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CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The revised fact sheet titled "Sole Community Hospital" (October 2010), which provides information about Sole Community Hospital (SCH) classification criteria and SCH payments, is now available in print format from the Medicare Learning Network®. To place your order, visit http://www.cms.gov/MLNGenInfo, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page".

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Guidance on Hospital Inpatient Admission Decisions

Provider Types Affected

Inpatient Acute Care hospitals that bill Medicare contractors (Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries are affected.

What You Need to Know

It is important that any staff involved with the clinical decision to admit the patient stay abreast of all CMS national inpatient hospital policy and National and Local Coverage Determinations. Additionally, make sure medical documentation submitted demonstrates evidence of the clinical need for the patient to be admitted to the inpatient facility and fully and accurately identifies any subsequent care that was provided during the inpatient stay.

Background

Some hospitals have recently expressed concern about how the Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contractors (RACs), MACs, FIs, and the Comprehensive Error Rate Testing Contractor (CERT) are utilizing screening criteria to analyze medical documentation and make a medical necessity determination on inpatient hospital claims.

There are several commercially available screening tools that Medicare contractors in specific jurisdictions may use to assist in the review of medical documentation to determine if a hospital admission is medically necessary. These include Interqual, Milliman, and other proprietary systems.

CMS Policy Guidance

To assist hospitals regarding inpatient admission decisions, CMS would refer hospitals to the following:

Program Integrity Manual Guidance

Chapter 6, Section 6.5.1, of the Medicare Program Integrity Manual requires that contractor review staff use a screening tool as part of their medical review process for inpatient hospital claims. CMS does not require that the contractor use specific criteria nor endorse any particular brand of screening guidelines. CMS contractors are not required to pay a claim even if screening criteria indicate inpatient admission is appropriate Conversely, CMS contractors are not required to automatically deny a claim that does not meet the admission guidelines of a screening tool. In all cases, in addition to screening instruments, the reviewer shall apply his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.

For each case, the review staff will utilize the following when making a medical necessity determination

- Admission criteria;
- Invasive procedure criteria;
- CMS coverage guidelines;
- Published CMS criteria; and
- Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community).

NOTE: CMS considers the use of screening criteria as only one tool that should be utilized by contractors to assist them in making an inpatient hospital claim determination.

Chapter 6, Section 6.5.2, of the Medicare Program Integrity Manual states that the review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate

signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

The reviewer will consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission.

Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

Chapter 6 of the Medicare Program Integrity Manual, Section 6.5 is available at http://www.cms.gov/manuals/downloads/pim83c06.pdf on the CMS website.

Medicare Benefit Policy Manual Guidance

The Medicare Benefit Policy Manual, Chapter 1, Section 10 also contains relevant information regarding what constitutes an appropriate inpatient admission. According to that manual section, an inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight 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 a 24-hour period as a benchmark (i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis). 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 non-covered solely on the basis of the length of time the patient actually spends in the hospital.

Chapter 1, Section 10 of the Medicare Benefit Policy Manual is at http://www.cms.gov/manuals/Downloads/bp102c01.pdf on the CMS website.

Additional Information

Chapter 6 of the Medicare Program Integrity Manual, Section 6.5 is available at http://www.cms.gov/manuals/downloads/pim83c06.pdf and Chapter 1, Section 10 of the Medicare Benefit Policy Manual is at http://www.cms.gov/manuals/downloads/bp102c01.pdf on the CMS website.

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