

## **When Is a Hospital Inpatient Stay Not an Inpatient Hospital Stay – Hospital “Observation Services”**

We introduce our readers to a new topic today: Being in a hospital bed in a Medicare-participating hospital is no guarantee that a Medicare beneficiary is an inpatient. In the Center for Medicare Advocacy’s December 11, 2008 *Alert*, we described the increasingly common practice of placing Medicare beneficiaries in acute care hospital beds and calling them outpatients, on “observation status.”<sup>[1]</sup> It may sound like *Alice in Wonderland* or *1984* or some other fiction. Unfortunately – it’s not.

Beneficiaries who remain in hospital beds for multiple days, or even weeks, receiving physician and nursing services, tests, medications, food, and supplies, are in many instances nevertheless identified as outpatients. **One major consequence of outpatient status is that beneficiaries are denied coverage for a subsequent stay in a skilled nursing facility (SNF) on the grounds that they have not been inpatients in the hospital for three or more consecutive days. Beneficiaries receiving outpatient observation services, which are covered under Medicare Part B, are also billed for services such as prescription drugs that would ordinarily be covered under Medicare Part A during an inpatient hospital stay. Placement in observation services has the effect of shifting significant health care costs that should be covered under Medicare Part A from the Medicare program to Medicare beneficiaries.**

At the same time that the use of observation services is becoming more extensive by hospitals throughout the country, some beneficiaries who have appealed the denials of their hospital stays have been successful. This *Alert* describes a new brochure from the Centers for Medicare & Medicaid Services (CMS) – CMS’s first description of observation services for beneficiaries. It also discusses three recent favorable decisions – two at the Administrative Law Judge level of appeal and a third at the level of the Qualified Independent Contractor (QIC), Maximus Federal Services. A fourth case, which is not about observation services, addresses the InterQual criteria and process that are used by hospitals to determine whether a patient is receiving inpatient care.

### **What are Observation Services?**

Observation services are defined in Medicare’s manuals as a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.<sup>[2]</sup>

The Manuals suggest that a patient may not remain in observation status for more than 24 or 48 hours.<sup>[3]</sup> Since 2004, CMS has authorized hospitalization utilization review (UR) committees to change a patient’s status from inpatient to outpatient, retroactively, if (1) the change is made while the patient is still hospitalized; (2) the hospital has not submitted a claim to Medicare for the inpatient admission; (3) a physician concurs in the UR committee’s decision; and (4) the physician’s concurrence is documented in the patient’s medical record.<sup>[4]</sup> CMS anticipated that

retroactive reclassifications would occur infrequently, “such as a late-night weekend admission when no case manager is on duty to offer guidance.”[\[5\]](#)

## **CMS Brochure**

A new six-page CMS brochure entitled “Are You a Hospital Inpatient or Outpatient?”[\[6\]](#) begins with the statement, “Did you know that even if you stay in the hospital overnight, you might still be considered an ‘outpatient’?” The brochure suggests that patients who are in the hospital for “more than a few hours” ask their doctor or hospital staff if they are inpatients or outpatients.

**The brochure incorrectly suggests in two places that decisions to place a beneficiary in observation are made by the beneficiary’s own physician.[\[7\]](#) In fact, this is often not the case; CMS allows *any* physician to confirm a decision by a hospital’s UR committee to reverse an inpatient admission decision made by an attending physician.**

Even more significant, while the brochure may give beneficiaries notice of their status as observation patients, it does not give them any rights to challenge their placement in observation. The brochure’s discussion of “rights” says only that beneficiaries have the right to “get a review of (appeal) certain decisions about health care payment, coverage of services.”

The brochure may have the effect of discouraging beneficiaries from appealing their placement in observation services if they erroneously believe that their attending physician ordered observation services. As discussed below, the Center encourages beneficiaries and their advocates to appeal observation decisions, regardless of whether the decisions are made by attending physicians or hospitals’ UR committees. Moreover, despite the lack of clarity about beneficiary appeal rights,[\[8\]](#) some beneficiaries have filed appeals and prevailed.

## **Favorable Decisions**

In January 2010, Administrative Law Judge (ALJ) P. Arthur McAfee overruled a decision by Maximus Federal Services and held that a Medicare beneficiary’s entire five-day stay in an acute care hospital should have been covered by Medicare Part A.[\[9\]](#)

The beneficiary’s physician had ordered that she be admitted “for inpatient care secondary to a diagnosis of an L1 compression fracture.” Her condition was “fair” and she required monitoring, assessment, and intravenous fluids, including multiple doses of intravenous morphine. On her third day in the hospital, October 25, 2008, she was notified that her status was being changed from inpatient to outpatient. On appeal, the Quality Improvement Organization (QIO) found that inpatient coverage was appropriate for days three through five, October 25-27. The QIO did not review the beneficiary’s observation status for the first two days of her hospital stay. On appeal, Maximus issued an unfavorable decision, finding that the claim had already been processed for payment.

The ALJ cited the Medicare statute and two Manual provisions as guiding his analysis. First, he cited the Medicare Benefit Policy Manual, which describes the decision to admit a patient [as] a complex medical judgment which can be made only after the physician has considered a number

of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.<sup>[10]</sup>

Relevant factors to be taken into consideration include "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 appropriately are outpatient services," and "the availability of diagnostic procedures at the time when and at the location where the patient presents."<sup>[11]</sup> He also cited Chapter 1, §10 of the MBPM, which uses "a 24-hour period as a benchmark" and wrote, "physicians should order admission for patients who are expected to need hospital care for 24 hours or more."

The second Manual relied on by the ALJ was the QIO Manual, which gives guidance to QIOs on reviewing inpatient hospital admission decisions and directs a physician reviewer to "consider, in his/her review of the medical record, any preexisting medical problems or extenuating circumstances that make admission of the patient medically necessary."<sup>[12]</sup> Inpatient care is "required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting."

Applying these criteria, the ALJ reversed Maximus's denial of inpatient status for the beneficiary's entire five-day stay, finding "The documentation provides no foundation to go against the judgment of the admitting physician."

A second favorable decision, issued by Maximus on November 10, 2009, involved "a 79-year old man who presented to the emergency room (ER) from his assisted living facility with progressive altered mental status over the prior week."<sup>[13]</sup> The man had been "fully oriented," but at the time he was brought to the ER, he was "quite disoriented" or delirious.

The Maximus decision recognized that "Delirium represents an acutely life-threatening condition, evaluation and management of which can be complex and extended." Although it turned out that the management of the patient was not complex, Maximus wrote, "it was not reliably predictable at the time of admission that the necessary work-up of the balance of the differential diagnosis would have been able to be completed within a reasonable period of hospital observation." Relying on the Medicare Benefit Policy Manual, Pub. 100-2, Chapter 1, §10, the same provision relied on by the ALJ in the decision discussed above, and on the Program Integrity Manual, Pub. 100-8, Chapter 8, §6.5.2,<sup>[14]</sup> Maximus authorized inpatient hospital coverage for the entire five-day period.

A third decision addressed the denial of coverage for a 30-day stay in a SNF because of the absence of a three-day prior hospital stay, despite the fact that the beneficiary, classified as an outpatient receiving observation services, had been hospitalized for 13 days. Following a telephone hearing, ALJ Michael D. Bartko ruled both that the beneficiary met the three-day qualifying hospital stay required for SNF coverage and that she needed and received Medicare-covered care in the SNF.<sup>[15]</sup>

The fourth decision addressed whether a Medicare Advantage beneficiary's inpatient hospital admission ended, as set out in the Notice of Denial of Medicare Coverage, or should continue.<sup>[16]</sup> The ALJ discussed the hospital's reliance on InterQual criteria, which are also used in observation cases to determine whether a beneficiary should be classified as an inpatient.

At the ALJ level, the hospital was required to produce the patient's complete medical records, the CareEnhanced Review Manager Enterprise (CERME), and the InterQual/McKesson Manual. The ALJ found "a significantly limited *independent review of the approximately 6000 pages of medical records in this case* [italics in original]" by the QIO physician who cited physical therapy notes, wound care notes, and a single physician note in upholding the discharge notice. He then described the InterQual Manual and CERME as proprietary tools that are used for various purposes, including "coverage denial management programs." He wrote, "Information is obtained from patient medical charts and from other captured data which is input into a software program that generates a summary report." Although the ALJ sealed the InterQual and CERME documents because they were proprietary, he found that "the inputs are very subjective" and that, in this case, they were "inconsistent with the known medical treatment" provided to the patient, as described in her medical records. He concluded that the patient's inpatient stay was medically necessary and that Medicare coverage properly continued after the beneficiary received the notice denying further coverage.

### **What Should Beneficiaries and Their Advocates Do?**

**The Center for Medicare Advocacy suggests that beneficiaries file an appeal from any hospital notices describing their observation status and any subsequent Advanced Beneficiary Notice/Notice of Exclusion from Medicare Benefits they receive from a SNF.<sup>[17]</sup> In the likely absence of any notice, particularly from a hospital, the Center recommends that beneficiaries appeal when they receive the Medicare Summary Notice, which sets out all health care services received by a beneficiary in the prior quarter.**

In all cases, beneficiaries and their advocates should gather the complete medical records from the hospital to establish the entire set of services and treatments that were received during the period of hospitalization. Advocates should request copies of all documents used by the hospital, its UR committee, and outside consultants to determine beneficiaries' status. Advocates should present the medical and nursing facts and cite any physician support for inpatient status to demonstrate that the beneficiary met Medicare's criteria for an inpatient stay. If SNF coverage is also at issue, advocates must demonstrate not only that the beneficiary met the criteria for Medicare-covered care in the SNF but also that the beneficiary *received* Medicare-covered care in the SNF.

Advocates should not be discouraged if they lose at the early stages of appeal: reconsideration, QIO, and QIC review. Three of the four cases discussed in this Alert were won later, at the ALJ level.

## Continuing Work

The increasing use of administratively-created observation services is undermining the Medicare Part A hospital benefit, which authorizes inpatient hospital care for both diagnosis and treatment,[\[18\]](#) by essentially redefining diagnosis as observation under Part B. Observation services also violate the Medicare statute by allowing hospital UR committees to issue retroactive and binding determinations that a patient, admitted to inpatient status by the patient's attending physician, is instead receiving observation services.[\[19\]](#)

The Center for Medicare Advocacy is interested in hearing from advocates, beneficiaries, and providers about their experiences with hospital Observation status, including issues stemming from the lack of notice and the inability to use existing appeals processes.

For more information, or to share an experience with observation services, contact attorney Toby S. Edelman (tedelman @ medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 293-5760.

## Bloomberg Report

### Medicare Fraud Effort Gives Elderly Surprise Hospital Bills

*By Drew Armstrong - Jul 12, 2010*

Larry Barrows, 76, spent eight days in a Canton, Connecticut, hospital after falling twice in a day. Despite being covered by Medicare, the federal health plan for the elderly, Barrows was hit with \$36,000 in normally reimbursed bills because of an unintended glitch in U.S. rules.

[John Dempsey Hospital](#) said Barrows was under "observation" during his stay, said his wife, Lee. Under Medicare rules, patients listed as under observation face 20 percent co-payments that wouldn't be required if they were admitted, and expensive aftercare isn't covered at all. Larry Barrows needed three months of rehabilitation that Medicare wouldn't pay for because the hospital didn't call him an inpatient, something his family didn't learn until halfway through his hospital stay, said his wife.

"A hotshot doctor came down armed with a social worker and Larry's doctor, and said, 'Gee, I'm sorry, your husband's never been admitted,'" Lee Barrows, 75, said in a telephone interview. "I said, 'Who the hell have I been visiting?'"

Elderly patients caught between U.S. hospitals and [Medicare](#) auditors pushing to cut costs are increasingly facing tens of thousands of dollars in unexpected medical bills like the Barrowses, patient advocates say.

The observation classification is designed to be used when there isn't an immediate diagnosis, or if it is determined the condition isn't normally treated within an inpatient setting, such as setting broken bones.

Challenging Admissions

**Hospitals, though, sometimes extend the use of observation status to avoid being challenged by [Medicare auditors](#) on patient admissions when cases fall in a gray area between inpatient and outpatient. Inpatients are more costly to Medicare, said [Robert Corrato](#) of Executive Health Resources, a consultant for hospitals on how to classify patients. Medicare watches admissions closely, and if an admission is ruled inappropriate, the hospital doesn't get paid.**

“There's fear they will be brought under scrutiny for making a false claim,” Corrato, whose closely held company is in Newton Square, Pennsylvania, said in a telephone interview.

That shouldn't be happening, said [Marilyn Tavenner](#), acting administrator of the [Centers for Medicare and Medicaid Services](#). In most instances, observation shouldn't last for more than 48 hours, she said in a July 2 telephone interview.

“Patients staying three, four, five, six days is not the intent of observation,” Tavenner said. “Observation is designed for the first 24 to 48 hours. Beyond that, hospitals should make a decision about whether to admit.”

#### Medicare Letters

[Medicare](#) has begun looking into how hospitals use the observation classification. In letters sent July 7 to the [American Hospital Association](#), the Federation of American Hospitals, and the Association of American Medical Colleges, Tavenner asked the trade associations why use of observation cases lasting more than two days had doubled from 2006 to 2008.

“Observation care of more than 24 hours can have tremendous impact on Medicare beneficiaries,” Tavenner wrote. “Only in rare and exceptional circumstances would it be reasonable and necessary for outpatient observation services to span more than 48 hours.”

Anecdotal reports indicate that use of observation may have grown since 2008. In December 2008, Medicare expanded a pilot auditing program nationwide to cut fraud. Since then, the number of patients in long-term observation has increased, said Toby Edelman, senior policy attorney with the [Center for Medicare Advocacy](#), in Washington. Lee Barrows isn't alone in her frustration, Edelman said.

#### ‘Calls From All Over’

“We're getting calls from all over the place about this,” said Edelman, citing complaints from 18 states since 2008. “They're told when they're being discharged, that ‘By the way, Medicare won't pay for your nursing home care because you weren't an inpatient.’”

The hospital audit program began in 2005 in the three states with the biggest Medicare markets, New York, California and Florida. Medicare expanded it in 2006 on the way to a national rollout. [Contractors](#) who run Medicare claims processes have also upped enforcement, and Democrats added \$350 million to fight fraud in the 2010 health-care law.

Mike Summerer, director of [John Dempsey Hospital](#), where Larry Barrows stayed, said the hospital is feeling pressure from auditors. “It’s not unusual to have an inpatient admission denied that we then have to correct to outpatient, or observation,” he said in a telephone interview.

Dempsey Hospital’s average time for observation is 24 hours, he said, though there are exceptions when patients don’t have an available next step of care. He declined to discuss Barrows’ case, citing privacy law concerns.

#### ‘A Few Extra Days’

“We use observation status, as defined in our policy, to observe patients and decide what their status will be,” Summerer said. Sometimes, “they might stay in outpatient status for a few extra days.”

Hospital associations and patient advocates interviewed said they’ve been getting the same type of feedback from patients as the advocacy center’s Edelman about increasing numbers of long-term observation stays.

“We certainly have been aware of an increased trend in observation and have been monitoring it in southeast Pennsylvania for the past year or so,” said Pam Clarke, vice president of health-care finance at the [Hospital & Healthsystem Association of Pennsylvania](#), based in Harrisburg.

#### Health Overhaul

The issues surrounding hospital classifications are likely to become more prominent as a result of a provision in the health overhaul signed into law by President [Barack Obama](#) in March. The new program aims to retrieve about \$1 billion a year from hospitals that re-admit too many patients, according to a [Congressional Budget Office](#) analysis.

“Certainly, hospitals will have an incentive not to admit people if they’re going to be penalized if they re-admit them,” said [Nora Super](#), director of government relations with AARP, the lobby for people ages 50 and older.

Hospitals need to make sure patients receive the kind of treatment they require based on their condition and not “on how to generate the most revenue,” AARP, based in Washington, said today in an e-mail.

“AARP expects Medicare and hospitals to work together to address this disturbing trend,” said Executive Vice President [John Rother](#) in the statement. He said the observation classification may lead to higher costs and lower quality for Medicare patients and may deprive them of necessary follow-up care, such as stays in a skilled nursing home.

#### Observation Only

Dot Kirby, 90, of Saratoga, California, said she didn’t know the consequences of the observation status after she fell in her garage in January, fracturing her hip in two places. She was taken to [El](#)

[Camino Hospital](#) in Mountain View, California, where she has worked as a volunteer for 30 years, before stopping a decade ago.

After her fall, “I couldn’t walk, I couldn’t do anything,” she said. When she entered the hospital, a staff person had her sign a form saying she was in observation, Kirby said in a telephone interview.

“I didn’t know anything about it and she didn’t explain it to me,” Kirby said. The hospital took X-rays of her hip and, according to a record of the hospital charges provided by Kirby, performed \$25,498.73 of care and services.

When she left the hospital, she needed five weeks of physical therapy at a nursing facility to walk again. Medicare refused to pay the \$11,180.93 bill, she said.

### Lost Benefits

Under the agency’s rules, Medicare would have covered Kirby’s bill had she been a hospital inpatient for three days or more.

While a patient’s doctor decides whether someone is admitted, hospitals review those decisions. The status of patients can be changed as a result of these reviews, said Corrato, the hospital consultant.

“In the past, the reality was that hospitals and physicians were on their honor,” he said. “No more.”

Medicare’s Tavenner disputed the idea that pressure from the audits, which are contracted to private companies, were causing hospitals to put more patients in observation longer.

In her July 7 letter to hospital groups, Tavenner wrote that “Some have speculated that the recent increase in the duration of observation care is due to hospitals’ concern about post-payment review of inpatient claims. We wish to emphasize that that there has been no change in CMS policy for how hospitals should approach such cases.”

### Medicare Monitoring

Corrato disagreed. He said auditors in the Medicare program are increasingly looking at whether a patient should have been admitted. The agency has “made it very clear that they were going to be looking very closely at medical utilization,” Corrato said.

A 2008 Medicare [report](#) on the audit program supports his statement. It says that 41 percent of the overpayments found by the auditors “was due to the service being rendered in a medically unnecessary setting ... These are situations where the beneficiary needed care but did not need to be admitted to the hospital to receive that care.”



Edelman and the Center for Medicare Advocacy have demanded that Medicare, which pays hospitals almost \$200 billion a year, stop them from using “observation services” for long periods.

“Congress needs to make clear that anyone who is in a hospital for 24 hours or more is considered an inpatient,” Edelman wrote in an e-mail. “Medicare beneficiaries either forego nursing home care entirely or pay tens of thousands of dollars privately for care that Medicare should have covered.”

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