

Documenting Medical Necessity

1. Inpatient admission must be supported by documentation of medical necessity.
2. Review Inpatient Only List – these procedures are found at [cms.gov](https://www.cms.gov).
3. Medical necessity of inpatient status can be supported with the following risk factors (but not limited to):
 - Age \geq 75 years
 - BMI \geq 40 kg/m²
 - Charlson Score \geq 2
 - American Society of Anesthesiologists (ASA) Score \geq III
 - Preoperative Hemoglobin < 12g/dl
 - Home Social Support RAPT score < 9
 - High-risk patients include:
 - Chronic opioid use
 - Cardiopulmonary disease
 - Diabetes Mellitus
 - Advanced cirrhosis
 - Therapeutic anticoagulation
 - Ambulatory status requiring walking aids (walker, cane, crutches, etc.)
 - Morbid Obesity +/- Obstructive Sleep Apnea (OSA)
 - Chronic Kidney Disease (CKD)
 - Chronic Respiratory Failure
 - Chronic Systolic/Diastolic Heart Failure (HF)

Note: a high-risk patient often has a combination of these conditions.

4. **Physician documentation is what matters!** It is **physician DOCUMENTATION** of the factors that make the patient appropriate for inpatient.

Examples of documentation that supports inpatient stay:

- Because of their morbid obesity (**list BMI**), and elevated cardiovascular risks (**list specific cardiovascular risks**), an inpatient stay is necessary. **Because of the findings listed below, I am going to admit this patient as an inpatient.**
 - List co-morbidities such as chronic heart failure with worsening shortness of breath, and increased lower extremity edema
 - Note specific lab values and imaging results pertaining to cardiovascular risks
 - Examples: BNP, troponin, chest x-ray, any EKG abnormalities
 - List medications prescribed as home or outpatient regimen that have failed as a therapy
 - Because of their co-morbidities (**give specific examples**) such as morbid obesity and sleep apnea requiring post-op oxygen (list oxygen ___ ml/L) or BIPAP, pain uncontrolled and requiring IV pain medication (list drug, dose, frequency) of Morphine 4mg IVP every 3 hours, monitoring for return of bowel function. **I expect this patient to require a greater than a two midnight stay so will admit the patient as an inpatient.**
5. If a patient has Traditional Medicare/Medicaid and you expect they will stay > 2 midnights due to comorbidities/medical necessity, that patient should be boarded as inpatient (IP). Ensure there is complete documentation of reasons the patient will need a 2 midnight stay.

6. Important Definitions:
 - **Ambulatory:** Anticipate discharge from PACU post procedure.
 - **Extended Recovery:** A 4-to-6-hour time frame in PACU post procedure that is billed as recovery room services.
 - **Outpatient in a Bed:** A status that is used following extended recovery when criteria for observation are not met.
 - **Observation:** A status that is used following extended recovery on the basis of medical criteria if a patient may remain hospitalized less than 2 midnights.
 - **Inpatient:** A status that is determined by being on the Medicare Inpatient Only list or by complex medical factors that necessitate an inpatient stay. Complex medical patients generally require a greater than 2 midnight stay for Traditional Medicare/Medicaid.
 - **Condition Code 44:** A code used when an inpatient admission has been downgraded to observation, using appropriate criteria for certain payers. This requires the attending physician and Care Management medical director to agree on downgrade.
7. If a patient is not a candidate for an outpatient surgery center, document clearly and specifically (the more documentation, the better) why they are not - what makes them high risk that they need to go to the hospital.
8. In the end, it may be necessary to connect with the physician for a status change because the patient's particular payer does not follow Traditional Medicare rules.