The inpatient list

by Vinita M. Ollapally, JD

This column describes the Centers for Medicare & Medicaid Services’ (CMS) inpatient list and CMS’ policies for payment of services that are either included or not included on this listing. Although the inpatient list directly affects Medicare reimbursement to hospitals and other patient care centers, surgeons should be aware of the inpatient list, because the inclusion of services on the list could affect interactions with their hospitals.

What is the inpatient list?
The Social Security Act allows CMS to define services that are appropriate for payment under the Outpatient Prospective Payment System (OPPS). Under this authority, CMS also identifies services that should be performed in the inpatient setting. These services are itemized on the inpatient list, also known as the inpatient-only list.

The inpatient list is a litany of services for which Medicare will only reimburse hospitals if the services are provided in the inpatient setting. Services are included on this list based on the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be discharged safely.

Medicare will not pay the facility for inpatient list services if they are provided outside of the inpatient setting, such as in a hospital outpatient department, an ambulatory surgical center (ASC), or a physician’s office. However, the inpatient list does not affect physician reimbursement. If the medical record documents the medical necessity of a service, taking into consideration any Medicare coverage policy requirements, then the physician will typically receive the Medicare Part B reimbursement for an inpatient list service, regardless of the setting.

The services on the inpatient list are predominately surgical services and are expressed in terms of Current Procedural Terminology (CPT) codes.* CMS maintains and updates the list annually as part of the OPPS rulemaking process.

If a service is not on the inpatient list, will Medicare still reimburse a physician and a hospital for providing that service in the inpatient setting? Generally, yes. Procedures that are not on the inpatient list may be performed in either the inpatient or outpatient setting. As long as the medical record shows that the service was medically necessary, the physician and the hospital will be reimbursed. In other words, inclusion on the inpatient list is not a prerequisite for physician or hospital reimbursement if a physician determines the service should be provided in the inpatient setting.

It is important to note, however, that other factors could potentially prevent a hospital from receiving full reimbursement for services provided in the inpatient setting that are not on the inpatient list. For example, a Medicare recovery audit contractor might determine that an inpatient admission was not medically necessary. To protect the hospital’s reimbursement in an audit, surgeons should clearly document both the medical necessity of the procedure as well as the medical necessity of the inpatient admission.

Although CMS’ rules state that the decision to admit a patient is a medical one based on many factors and that hospitals must obtain concurrence from the practitioner responsible for the care of the patient before changing the patient’s status from inpatient to observation, both facilities and physicians often misunderstand these rules. As such, the ACS is actively working to encourage CMS to clearly define the rules regarding patient status and is
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offering recommendations to CMS on how the rules should be revised to most effectively support the surgical patient.

**What criteria does CMS use when determining whether to remove a procedure from the inpatient list?**

CMS uses the following criteria when reviewing procedures to determine whether they are frequently and safely performed on an outpatient basis and should be removed from the inpatient list:

- Most outpatient departments are equipped to provide the services to the Medicare population
- The simplest procedure described by the CPT code may be performed in most outpatient departments
- The procedure is related to codes that CMS has already removed from the inpatient list
- The procedure is being performed in numerous hospitals on an outpatient basis
- The procedure can be performed appropriately and safely in an ASC and is on the list of approved ASC procedures, or CMS has proposed that it be added to the ASC list

**Where can I find the inpatient list?**

The list is included as Addendum E to the hospital OPPS rule and is posted at [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) under the “Hospital Outpatient Regulations and Notices” tab.

On the same CMS website, under the “Addendum A and Addendum B Updates” tab, Addendum B lists the payment status indicator (SI) for all CPT codes. The payment SIs are updated quarterly and indicate whether a service is payable under the Inpatient PPS, the Hospital Outpatient PPS, or another payment system. If a code has the SI of “C,” that code is on the inpatient list and the facility will receive payment only if performed in the inpatient setting. However, if a code has the SI of “T,” the code is payable under the Hospital Outpatient PPS, but may also be paid under the Inpatient PPS. 

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