Patient Status Training Toolkit for Medicare Utilization Review

SECOND EDITION

Kimberly A.H. Baker, JD, CPC

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Chapter 1

Medicare Requirements for Observation

Observation Services

Medicare covers observation care as an outpatient service under Part B. *The Medicare Benefit Policy Manual* defines observation as a “well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

Two key parts of this definition are the assessments and decision. Medicare mentions assessments and reassessments, presumably to emphasize the active period of care leading to the decision to discharge the patient or admit him or her as an inpatient. Once a decision has been made regarding the patient’s disposition, the care no longer meets this definition of observation, which becomes especially important if the decision has been made to discharge the patient to an alternate, lower level of care that is not available. In these cases, the continued care at a lower level, in lieu of discharge, does not meet the definition of observation because the decision to discharge the patient has been made.

Notices for these cases will be discussed in a later chapter.

Chapter 2

Medicare Requirements for Inpatient Admission

Inpatient Admission

Medicare makes payment under Part A for services provided to hospital inpatients. CMS has defined the conditions under which they believe Part A payment is appropriate for inpatients of hospitals. Generally, this includes:

- A valid inpatient order
- An expectation that the patient will require hospital care for two midnights, unless the patient is receiving an inpatient-only procedure or the physician has made a case-by-case determination to admit the patient
- A physician certification for cases that are 20 days or greater or cost outliers

CMS has provided the requirements for inpatient admission in *The Medicare Benefit Policy Manual,* Chapter 1, Section 10.2, and *The Medicare Program Integrity Manual,* Chapter 6, Section 6.5. Additionally, CMS has published an algorithm to assist their auditors on the Inpatient Hospital Reviews page of the CMS website. This algorithm is also helpful for hospitals in applying the 2-midnight benchmark.

Note that inpatient rehabilitation facilities (IRF) and inpatient psychiatric facilities (IPF) have separate requirements for coverage and certification respectively that must also be met. Refer to the IRF and IPF regulations and guidance.

Providers should verify coverage under national and local coverage determinations (NCD/LCD) even if the patient meets inpatient coverage criteria.

Inpatient Order Requirements

A patient is considered an inpatient of a hospital when they are formally admitted pursuant to a physician order for inpatient admission. The order must meet specific requirements to be considered a valid order. CMS has provided the requirements for inpatient orders in *The Medicare Benefit Policy Manual,* Chapter 1, Section 10.2.

Qualified ordering practitioner

A qualified ordering (admitting) practitioner must be licensed by the state and have privileges to admit to the hospital. Some practitioners may be able to admit patients to a hospital under their license, but are not permitted to admit patients under their hospital-granted privileges. Commonly, this includes ED physicians, residents, physician assistants, and nurse practitioners.

To the extent that a particular hospital has granted these individuals the ability to admit patients to the hospital, they will qualify as ordering practitioners. If they do not qualify, they may nevertheless be able to admit patients as a proxy for a qualified ordering practitioner.

A practitioner acting as a proxy for a qualified ordering practitioner may write an initial order for inpatient admission

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Chapter 3

Utilization Review Requirements and Processes

Conditions of Participation for Utilization Review

The Medicare *Conditions of Participation (CoPs)* require hospitals to have a utilization review (UR) plan in place to review the services furnished by the hospital and the members of the hospital's medical staff. The full scope of the *CoPs* for UR is beyond the scope of this handbook; however, more information can be found in the *CoPs* located at 42 *CFR* 482.30 and the *State Operations Manual,* Appendix A, Interpretive Guidelines and Survey Procedures for Tags A-0652 through A-0658 related to 42 *CFR* 482.30.

Section (b) of the *CoPs* for UR specifies the UR committee is a committee of the medical staff or may be a group outside the hospital established by a local medical society or in another manner approved by CMS. The membership must consist of at least two doctors of medicine or osteopathy. Other specified practitioners listed in 42 C*FR* 482.12 (c)(1) may be on the UR committee as appropriate, including:

- Doctor of dental surgery or dental medicine
- Doctor of podiatric medicine

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The ***Patient Status Training Toolkit for Medicare Utilization Review, Second Edition*** is a quick-reference handbook and pocket card that will serve as an everyday guide to utilization review (UR).

The handbook is a practical guide that UR committee members can keep at their desk to refer to as they work through UR processes. It offers an overview of regulatory requirements for UR in addition to case studies that can help guide committee members through real-world situations.

The pocket card is an easy-to-digest reference that uses a flow chart and helpful tips to walk UR committee members through the process of verifying patient status determinations. If the UR committee member reviews a case and determines the patient's status must be changed, the pocket card will offer guidance on this process through days one and two, if applicable.

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