Health Care Alert: CMS Clarifications to Medicare Requirements for Inpatient Admission Orders Reflect Promising Development for Hospitals

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Effective October 1, 2018, the Centers for Medicare and Medicaid Services (CMS) implemented important changes to the Medicare Inpatient Prospective Payment System (IPPS) affecting the documentation of hospital inpatient admissions. Specifically, as provided in the 2019 IPPS final rule, CMS removed a regulatory provision that required physician orders for inpatient admission to "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."[1] **Although a physician order is still expected to substantiate that an inpatient admission is medically necessary, if the order is verbal, and/or if written documentation of the order fulfilling all technical requirements is not present in the medical record, the services may still be eligible for payment under Medicare Part A.**

Given that claim denials based on alleged non-compliance with the requirements for inpatient admission affect all services rendered to the patient during the related inpatient stay, this change is particularly noteworthy for hospitals across the country. Also of interest are CMS' comments to the 2019 IPPS final rule recognizing that Medicare Recovery Audit Contractors (RACs) have been inappropriately denying Part A claims based solely on "technical discrepancies," such as missing or late signatures.

According to CMS, in the "extremely rare circumstance" that the admission order is missing or defective, but the "intent, decision, and recommendation of the ordering physician" can be clearly determined from the medical record, RACs have – and, since this condition of payment was first added, have had – "discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record." Nonetheless, RACs have repeatedly denied Part A claims based on technical non-compliance in documentation, including non-compliance with little-known 2014 sub-regulatory guidance stating that the admission order must be authenticated before the patient is

discharged. Explaining its revisions in the 2019 IPPS final rule, CMS stated that "[i]t was not our intent when we finalized the admission order documentation requirements that they should by themselves lead to the denial of payment for medically reasonable and necessary inpatient stays."

CMS' comments reflect both (1) the tendency of RACs to enforce regulatory requirements inflexibly and in a manner that is not necessarily informed by best practices in patient care or the practical realities of delivering patient care, and (2) the significant impact of "sub-regulatory" Medicare guidance on hospitals' ability to receive payment for otherwise appropriately rendered services. With respect to the former issue, hospitals are encouraged **not** to simply accept the initial findings of a RAC when claims are denied, but rather to carefully evaluate the authority relied on for denial, and any potential arguments that the applicable requirements were constructively satisfied.

The latter issue is particularly timely in light of the U.S. Supreme Court's recent grant of review in *Allina Health Services v. Azar*, in which the D.C. Circuit Court of Appeals held that the U.S. Department of Health and Human Services (HHS) was required to follow formal rule-making procedures in changing the Disproportionate Share Hospital (DSH) reimbursement adjustment calculation method. Under Medicare, formal rule-making is required to give the force of law to any requirement that changes a substantive legal standard governing payment for services. Because the *Allina* court found that (1) the DSH adjustment percentage "readily" met this standard and (2) Medicare does not incorporate the Administrative Procedure Act's exception for interpretive rules, this holding, if affirmed, could give providers powerful new authority with which to challenge claims denials based solely on non-compliance with provider manuals and other informal guidance.

If you have questions about the revised inpatient admission order requirements, the impact of the *Allina* holding on a Medicare appeal, or the reimbursement appeals process generally, please feel free to contact Jolie Havens, Matt Albers, Liam Gruzs, Mairi Mull, or your regular Vorys attorney.

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[1] 42 C.F.R. § 412.3(a) (as effective 11/13/2015 through 9/30/2018).