administrative Contractors is that they should exercise judgment on cases already in the claims processing pipeline, approving coverage where the evidence supports the medical necessity of the stay even when a signed order is not in the record. Otherwise, the issue will generate more appeals as providers pursue a legal decision on the impact of the rule change.