DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
MLN Matters® CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash –

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- "Acute Care Hospital Inpatient Prospective Payment System," Fact Sheet, ICN 006815, Downloadable

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Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders

Provider Types Affected

This MLN Matters® Special Edition Article is intended for hospitals that bill Medicare contractors (Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs)) for renal and urinary tract disorders in Medicare beneficiaries.

What You Need to Know

Recovery Auditors complete medical necessity reviews of renal and urinary tract disorders. The auditors found that the medical necessity for the inpatient admission was not supported. The claim was identified as an overpayment. This article discusses documentation and billing for inpatient status.

Problem Description

When a patient is examined in the Emergency Department (ED), the physician decides whether the patient can safely go home or needs to stay in the hospital for further clinical evaluation and treatment. A patient can be admitted to the hospital to receive those additional services or a patient can receive observation services (OBS) as an outpatient. The purpose of observation is to provide services to determine whether the patient should be admitted as an inpatient or released from the hospital. Observation services are billed the same as all other outpatient services. The physician responsible for the patient's care can write an order for an inpatient admission changing the patient's status from

outpatient to inpatient (IP) status anytime during the hospital stay. If the physician admits the patient as inpatient but wishes to change the status to outpatient, the patient must be notified prior to discharge. Providers are admitting patients as inpatients when the clinical situation supports the use of outpatient observation in accordance with Medicare manual instructions.

Guidance on How Providers Can Avoid These Problems:

Outlined below are billing directions based on physician documentation:

- The Type of Bill (TOB) on the claim MUST match the physician order
  - Physician orders inpatient (IP), must bill IP (11x or 12x)
  - Physician orders observation (OBS) and there is no IP order, must bill OP
  - Physician orders neither, must bill outpatient (OP)
- Focus on the OBS order
  - If OBS is ordered, the facility cannot decide that the stay should be IP and bill IP unless there is a subsequent order to admit the patient by the physician responsible for the patient's care at the hospital.
  - If OBS is ordered and the patient is subsequently admitted based on an IP order, the admission must be medically reasonable and necessary (R&N) at the time the order is written. In this case, charges for OBS are included on the IP bill.
  - If IP is ordered, and the hospital wishes to change the patient to OBS, this can done using condition code (CC) 44—if the practitioner responsible for the care of the patient agrees to the change and the ***patient is notified prior to discharge.*** *Please review CMS, "Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: "Inpatient Admission Changed to Outpatient", MLN Matters® SE0622, April 2006 at http://www.cms.gov/MLNMattersArticles/downloads/SE0622.pdf on the Centers for Medicare & Medicaid Services (CMS) website.*
  - Observation is a set of services provided to determine if the patient requires to be admitted to the hospital. It is not a status.
  - No changes to a patient's status (IP order or CC44) may be made after the patient has been discharged.

Example 1: 69 year old female presented for an elective outpatient cystoscopy, excision of extruded sling, and insertion of Aris suburethral sling for recurrent urinary incontinence and was admitted and billed as an acute inpatient after the procedure. The patient's past medical history was significant for recurrent type 1 stress urinary incontinence with possible mild intrinsic sphincter dysfunction, sling extrusion beneath bladder base, mild pelvic relaxation, hypothyroidism, obesity, and recent urinary tract infection.

Past medical history and the pre-existing conditions were stable. The medical record did not document any exacerbation of pre-existing conditions or post-operative complications, that made the acute inpatient admission medically necessary.

In this case, there was no clinical evidence to suggest a need for a stay longer than 24 hours even if the surgeon wanted to watch the patient for an extended or overnight period after the procedure.

Medicare states that procedures that require less than 24 hours in the hospital should be considered outpatient. Moreover, the patient could also have been placed in observation if the physician was concerned about sending her home during the usual recovery period. If the patient's clinical status then changed, the patient could have been admitted as an inpatient at any time.

Example 2: A 73-year-old female patient presented on 03/30/2011 for a scheduled outpatient elective angioplasty of the renal artery and was admitted and billed as an acute inpatient after the procedure. The patient had a medical history of hypertension (HTN), hyperlipidemia, coronary artery disease/percutaneous cardiology intervention, chronic obstructive pulmonary disease, non-ruptured cerebral aneurysm, and diabetes mellitus. The notable events thru the patient's hospital admission: the patient's procedure was completed without any complications; an Activated Clotting Time (ACT) level of 140 which is within normal limits; #7 arterial sheath removed without any issues by surgical house doctor no hematoma, ecchymosis, bleeding, & pedal pulses 2+; nursing assistance required for patient's initial ambulation but patient remains independent with activities of daily living (ADLs).

After a medical review of the inpatient records, the medical record did not contain documentation to support the need for an inpatient stay such as an exacerbation of a pre-existing condition or post-operative complication. However, if the physician was not comfortable sending the patient home in the normal post operative recovery period, the physician could have placed the patient in observation. If her clinical status changed and complications developed, she could have been admitted as an inpatient at that time.

Additional Information

If you have any questions, please contact your FI or MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.