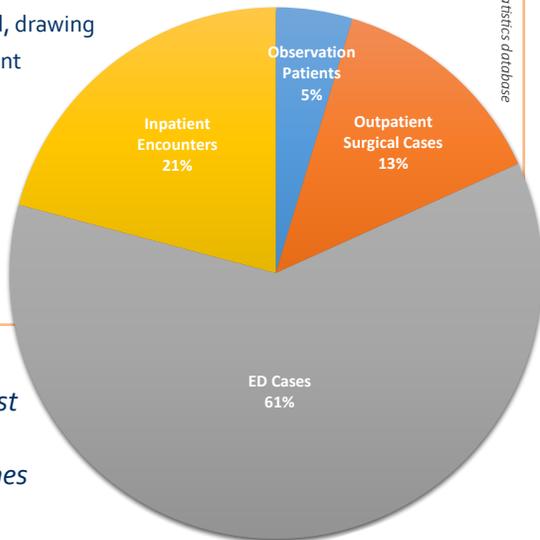


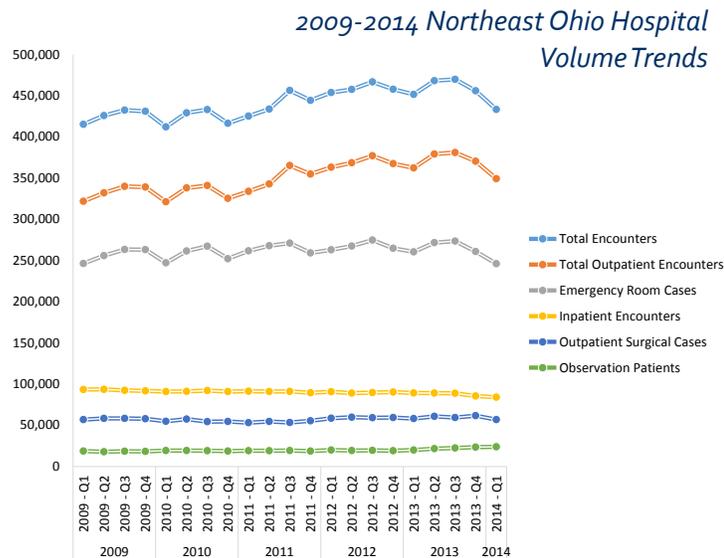
Hospital observation status regularly gets a bad rap. This label's less-than-glowing reputation results for many legitimate reasons but also because the rules and reasons behind it are generally not well understood. Though it was created to address specific concerns about our healthcare system, and works as it was intended in many situations, there's no question that it can create challenges for patients and hospitals.

Over the last several years, the number of patients placed in observation status has grown, both in the U.S. and in the region. However, because of the growth in observation services, which has occurred for a number of reasons, the challenges faced by hospitals and patients have been amplified. Today, media stories about these frustrations abound, drawing an increasing amount of attention to a well-intentioned but flawed rule originally intended to bring down healthcare costs.

The Center for Health Affairs, Volume Statistics database



2013 Northeast Ohio Hospital Patient Volumes



The Center for Health Affairs, Volume Statistics database

Observation Status Explained

When a patient arrives at the hospital emergency department (ED), healthcare professionals make their best judgment about the most appropriate setting in which to provide care. Some patients will be treated in the emergency department and then discharged, others will be seen in the emergency department and then admitted as an inpatient, and others will be placed in observation status.

While ED and inpatient treatment are commonly understood, there has been some confusion about what observation status means. Observation status was created by The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers those programs. CMS established this designation to enable hospitals to provide "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."¹ Observation status, which is an *outpatient designation*, allows physicians to watch a patient for a short time in the hospital – usually 24 to 48 hours – and make a sound decision about whether or not to admit.

While observation status is most commonly used after a patient arrives at the hospital ED, it can also be used in other circumstances. For example, a patient who has just had surgery may enter observation status if they were supposed to go home but were unable to recover fully within the surgical recovery time frame.

Observation Status from the Patient's Perspective

When patients are being treated at the hospital it can frequently be indistinguishable whether they are classified as an inpatient or as an observation patient. Yet for patients, the distinction between observation stays and inpatient stays can have significant financial implications. Since observation status is an outpatient designation, it can have different cost-sharing components than an inpatient stay. Medicare outpatient visits are subject to patient co-payments, deductibles and co-insurance, which are different – and sometimes higher than – the patient's co-payments, deductibles and co-insurance associated with inpatient care.

For patients who require skilled nursing care after an observation stay, the cost implications can be significant and can cause frustration for patients when they review their billing statements. Medicare will only cover the cost of skilled nursing care if it is preceded by a 3-day hospital *inpatient* stay. Given that observation status is an *outpatient* service, observation patients who are transferred to a skilled nursing facility must cover the entire cost of the subsequent skilled nursing care.

Because these skilled nursing facility (SNF) rules were first created in 1966, when inpatient stays were much longer and more commonplace, a recent study by the AARP Public Policy Institute argued that Medicare's 3-day prior inpatient stay requirement for SNF coverage may need to be revisited. Hospitals are in agreement that the policy created by CMS needs to be updated; however, until there are regulatory changes, hospitals must abide by the current rules when they bill patients for observation stays.²

Observation Status from the Hospital's Perspective

From the hospital's perspective, CMS has put hospitals in a very complicated position by forcing them to second guess and evaluate clinical conditions through the prism of financial penalties. A Medicare patient's confusion when they receive a bill for outpatient services is valid because from their perspective there is no meaningful distinction between an observation stay and an inpatient admit. Key to understand is that observation status is simply a blunt tool devised by CMS to reduce the cost of care. Doctors and hospitals are forced to use the observation status designation to ensure patient safety and avoid financial penalties.

Despite the challenges associated with observation status, there are times when it is a beneficial tool for hospitals. Observation status enables providers to effectively manage patients' pain levels while they keep an eye on patients whose symptoms are changing to determine if they require further assessment or if they can be discharged from the hospital. Studies have shown that short observation stays allow hospitals to more quickly triage patients in the emergency department, thus improving efficiency and quality of care.³

Hospitals also use observation status as a tool to help ensure that they are reimbursed for the care they provide patients. CMS will only reimburse hospitals for inpatient care when it meets their inpatient care criteria. Hospitals must be careful to ensure patients meet all the Medicare requirements to qualify for admission as an inpatient. In some extreme cases, hospitals can even be charged with fraud if they admit patients that don't meet CMS' guidelines for inpatient care.

Yet even when a patient is admitted because a hospital or physician feels it is the right course of treatment, CMS will still sometimes make the determination that, according to its guidelines, the patient should not have been admitted as an inpatient, resulting in denial of payment for services rendered. Hospitals rely on observation status, which allows them to provide necessary care while a decision about admission is made, for any borderline patient until they are certain the patient meets CMS' inpatient criteria.

One of the vehicles CMS uses to help decide whether a provider rightfully admitted a patient as an inpatient is the Recovery Audit Program. Since 2010, recovery audit contractors (RACs) have audited provider claims across the country to ensure accurate payments to Medicare providers.⁴

When a RAC decides that a patient who was admitted to the hospital should have instead received outpatient treatment, the original inpatient payment to the hospital is recovered by the Medicare program. At this point, it becomes difficult for hospitals to bill the service as an outpatient treatment. RACs have the ability to audit hospital claims from the *prior three years* but the hospital only has the ability to rebill for services provided in the *prior year*. In fact, 75 percent of all RAC denials are for services that fall outside of the one-year filing window for Medicare rebilling.⁵

When rebilling is not an option, hospitals are then left with the remaining option of trying to recoup the money they spent providing healthcare services to a Medicare patient by filing a Medicare appeal. Causing further administrative headaches, hospitals must separately appeal each RAC denial and the Medicare appeals process often takes two or more years until a final decision is issued.⁶

Hospitals nationwide appeal more than 40 percent of RAC denials. Of those appeals, nearly 70 percent of RAC denials are eventually overturned in favor of the hospital.⁷ Yet currently roughly three out of every four appealed claims are still in the appeals process. Using valuable resources to fight each claim that is denied is a practice that is both lengthy and costly for providers. Federal legislation, H.R. 1250 and S. 1012, that would remedy some of the problems with the RAC program is currently being considered by Congress.⁸

Readmissions Penalties

Adding to hospitals' concerns about the proper admission of patients for inpatient services is a provision in the Affordable Care Act (ACA) that relates to readmissions. Specifically, this provision requires CMS to begin penalizing hospitals with "excess" readmissions of Medicare patients compared to Medicare-calculated "expected" levels of readmissions within 30 days starting in October 2012. Financial penalties for fiscal year 2014 are a maximum of a 2 percent reduction for all payments related to Medicare discharges and will rise to 3 percent in fiscal year 2015 and for years beyond. Current patient conditions that can trigger readmission penalties include heart attack, heart failure and pneumonia, with hip or knee replacement and chronic obstructive pulmonary disease slated to be added in the future.⁹

Hospitals are working hard to address issues that can impact readmissions. While hospitals continue to improve their readmission rates, some people have voiced concern that readmission penalties could be contributing to the rise in observation status patients both locally and across the nation. Observation status patients are considered outpatients so if they are hospitalized within 30 days of their original stay (or if they were hospitalized within 30 days prior to their observation stay) neither scenario would constitute a readmission. Yet key to remember is that compared to the hefty reimbursement consequences of having an inpatient Medicare stay deemed improper by CMS, and the resulting denial of payment for the *entire inpatient stay*, the penalties levied against hospitals with "excess" readmissions are relatively small. Furthermore, there simply isn't enough data available to demonstrate that there is a direct cause and effect relationship between readmission penalties and the rise in observation status patients.

Conclusion

From a clinical perspective, medical professionals will always use their best judgment when deciding the most appropriate setting in which to provide care. Hospital caregivers will always ensure that patients receive the full spectrum of care that needs to be provided.

Observation status is an imperfect solution to a complicated problem that presents challenges to all parties involved. Payers are trying to hold down costs, hospitals are striving to provide the highest quality of care while adhering to complicated payer regulations, and patients are hoping to receive top-notch care that doesn't break the bank.

The hospital community is working hard to ensure that payment policies created by CMS do not hinder their efforts to provide the highest quality of care to patients and unfairly burden patients with excessive bills. While they work to convince lawmakers of the need to restructure Medicare payment policies, hospitals will stay focused on their primary objective of ensuring that patients receive the highest quality of care possible.

Endnotes

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