OBSERVATION UNITS:
A Growing Concern

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Disclaimers

- Not Legal Advice
- Consult your attorneys
- Not Certified Coders
- Not the opinions of Cape Fear Valley Health System
- Not the opinions of the United States Department of Health & Human Services

Objective

Learn how observation units work, what issues are commonly seen, legal and contractual concerns, Medicare & Medicaid rules and red flags and audit tips.

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Outline

- "Fraud" Overview
  - Hospital "Fraud"
- Observation v. Inpatient Admission
  - Observation: Why?
  - Observation: What?
  - Inpatient Admission: What?
  - Observation / Inpatient: How?
  - Condition Code 44
  - Audit Tips
- Summary

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"Fraud" Overview

"Fraud"

- "Fraud" Elements
  - Material false statement,
  - Intent,
  - Reliance on the false statement by the victim,
  - Damages.

Federal Health Care Fraud Statute, 18 USC § 1347

"Fraud" under "Health Care Reform"

FERA

- On May 20, 2009, the Fraud Enforcement and Recovery Act of 2009 ("FERA") became law
- FERA significantly expanded potential liability under the civil False Claims Act, 31 U.S.C. § 3729 ("FCA")
- FERA created an affirmative duty to refund overpayments under the FCA (knowing and intentional retention of any overpayment)

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"Fraud" under "Health Care Reform"

PPACA

- On March 23, 2010, "health care reform" – also known as the Patient Protection and Affordable Care Act ("PPACA") – became law
- PPACA specifically addressed what was considered an "overpayment" and how quickly an overpayment had to be refunded to avoid improper retention
- "Overpayment" is defined very broadly for the purposes of the FCA: any Medicare or Medicaid funds that a person receives or retains to which the person, "after applicable reconciliation," is not entitled under Medicare or Medicaid laws
- Identified Medicare and Medicaid overpayments must be reported and returned no later than 60 days after the overpayment was identified
- The retention (i.e., the failure to make a refund) of an identified overpayment after the 60-day period is an "obligation" under the FCA

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Basics – Provider Fraud and Abuse

- Submitting Claims for Services Not Rendered
- Submitting Claims for Not Medically Necessary Services
- Misrepresentation of Services, Dates of Service, and Charges – Providing false or misleading information regarding services to manipulate payment benefits
- Upcoding – billing for a higher level of services or supplies than were actually provided or when a provider submits a code that represents a more extensive procedure or service than was actually performed
- Unbundling – separate billing of services covered under one billing code or billing each component of a procedure as if it is a separate procedure, i.e., in a lab unbundling scheme, tests separately conducted in consolidated profile are billed separately
- Services rendered by non-licensed staff members

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Hospital "Fraud"

- **Billing Fraud / False Claims**
  - Observation v. Inpatient
  - Duplicate billing
  - Number of days in hospital
  - Incorrect room charges (semi-private v. private, OR time)
  - Unnecessary services
  - Upcoding
  - Cancelled work
- **Kickbacks**
  - Paying for referrals, i.e., patients are referred in exchange for cash, football tickets, referrals

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Observation: Why?

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Why do we care about Observation?

- ***Primarily a Medicare issue***
- Observation guidelines for private insurance companies vary based upon each individual plan.
- Medicaid typically includes state-specific rules.
- Definition of "Observation" has not always been clear.
- Confusing factor: Typically, the patient receives the same level of service whether they are in Observation or Inpatient status. The only differences are in the coding, billing, and payment.
- Medicare "believes" that hospitals are committing fraud by inappropriately billing for Observation services. Typically, third party payors are OK with Observation because they "believe" it saves them money.

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RAC Program

- CMS Recovery Audit Contractor ("RAC's") Program.
- Started as a demonstration project in 2003, RAC's were tasked to identify and correct Medicare overpayments and underpayments.
- RAC's were compensated on a contingency basis and the demonstration project was very successful (over $1 billion recovered).
- In 2006, RAC program was expanded.
- Focus areas from the RAC demonstration project:
  - Inpatient v. outpatient designations: Inpatient admissions for procedures eligible to be performed in outpatient settings.
  - One Day Stays: One day stays that would qualify as observation (chest pain, non-acute CHF, back pain, gastroenteritis, elective defibrillator implantation).

RAC Focus on Patient Classification

- Determination of patient status is reserved to the physician and should be based on the care the patient is expected to receive.
- Physician should order an inpatient admission for a patient expected to need inpatient care for 24 hours or longer and treat other patients on outpatient basis.
- RACS found that certain diagnoses and procedures (i.e., implantable cardiac defibrillators, chest pain admissions) do not support an inpatient admission and fall within the definition of outpatient observation.

Notable Observation / Inpatient Cases

- **El Centro Regional Medical Center (CA):** $2.2 million settlement to resolve allegations that short inpatient stays (usually one day or less) should have been billed as outpatient or observation visits
- **Wheaton Community Hospital (MN):** $850,000 settlement to resolve allegations that inpatient admissions were not medically necessary
- **St. Joseph's Hospital of Atlanta (GA):** $26 million settlement to resolve allegations that short inpatient stays (usually one day or less) should have been billed as outpatient or observation visits.
- **Kyphoplasty Cases (U.S.):** U.S. Attorney's Office National Project; started in NY
  - Procedure to reduce pain associated with spinal fractures; inpatient v. obs
  - Since May 2009, approximately 26 hospitals have entered into settlements
  - Total settlement amount approximately $28 million (Avg Recovery $1 million)

Notable Observation / Inpatient Cases

- **Tenet Healthcare v. Community Health Systems (TX):** In April 2011, Tenet filed a civil lawsuit against CHS (which introduced a hostile takeover bid for Tenet) accusing CHS with admissions procedures that overbill Medicare.
  - Allegation that CHS systematically billed cases at its hospitals as higher-paying inpatient admissions versus lower-paying observations;
  - Allegation that CHS' admissions policies lead to inflated revenue and earnings
- **Bagnall vs. Sebelius (CT):** In November 2011, a proposed class-action lawsuit was filed by the Center for Medicare Advocacy and the National Senior Citizen Law Center against Health and Human Services (HHS) Secretary Kathleen Sebelius, who has authority over the Medicare program.
  - Allegation that Medicare beneficiaries should have been admitted, but were instead placed on "observation status" which resulted in them having to pay large out-of-pocket expenses;
  - Allegation that they have been deprived of coverage by the government because of a policy that allows hospitals to avoid admitting elderly people with chronic ailments as inpatients;
  - Suing to halt the practice of extended observation status and to be paid for the expenses their families incurred as a result of not being admitted to the hospital

Financial Considerations

Observation

- Hospital receives an average of approximately $550.
- Patient pays a Medicare Part B copayment for each individual outpatient hospital service. The total copayment for all outpatient services may be more than the inpatient hospital deductible.

Inpatient

- Hospital receives an average of approximately $6,000.
- Patient pays a one-time Medicare Part A deductible for all of their hospital services for the first 60 days (approximately $1,132).
- Medicare will only cover care in a skilled nursing facility if the patient first has a "qualifying hospital stay" (hospital inpatient for at least 3 days in a row). Observation time does not count towards the 3 day inpatient hospital stay needed for Medicare to cover the SNF.

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What is the appropriate status?

- ***Observation or Inpatient Admission***

- Factors for Consideration
  - Current needs of the patient
  - Severity of the signs and symptoms
  - Existence of comorbid conditions likely to impact clinical course
  - Intensity of services
  - Medical predictability of the clinical course
  - Potential for adverse complications

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Observation: What?

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What is Observation?

- Medicare defines Observation Services as those services furnished by a hospital on its premises including the use of a bed, periodic monitoring by nursing and other staff, and any other services that are reasonable and necessary to evaluate a patient's condition or to determine the need for a possible (inpatient) admission to the hospital.
- Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.
- Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.
- Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

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Observation Time?

- **Minimum time?:** Observation services must last at least 8 hours for Medicare purposes
- **Maximum time?:** Generally, the decision to admit as an inpatient or resolution for the reason requiring observation care can be made in less than 48 hours (typically less than 24 hours)
  - More than 24 hours = inpatient
  - Less than 24 hours = outpatient
- **Start Time:**
  - Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. The physician's order must specify "observation status" and must be signed, dated, and timed.
- **End Time:**
  - Observation time ends when all medically necessary services related to observation care are completed; OR
  - The end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation Place?

- **Any place –**
  Observation is a status and not a location
- **Sources for Observation status**
  - Through the ED
  - Directly from a clinic or physician's office (direct admit)
  - Post outpatient surgery

Observation in Short

- For evaluating a patient for possible admission
- Treating patients expected to be stabilized and released in 24 to 48 hours (must be well documented over 24 hours)
- Treating complications following outpatient surgery or procedures
- Evaluating an unconfirmed acute diagnosis
- Allows physicians to observe patient
- Avoids potentially unnecessary inpatient admissions and costs
- Decreases burden on the ED
- Does not preclude an eventual admission

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Observation in Short – Continued

Appropriate Observation situations

- Short term treatment, assessment and reassessment before determining if the patient will require inpatient treatment or can be discharged to a lower level of care (generally less than 48 hours)
- Evaluation of unconfirmed acute diagnosis
- Brief stays following a complicated outpatient procedure

Inappropriate Observation situations

- Medically stable patients
- Nursing home placement
- Diagnostic testing that can be done in the outpatient setting
- Patient, family, physician convenience
- For routine prep or recovery for outpatient procedures
- Normal postoperative recovery time following an ambulatory procedure or surgery

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What Observation is Not in Short

- A substitute for inpatient admission
- For continuous monitoring
- For medically stable patients who need diagnostic testing or outpatient procedures
- For patients who need therapeutic procedures that are routinely provided in an outpatient setting
- For patients waiting for nursing home placement
- To be used as a convenience to the patient, his or her family, the hospital, or the physician
- For routine prep or recovery prior to or following diagnostic or surgical services
- A routine stop between the ED and inpatient admission

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How does a Patient get into Observation?

- A physician must order
- There must be medical necessity
- Proper documentation must be provided
- All dependent on the physician
- Post operation surgery greater than 4 to 6 hours recovery time may lead to admission for observation (standard recovery period)

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Inpatient Admission: What?

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What is an Inpatient Admission?

- CMS defines an Inpatient as a person who has been admitted to the hospital for bed occupancy for purposes of receiving inpatient hospital services.
- Inpatient status can be further defined as medically necessary services or items as those which are proper and needed for diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of a medical condition, meet the standard of good medical practice in the medical community and are not primarily for the convenience of the beneficiary or their physician.
- Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

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Inpatient in Short

- The decision to admit a patient is 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 bylaws and admission policies, and the relative appropriateness of treatment in each setting.

- Factors to be considered when making the decision to admit include such things as:
  - 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 (i.e., their performance does 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; and
  - The availability of diagnostic procedures at the time when and at the location where the patient presents.

Inpatient in Short – Continued

- **Diagnoses that usually do not support an inpatient admission:**
  - Chest pain
  - Asthma
  - Syncope
  - Congestive Heart Failure (CHF) – mild
  - Cardiac catheterization or electrophysiological (EP) studies
  - Renal colic
  - Dialysis, transfusions, drug administrations, and chemotherapy

Outpatient / Inpatient: How?

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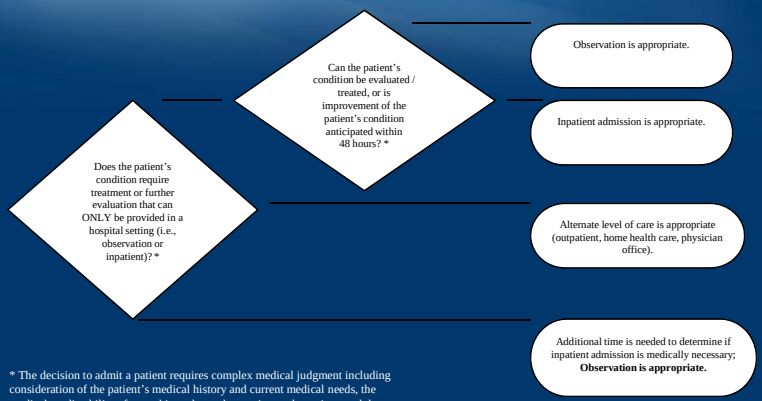
Observation or Inpatient Admission?



* The decision to admit a patient requires complex medical judgment including consideration of the patient's medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services / procedures when and where the patient presents.

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InterQual Level of Care Criteria

- Consist of rule-based clinical indicators of illness
- Nationally recognized and accepted for over 30 years
- Evidence-based
- Incorporates medical literature and best medical practice
- Annually reviewed and updated
- Patient specific
- Focus on each individual patient's clinical presentation
- Include inpatient and outpatient criteria

InterQual Level of Care Criteria Questions

- Is the patient's illness severe enough to require the current or proposed level of care?
- Are the provided services appropriate for the patient's current or proposed level of care?
- Is the patient clinically stable, and if so, can the patient's care needs be met at an alternate level of care?

Physician Orders (Audit Traps?)

- Should be clear, concise, and convincing
- Should be dated, timed, and signed
- Orders should be written “Inpatient status,” “Observation status,” or “Outpatient status.”
- “Admit to observation” = inpatient or observation?
- “Admit” = inpatient or observation?
- “Discharge from Observation” or “Release” or “Depart”?

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Condition Code 44

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Condition Code 44

- For use on outpatient claims only when the physician ordered inpatient services.
- Condition Code 44 is used when an inpatient admission is changed to outpatient (for observation), when a physician ordered inpatient services, but upon internal review performed, the hospital determines the services do not meet its inpatient criteria before the claim was originally submitted.

Condition Code 44

- All of the following must be met in order to apply Condition Code 44:
  - The change in patient's status from inpatient to outpatient observation is made prior to discharge or release while the beneficiary is still a patient in the hospital;
  - Patient has been notified of change;
  - The hospital has not submitted a claim to Medicare for inpatient admission;
  - A physician concurs with the utilization review committee's decision; and
  - The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record along with the reason for the change.

Audit Tips

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Audit Tips

- Documentation requirements
  - Signed, dated, timed physician order
  - Diagnostic conditions
  - Documentation of care
- Medical necessity concerns
- Time of admission / discharge
- Direct admits – documentation?
- Physician services during observation (physician see patient)
- Total allowable observation time
- Observation versus same day admits / discharges
- Outpatient surgery – when does extended recovery become observation?
- Hospital Policies

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Audit Tips – Continued

- Documentation Audit
  - Patient's Name
  - Physician's Name(s)
  - Date and Time of Admission
  - Date and Time of Discharge
  - Condition(s) Requiring Observation Status
  - Information Pointing to Location of Documentation
  - Number of Hours in Observation Status
  - Number of Units Billed
  - Charges Made for the Observation Services
  - Time / Activities Interrupting Observation Services During the Stay
  - Utilization Review Notes

Consider Hospital Role

- Education of staff and physicians
- Monitoring of observation appropriateness
- Monitoring appropriateness of inpatient admissions
- Utilization review committee
- Appropriate application of admission criteria
- Conduct monitoring, auditing, and development of process improvement for utilization management

Consider Physician Role

- Physician drives the entire process
- Knowledge of the definition and appropriate use of observation and inpatient status
- Determination and documentation of admission status
- Documentation of clinical rationale for status decision
- Conflict?: Physician paid for each individual service versus hospital only paid for Observation or Inpatient Admit
- Defensive Medicine?

Consider Patient Impact

- Quality of care
- Cost difference
- Liability
  - Three day qualifying stay
- Risks
  - Falls
  - Infections
  - Medical errors

Summary

Summary

- Basics for Observation: The physician must order, justify and document the observation services. The decision as to whether the admit is observation or inpatient is to be made at the time the decision is made by the physician.
- Basics for Inpatient: The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors.
- Condition Code 44 (change from inpatient to observation) complicates it all!
- Basics for Audit: Focus on documentation & medical necessity.

Questions

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