



January 30, 2014

Hospital Inpatient Admission Order and Certification

As a condition of payment for hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis. The order to admit as an inpatient (“practitioner order”) is a critical element of the physician certification, and is therefore also required for hospital inpatient coverage and payment under Part A. The physician certification, which includes the practitioner order, is considered along with other documentation in the medical record as evidence that hospital inpatient service(s) were reasonable and necessary. When a physician signs the certification, they are certifying that inpatient hospital services were reasonable and necessary.

The following guidance applies to all inpatient hospital and critical access hospital (CAH) services unless otherwise specified. For the remainder of this guidance, when we refer to hospitals, we are also referring to CAHs. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B and 42 CFR 412.3. An electronic version of the CFR is available online at:

http://www.ecfr.gov/cgi-bin/text-idx?sid=0ccf28130d181e0b9118119c2b4d40ed&c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl.

A. Physician Certification. For physician certification of inpatient services of hospitals other than inpatient psychiatric facilities:

- 1. Content:** The physician certification includes the following information:
 - a.** Authentication of the practitioner order: The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and in the case of services not specified as inpatient-only under 42 CFR 419.22(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark. The requirement to authenticate the practitioner order may be met by the signature or countersignature of the inpatient admission order by the certifying physician.
 - b.** Reason for inpatient services: The physician certifies the reasons for either— (i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for outlier cases under the applicable prospective payment system for inpatient services. For example, documentation of an admitting diagnosis could fulfill this part of the certification requirement.
 - c.** The estimated (or actual) time the beneficiary requires or required in the hospital: The physician certifies the estimated time in the hospital the beneficiary requires (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed at discharge). Estimated or actual length of stay is most commonly reflected in the progress notes where the practitioner discusses the assessment

and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, 42 CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

- d. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.
- e. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Time as an outpatient at the CAH does not count towards the 96 hours requirement. The clock for the 96 hours only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour inpatient limit.

If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH and something unforeseen occurs that causes the individual to stay longer at the CAH, there would not be a problem with regards to the CAH designation as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay.

- f. Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

2. **Timing:** Certification begins with the order for inpatient admission. The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. With regard to the time of discharge, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the physician as having to occur prior to discharge (e.g., "discharge after supper" or "discharge after voids"). So discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the physician's order for discharge is effectuated.

3. **Authorization to sign the certification:** The certification or recertification may be signed only by one of the following:

- (1) A physician who is a doctor of medicine or osteopathy.
- (2) A dentist in the circumstances specified in 42 CFR 424.13(d).
- (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.

Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff (or by the dentist as provided in 42 CFR 424.11). Medicare considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician: the admitting physician of record ("attending") or a physician on call for him or her; a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her; a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above. The admitting physician of record may be an emergency department physician or hospitalist. Medicare does not require the certifying physician to have inpatient admission privileges at the hospital.

- 4. Format:** As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.

B. Inpatient Order: A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner. As we stated in the CY 2014 IPPS final rule, if the order is not properly documented in the medical record, the hospital should not submit a claim for Part A payment (78 FR 50941). Meeting the 2 midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A. Rather, as provided in our regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by a physician or other required practitioner.

1. **Content:** The practitioner order contains the instruction that the beneficiary should be formally admitted for hospital inpatient care. The order must specify admission for inpatient services. Inpatient rehabilitation facilities (IRFs) also must adhere to the admission requirements specified in 42 CFR 412.622, and the 2-midnight benchmark does not apply in IRFs.
2. **Qualifications of the ordering/admitting practitioner:** The order must be furnished by a physician or other practitioner ("ordering practitioner") who is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision. The ordering practitioner is not required to write the order but must sign the order reflecting that he or she has made the decision to admit the patient for inpatient services.

The ordering practitioner may be, but is not required to be, the physician who signs the certification. Please see section (B)(3) for a discussion of the requirements to be knowledgeable about the patient's hospital course. See section (A)(3) for the list of physicians authorized to certify a given case.

The admission decision (order) may not be delegated to another individual who is not authorized by the state to admit patients, or has not been granted admitting privileges by the hospital's medical staff (42 CFR 412.3(b)). However, a medical resident, a physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner provided they are authorized under state law to admit patients and the requirements outlined below are met.

- a. **Residents and non-physician practitioners authorized to make initial admission decisions-** Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same. The ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by countersigning the order prior to discharge. (Please see (A)(2) for guidance regarding the definition of discharge time and (B)(3) for more guidance regarding knowledge of a patient's hospital course). In countersigning the order, the ordering practitioner approves and accepts responsibility for the admission decision. This process may also be used for physicians (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or "bridge" inpatient admission orders.

The countersigned order satisfies the order part of the physician certification, as long as the ordering practitioner also meets the requirements for a certifying physician in section (A)(3).

- b. Verbal orders-** At some hospitals, practitioners who lack the authority to admit inpatients under state laws and hospital by-laws (such as a registered nurse) may nonetheless enter the inpatient admission order as a verbal order. In these cases, the ordering practitioner directly communicates the inpatient admission order to staff as a verbal (not standing) order, and the ordering practitioner need not separately record the order to admit. Following discussion with and at the direction of the ordering practitioner, a verbal order for inpatient admission may be documented by an individual who is not qualified to admit patients in his or her own right, as long as that documentation (transcription) of the order for inpatient admission is in accordance with state law including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. In this case, the staff receiving the verbal order must document the verbal order in the medical record at the time it is received. The order must identify the qualified “admitting practitioner”, and must be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge. (Please see (A)(2) for guidance regarding the definition of discharge time).

A transcribed and authenticated verbal order for inpatient admission satisfies the order part of the physician certification as long as the ordering practitioner also meets the requirements for a certifying physician in section (A)(3).

Example: “Admit to inpatient per Dr. Smith” would be considered an acceptable method of identifying the ordering practitioner and would meet the verbal order requirement if the verbal order (1) is appropriately documented in the medical record by the individual receiving the verbal order when the order is received; and (2) is authenticated (countersigned) by Dr. Smith promptly, prior to discharge. If Dr. Smith meets the qualifications for a certifying physician, then the authentication (countersignature) of this order by Dr. Smith also meets the requirement for the order component of the certification.

- c. Standing orders and protocols-** The inpatient admission order cannot be a standing order. While Medicare’s rules do not prohibit use of a protocol or algorithm that is part of a protocol, only the ordering practitioner, or a resident or other practitioner acting on his or her behalf under section (B)(2)(a) can make and take responsibility for the inpatient admission decision.
- d. Commencement of inpatient status-** Inpatient status begins at the time of formal admission by the hospital pursuant to the physician order, including an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)) that is countersigned timely, by authorized individuals, as required in this section. If the physician or other practitioner responsible for countersigning an initial order or verbal order does not agree that inpatient admission was appropriate or valid (including an unauthorized verbal order), he or she should not countersign the order and the beneficiary is not considered to be an inpatient. The hospital stay may be billed to Part B as a hospital outpatient encounter.

- 3. Knowledge of the patient’s hospital course:** Medicare considers only the following practitioners to have sufficient knowledge about the beneficiary’s hospital course, medical plan of care, and current condition to serve as the ordering practitioner: the admitting physician of record

("attending") or a physician on call for him or her, primary or covering hospitalists caring for the patient in the hospital, the beneficiary's primary care practitioner or a physician on call for the primary care practitioner, a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her, emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission, and other practitioners qualified to admit inpatients and actively treating the beneficiary at the point of the inpatient admission decision. Although a utilization review committee physician may sign the certification on behalf of a non-physician admitting practitioner, a practitioner functioning in that role does not have direct responsibility for the care of the patient and is therefore not considered to be sufficiently knowledgeable to order the inpatient admission. The order must be written by one of the above practitioners directly involved with the care of the beneficiary, and a utilization committee physician may only write the order to admit if he or she is not acting in a utilization review capacity and fulfills one of the direct patient care roles, such as the attending physician. Utilization review may not be conducted by any individual who was professionally involved in the care of the patient whose case is being reviewed (42 CFR 482.30(d)(3)).

4. **Timing:** The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (e.g., for a pre-scheduled surgery), but the inpatient admission does not occur until formal admission by the hospital. Conversely, in the unusual case in which a patient is formally admitted as an inpatient prior to an order to admit and there is no documented verbal order, the inpatient stay should not be considered to commence until the inpatient admission order is documented. Medicare does not permit retroactive orders. Authentication of the order is required prior to discharge and may be performed and documented as part of the physician certification.
5. **Specificity of the Order:** The regulations at 42 CFR 412.3 require that, as a condition of payment, an order for inpatient admission must be present in the medical record. The preamble of the FY 2014 IPPS Final Rule at 78 FR 50942 specifies that, "the order must specify the admitting practitioner's recommendation to admit 'to inpatient,' 'as an inpatient,' 'for inpatient services,' or similar language specifying his or her recommendation for inpatient care." While we are not requiring specific language to be used on the inpatient admission order, we believe that it is the interest of the hospital that the admitting practitioner use language that clearly expresses intent to admit the patient as inpatient that will be commonly understood by any individual that could potentially review documentation of the inpatient stay. We do not recommend using language that may have specific meaning individuals that work in the hospital (e.g. "admit to 7W") that will not be commonly understood by others.

Treatment of such admission orders as properly inpatient is consistent with CMS' historical interpretation of inpatient admission orders and hospitals' historical standards of practice. However, if the usage of the order to specify inpatient or outpatient status is ambiguous, the hospital is encouraged to obtain and document clarification from the physician before initial Medicare billing (ideally before the beneficiary is discharged). Under this policy, CMS will continue to treat orders that specify a typically outpatient or other limited service (e.g., admit "to ER," "to Observation," "to Recovery," "to Outpatient Surgery," "to Day Surgery," or "to Short Stay Surgery") as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.

The admission order is evidence of the decision by the physician (or other practitioner who can order inpatient services) to admit the beneficiary to inpatient status. In extremely rare circumstances, the order to admit may be missing or defective (that is, illegible, or incomplete, for example "inpatient" is not specified), yet the intent, decision, and recommendation of the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these extremely rare situations, we have provided contractors with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the physician order, there can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.

This narrow and limited alternative method of satisfying the requirement for documentation of the inpatient admission order in the medical record should be extremely rare, and may only be applied at the discretion of the medical review contractor. Even in those circumstances, all requirements for the other components of the physician certification must be met.