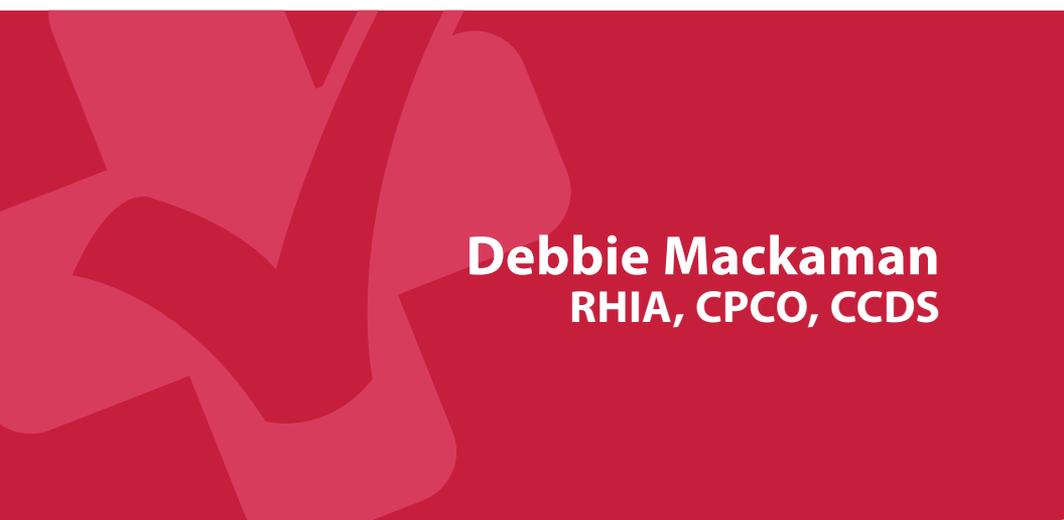




HCP Pro's  
**Medicare Compliance  
Training Handbook**

# **Inpatient-Only Procedures**



**Debbie Mackaman**  
RHIA, CPCO, CCDS



HCP Pro's

# Medicare Compliance Training Handbook

## **Inpatient-Only Procedures**

**Debbie Mackaman, RHIA, CPCO, CCDS**

HCP Pro

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# About the Author

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Debbie Mackaman, RHIA, CPCO, is the lead instructor for HCPro's Medicare Boot Camp®—Critical Access Hospital Version and Rural Health Clinic Version and an instructor for the Hospital Version and Utilization Review Version. Mackaman serves as a regulatory specialist for HCPro's Medicare Watchdog services, specializing in regulatory guidance on coverage, billing, and reimbursement. She has more than 24 years of experience in the healthcare industry, including inpatient and outpatient prospective payment systems (IPPS, OPSS), critical access hospital (CAH) and rural health clinic (RHC) documentation, coding, billing, and reimbursement issues. She has held the positions of compliance officer and director of health information services for healthcare systems.

Mackaman consults with hospitals, physicians, and other healthcare providers on a wide range of revenue cycle issues, including high-risk areas identified by government program auditors. She has expertise in conducting coding and billing compliance audits, charge description master reviews and maintenance, and providing oversight of documentation improvement programs.

Mackaman holds a bachelor's degree in health information administration and is certified in healthcare compliance. She is

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## CHAPTER 1

# Inpatient-Only Procedure Regulations

Identifying inpatient-only procedures can be a complex process and might easily cause confusion between departments in hospitals, and between hospitals and external auditors. Because inpatient-only procedure rules contradict Medicare's general rules for inpatient admissions, clinical staff may schedule and perform an inpatient-only procedure without making sure an inpatient admission order is provided.

Properly coordinating inpatient-only procedures requires cooperation, communication, and awareness across multiple departments. Recent regulatory changes and the expansion of the three-day payment window have reduced some of these problems, but certain criteria and time limits must still be met or payment will be denied.

Fortunately, inpatient-only procedures are guided by a few simple rules that can be applied in any setting. Ensuring that all departments that touch on this aspect of patient care—from clinical staff to revenue management and administration—understand inpatient-only rules will allow a hospital to create clear policies and procedures for handling these patients. Knowing the guidelines and criteria for exceptions to the general

inpatient-only rule, such as procedures performed on an unplanned or emergency basis, will allow clinical staff to remain focused on patient care while making sure the hospital minimizes delays and disruptions to revenue.

The basic inpatient-only rule is simple: **Certain surgeries may only be performed on patients who have been admitted as inpatients, or Medicare will not pay the hospital for the outpatient surgery or any other services provided on that day.** Keep this basic guideline in mind as we discuss the details of the regulation, finding and using inpatient-only resources, exceptions to the rule, and how to implement it.

## What Is the CMS Regulation?

---

Inpatient-only procedures are surgeries that, outside of certain circumstances, must be performed on an inpatient basis, according to CMS (2003). For example, cardiac bypass surgery is an obvious inpatient-only procedure, but so are certain procedures that may be performed as a sometimes unplanned add-on during a planned outpatient surgery. For example, a patient may be scheduled as an outpatient for a laparoscopic assisted vaginal hysterectomy, and during the surgery, a fallopian tube must be removed, which falls on the inpatient-only procedure list.

In most circumstances, if an inpatient-only procedure is performed on an outpatient, no payment will be made for the inpatient-only procedure or for any other services provided on the same date as the inpatient-only procedure (CMS, 2016: Chapter 4, Section 180.7). This is done because if the patient had been

admitted, all items listed on the claim would have been paid under one Medicare severity diagnosis-related group (MS-DRG), which is how CMS routinely pays inpatient services. However, if an inpatient-only procedure is performed on an outpatient, CMS can't apply its usual payment rules. Therefore, CMS denies all services and procedures on the claim.

<b>DRGs and MS-DRGs</b>
DRGs are a system used to classify illnesses and injuries and their treatment in hospitals into like groups based on the services provided. MS-DRGs are a refined version of the DRG system adapted by CMS.

Inpatient-only procedure regulations are payment rules, not coverage rules. When CMS developed the outpatient prospective payment system (OPPS) payment rates, the rates were based on payment data collected from the two previous years. If a procedure was usually performed only on an inpatient basis during those two years, CMS had no data on which to base an outpatient payment rate. Therefore, CMS determined that, if these procedures were performed on an outpatient basis, the claim would be denied because it couldn't identify an appropriate payment rate.

Although the inpatient-only rules still primarily govern reimbursement, CMS does consider patient safety and quality of care when it decides to add or remove procedures from the inpatient-only list.

It's important to note that a patient is considered an outpatient until he or she is formally admitted with a valid order by a practitioner with admitting privileges at the hospital. Admission

orders should be obtained before an inpatient-only procedure is performed. CMS allows for certain exceptions to this rule. These exceptions to the regulation will be covered in Chapter 2.

### **Outpatient Prospective Payment System**

The inpatient-only procedure regulation is published in the OPSS proposed and final rules.

The OPSS is the Medicare payment system developed by CMS. It defines what services Medicare may pay for and sets the payment logic and rates. The OPSS applies only to outpatient services. A different system, the inpatient prospective payment system, is used for inpatient services.

The inpatient-only list is published in the OPSS, even though those procedures must be performed on inpatients (CMS, 2016: Hospital outpatient payment prospective system).

## **How Are Inpatient-Only Procedures Identified, Added, and Deleted?**

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An inpatient-only procedure is one that CMS has determined can only be safely performed on an inpatient basis because of (CMS, 2016: Chapter 4, Section 180.7):

- The invasive nature of the procedure
- The need for at least 24 hours of postoperative recovery time or monitoring before the patient can be discharged
- The underlying physical condition of the patient

CMS reviews the inpatient-only list during the annual OPSS rulemaking process, adding or removing procedures from the inpatient-only list at that time. During this review process, new

procedures are examined for possible inclusion on the inpatient-only list, and procedures on the existing list are considered for removal. Procedures can be removed if:

- Most outpatient surgery departments are able and equipped to provide the service
- The simplest procedure defined by the code is permitted to be performed on an outpatient
- The procedure is related to codes that have been removed from the inpatient-only list
- CMS determines that the procedure is being successfully performed on outpatients in many hospitals

Inpatient-only procedures are defined by HCPCS codes, but are billed using ICD-10-PCS codes when the patient is properly admitted as an inpatient. To complicate matters, when an external auditor reviews a short-stay inpatient case, the reviewer might not translate the ICD-10-PCS code back to the inpatient-only HCPCS code, resulting in a denied inpatient claim that must be appealed. To prevent costly delays in appropriate reimbursement during the appeals process, identification of an admission due to the inpatient-only procedures regulation should be supported with strong documentation.

Although it may seem counterintuitive, claims with an inpatient-only procedure that was performed on an outpatient should be submitted to Medicare. Payment for the services will be denied. However, CMS will use this data to help decide whether a procedure should be taken off the inpatient-only procedure list in the future.

## Staying Up to Date on Annual Changes

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A new inpatient-only procedure list is published each year in Addendum E of the OPPS final rule. A discussion of changes made to the inpatient-only procedure list, and proposed changes that were rejected, is included as a section in the OPPS final rule usually called “Procedures Paid Only on an Inpatient Basis.” Search the OPPS final rule for these key terms to read CMS’ justifications and reasoning behind adding or removing codes from the list.

Proposed rules are open for public comment for a specified period of time before they are finalized. The OPPS proposed rule is published in August and the final rule is usually published in November of the year before it becomes effective. For example, the 2016 OPPS final rule was published on November 13, 2015, and was effective on January 1, 2016. The comment period allows providers the opportunity to submit remarks about changes to the inpatient-only list based on their clinical experiences.

Updates to rules and regulations that affect inpatient-only procedures can be published throughout the year. For example, *Transmittal 3238*, published April 22, 2015, had a significant impact on inpatient-only procedures (CMS, 2015). This update to the OPPS expanded the three-day payment window to include inpatient-only procedures. Previously, surgeries on the inpatient-only procedure list were specifically excluded from being covered under the three-day payment window. *Transmittal 3238* removed the language excluding inpatient-only procedures, and

CMS confirmed that the change means inpatient-only procedures can be covered services under the three-day payment window. For more information on the three-day payment window, see Chapter 2.

Throughout the year, updates affecting inpatient-only procedures can come in any transmittal that makes changes or clarifications to the OPPS regulations. Providers must also stay up to date on changes to the regulations governing inpatient admission orders, commonly found in the IPPS rules and related guidance. Stay current on all Medicare communications and read transmittals carefully.

## **Locating the Inpatient-Only Procedure List**

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While the inpatient-only procedure list is published as part of the OPPS rules and can be found in both Addenda E and B, Addendum E should be the primary resource for finding inpatient-only procedures. Addendum B, which is updated quarterly, is an alternative way of finding inpatient-only procedures and some staff might be more familiar with it. This addendum lists all of the HCPCS codes, and the inpatient-only procedures are identified with a status indicator (SI) of “C.” Both of these addenda can be downloaded from CMS by going to the OPPS final rule page for the calendar year and downloading the Addenda.zip file.

At first glance, Addenda E and B appear to be very long. The key is to edit the table to show only the procedures performed at a particular facility, which can shorten the list considerably. If

using Addendum B, the file should be sorted by the SI column to group the “C” (inpatient-only) codes together first, and then the data can be copied to a separate spreadsheet for further editing.

The Addenda for OPPS 2016 can be downloaded by going to the final rule page ([www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending)) and looking under the Related Links section for 2016 OPPS Final Rule Addenda ([www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1633-FC-2016-OPPS-FR-Addenda.zip](http://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1633-FC-2016-OPPS-FR-Addenda.zip)). Select “Accept” for the download to begin.

Once you have downloaded and extracted the files, you will be able to open the Addenda folder. Inside will be two versions of each Addendum: a .txt document and an .xlsx spreadsheet.

Addendum E lists only the final HCPCS codes for all inpatient-only procedures.

## **Inpatient Order Requirements**

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The clinical decision to admit a patient is complicated and many different elements come into play. The patient’s well-being and outcome must be the primary factor in that decision. Certain documentation requirements must be met when a patient is admitted and the time inpatient admission orders are considered effective should be noted.

Hospital staff who monitor the process for identifying inpatient-only procedures should pay careful attention to the timing of the

inpatient admission order. If the order is written by the admitting physician, surgeon, or NPP before the patient presents at the hospital, the time of admission is when the patient is formally admitted. If the order is written after the patient has arrived at the hospital, the time of admission is the time of the order.

Verbal inpatient admission orders are effective at the time the verbal order is given, and are only valid when transcribed by the appropriate staff.

If an initial inpatient admission order is written by a proxy provider and countersigned by an ordering physician or NPP, the time of admission is the time of the initial order. Regardless of which practitioner is responsible for the order to admit, the order must be signed prior to discharge to be eligible for payment under Part A. CMS auditors, including Medicare Administrative Contractors (MACs), will ignore an inpatient admission order as if it wasn't present in the documentation if it's not signed and authenticated (CMS, 2016: CMS-1633-FC; CMS-1607-F2).

In an ideal situation, inpatient admission orders are written before an inpatient-only procedure is performed. Inpatient admission orders cannot be backdated or timed (CMS, 2016: *Medicare Program Integrity Manual*, and *Medicare Claims Processing Manual*). Admission orders must be given before an inpatient-only procedure is performed, except in certain circumstances. See Chapter 2 for more information on these exceptions.

Patients can't be admitted after they have been discharged or transferred to another hospital. If the patient is discharged or transferred before he or she could be formally admitted, the

patient will remain an outpatient. See Chapter 2 for more information.

A hospital's inpatient admission policy should detail all of these requirements and allow physicians and non-physician practitioners (NPP) to make decisions that are in the best interest of the patient while meeting the complex Medicare regulations through sound documentation.

### **What Is an Inpatient?**

An inpatient is a patient who has been formally admitted following an inpatient admission order from a physician or NPP with admitting privileges at that facility. Inpatient admission orders must be properly documented and kept in the patient's medical record. Without this order, the patient can't be considered an inpatient and will remain an outpatient (U.S. Government Publishing Office, 2016, and CMS, 2016: Chapter 3, Section 40.2.2). A patient is admitted if the attending practitioner thinks he or she needs a level of care that is better provided as an inpatient rather than as an outpatient. For example, a patient who is experiencing moderate chest pain may not be admitted as an inpatient and could be observed as an outpatient, but a patient who is having an acute myocardial infarction is likely to be admitted. CMS uses different payment methodologies and rules for inpatients and outpatients.

Only a qualified, licensed physician or NPP may write an inpatient admission order. The practitioner must have admitting privileges at the facility and must be familiar with the patient's condition. In other words, the practitioner must be involved in the patient's care (U.S. Government Publishing Office, 2016).

Admitting physicians or NPPs could include:

- A surgeon performing an emergency inpatient-only procedure on a patient
- A hospitalist
- The patient's primary care provider who has admitting privileges at the hospital

For example, if a patient goes to his or her physician's office because he or she has the flu and the physician determines the patient's condition is severe enough to require inpatient care at a hospital, the physician may arrange for the patient to be admitted to the hospital at which the physician has admitting privileges.

In accordance with the 2-midnight rule and its exceptions, the physician or NPP should order inpatient care if:

- He or she reasonably expects that the patient will need at least two consecutive midnights of medically necessary hospital care
- The patient is receiving an inpatient-only procedure

A physician or NPP can also decide to admit a patient based on his or her clinical judgment, supported by the medical documentation, even if the expected length of stay is less than two midnights.

The medical record should clearly support the decision to admit the patient based on this guidance and whether it's medically necessary to do so. CMS' guidelines for determining medical necessity address (U.S. Government Publishing Office, 2016):

- 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 are performed as outpatient services (i.e., they do 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
- The availability of diagnostic procedures at the time when and at the location where the patient presents

**Admitting Patients for Planned  
Inpatient-Only Procedures**

A simple rule is that a planned inpatient-only procedure should always trigger an inpatient admission order prior to the performance of the procedure, regardless of how long the patient is expected to be at the hospital.

## **Inpatient-Only Pain Points**

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Several points relating to inpatient-only procedures have caused considerable confusion. Only the hospital's payment is affected by the inpatient-only rules. In general, a physician will still be paid even if he or she performs an inpatient-only procedure on an outpatient. This can make it difficult to ensure physicians comply with these regulations. See Chapter 3 for more information addressing this issue.

Additionally, physicians and clinical staff are usually directed by CMS to base admission decisions on the 2-midnight rule. However, the inpatient-only procedure regulation takes precedence over the 2-midnight rule. All procedures on the inpatient-only procedure list must be performed as an inpatient, regardless of how long the patient is expected to be in the hospital.

Physicians and other clinical staff may not have the time to consider whether a procedure they're performing is on the inpatient-only list. For example, clinical staff who are treating a trauma patient must remain focused on patient care and stabilization and will not be debating whether a lifesaving procedure is on the inpatient-only list. Fortunately, exceptions exist for procedures performed on an emergency basis; however, certain criteria must still be met, or payment will be denied.

In other cases, a planned outpatient procedure may unexpectedly turn into an inpatient-only procedure in the middle of the surgery. Again, in these cases, physicians and other staff must focus their attention on patient care. Exceptions covering certain inpatient-only procedures performed in combination with other outpatient procedures may apply in these cases if certain criteria are met.

Keep in mind that CMS' inpatient-only procedure list is distinct from other inpatient-only procedure lists, such as criteria-based inpatient-only procedure lists or third-party insurer lists. These lists can be contradictory, adding another layer of complexity. This handbook addresses only CMS' inpatient-only regulation.

Several of these issues will be addressed in Chapters 2 and 3.

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A large, abstract teal graphic at the top of the page, consisting of several overlapping, curved shapes that resemble stylized letters or organic forms.

Compliance with Medicare rules for inpatient-only procedures is a real challenge for hospitals. Staff members from patient access/registration, billing, CDI, utilization review, case management, and compliance all play a role in ensuring patients receiving these procedures are handled properly—and billed for correctly. There are also complexities related to unplanned emergency procedures and procedures that change midway through a surgery.

The ***Inpatient-Only Procedures*** training handbook, by nationally recognized and respected regulatory specialist Debbie Mackaman, RHIA, CPCO, CCDS, analyzes the regulations and provides practical information, strategies, and best practices for ensuring compliance and preventing denials and lost revenue.

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