

# **Health Care Compliance Association**

## **Inpatient Short Stay**

### **Admissions Enforcement Developments**

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### **Inpatient Short Stay Admissions Enforcement Developments**

The Department of Health and Human Services-Office of Inspector General (“OIG”) has long been focused on the issue of short stay inpatient hospital admissions. For a decade, OIG has targeted the issue of short stay or one-day hospital stays that are not medically necessary as an important area of focus, although a comprehensive or consistent solution has proven elusive. Despite the OIG’s emphasis, formal guidance continues to lack clarity and remains internally contradictory.

Patient hospital admission status is an issue that affects all hospitals across the country and remains a difficult one since patient status determinations are placed at the outset of care in the hands of the patient’s physician, not the hospital filing the hospital services claim. Due to the OIG’s interest in this issue and reviews by many state Quality Improvement Organizations (“QIOs”) on short hospital inpatient stays, many hospitals have implemented a variety of measures to reduce the error rates for one-day stays. Examples of measures hospitals have undertaken to reduce the number of unnecessary short stays include the development of educational programs and training for physicians and utilization review staff regarding the differences between inpatient and outpatient observation status as well as a greater focus on InterQual (or other inpatient screening criteria) guidelines for inpatient admission. It is essential that hospitals continue to focus on these issues as the Recovery Audit Contractors (“RACs”) plan to focus on complex medical necessity reviews in 2010.

#### **I. Definitions of Inpatient and Outpatient Observation Patient**

While neither a statute nor any applicable regulation defines the term “inpatient,” the Medicare Benefit Policy Manual (“MBPM”)<sup>1</sup> generally defines an inpatient as a person who has been formally admitted to a hospital.<sup>2</sup> Specifically, the MBPM defines an inpatient as follows:

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. 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.<sup>3</sup>

Furthermore, physicians should use a 24-hour benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and

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<sup>1</sup> Ctrs. for Medicare & Medicaid Servs., *Medicare Benefit Policy Manual*, available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> (follow “100-02” hyperlink).

<sup>2</sup> *Estate of Landers v. Leavitt*, 545 F.3d 98, 104 (2d Cir. 2009), *cert. denied*, 129 S. Ct. 2878 (2009).

<sup>3</sup> MBPM, *supra* note 1, at Ch. 1, §10.

treat other patients on an outpatient basis.<sup>4</sup> According to Highmark Medicare Services, Inc., the Medicare Administrative Contractor (“MAC”) for Jurisdiction I, a person is considered an inpatient if he is formally admitted based on the physician’s expectation of a need for an appropriate inpatient stay.<sup>5</sup> The justification for an inpatient stay is based on the information available at the time of admission.<sup>6</sup> Subsequent information may support a physician’s “hunch” that the patient needed inpatient care, but never serves to refute that original determination.<sup>7</sup>

In contrast to inpatient status, the MBPM defines outpatient observation services as follows:

[Outpatient] [o]bservation 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 services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.<sup>8</sup>

Observation services generally do not exceed 24 hours.<sup>9</sup> According to the MAC for Jurisdiction I, uncomplicated presentations of chest pain (including rule out myocardial infarction, mild asthma/chronic obstructive pulmonary disease, mild congestive heart failure, syncope and decreased responsiveness, atrial arrhythmias and renal colic) are all frequently associated with the expectation of a brief (less than 24-hour) stay unless serious pathology is uncovered.<sup>10</sup> It is essential that both the physicians and the utilization review staff understand the differences between inpatient and outpatient observation status and communicate early in the patient’s visit about the necessary level of care.

In June 2009, CMS provided further clarification regarding the use of outpatient observation services:

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<sup>4</sup> *Id.*; see also Trailblazer Health Enters., *Inpatient Admission Versus Outpatient Observation Following an Outpatient Procedure* (May 19, 2009), available at <http://www.trailblazerhealth.com/Publications/Job%20Aid/InpatientAdmissionvsOutpatientObservation.pdf>.

<sup>5</sup> Highmark Medicare Servs., Inc., *Acute Care: Inpatient, Observation and Treatment Room Services* (LCD 27548) (rev. effective date Oct. 28, 2009), available at <https://www.highmarkmedicare.com/policy/mac-ab/127548-r5.html> (“Highmark LCD”).

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> MBPM, *supra* note 1 at Ch. 6, § 20.6; see also Ctrs. for Medicare & Medicaid Servs., *Medicare Claims Processing Manual*, Ch. 4, § 290, available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> (follow “100-04” hyperlink).

<sup>9</sup> Highmark LCD, *supra* note 5, at 4.

<sup>10</sup> *Id.*

Editorial changes to the manuals remove references to ‘admission’ and ‘observation status’ in relation to outpatient observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term ‘admission’ is typically used to denote an inpatient admission and inpatient hospital services. For payment purposes, there is no payment status called ‘observation,’ observation care is an outpatient service, ordered by a physician....<sup>11</sup>

This recent CMS clarification regarding the terms ‘admission’ and ‘observation status’ indicates a continued government focus on inpatient hospital stays versus outpatient observation status.

## **II. Reimbursement Differences**

The OIG’s concern is that a significant proportion of the inpatient one-day or short hospital stays are more appropriately billed as outpatient observation stays which generally result in lower reimbursement than an inpatient stay. In 2005, the OIG issued guidance stating the following: "Often, the status of patients at the time of admission or discharge significantly influences the amount and method of reimbursement hospitals receive. Therefore, hospitals have a duty to ensure that admission and discharge policies are updated and reflect current CMS rules."<sup>12</sup>

Hospitals are reimbursed a Diagnostic-Related Group (“DRG”) for an inpatient stay under Medicare’s Prospective Payment System (“PPS”) for hospitals. The hospitals are reimbursed for an inpatient stay based on the patient’s diagnosis, which is categorized into a DRG code. The length of the hospital stay in most cases is not a factor and the hospital receives the same DRG payment whether the patient stays one day or multiple days.

CMS also implemented a Medicare PPS for hospital outpatient services. All services paid under the outpatient PPS are classified into groups called Ambulatory Payment Classifications (“APCs”). Services in each APC are similar clinically and in terms of the resources they require. Each APC has a payment rate. Depending on the services provided, hospitals may be paid for more than one APC for a hospital visit. In most instances, the hospital’s payment for observation services will be bundled with other services. Medicare, however, will reimburse hospitals separately for the following three medical conditions: (1) chest pain; (2) asthma; and (3) congestive heart failure. Hospitals may use observation status for these three conditions to provide care to the patient while determining whether a patient’s symptoms require an inpatient admission, or whether the condition improves so that the patient may be discharged. Medicare,

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<sup>11</sup> Ctrs. for Medicare & Medicaid Servs., Transmittal 1760, Change Request 6492, *July 2009 Update of the Hospital Outpatient Prospective Payment System OPPTS* (June 23, 2009), available at <http://cms.hhs.gov/transmittals/downloads/R1760CP.pdf>.

<sup>12</sup> OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858, 4861 (Jan. 31, 2005).

however, does not require all patients with those three conditions to be placed in observation status before being admitted as an inpatient.

On average, “Medicare pays about \$4,500 to \$5,000 more for a DRG than for an APC with its bundled observation fee.”<sup>13</sup> Further, billing one legitimate inpatient admission as an outpatient observation claim every day “adds up to about \$1.7 million in lost revenue annually.”<sup>14</sup> Therefore, hospitals need to ensure there is a process in place to identify the correct patient status preferably before the patient is discharged from the hospital.

### **III. Admission Decision is a Complex Medical Judgment**

The physician or other practitioner responsible for a patient’s care at the hospital is also responsible for determining whether the patient should be admitted as an inpatient. Generally, by state law, only physicians can order the admission of a patient to a hospital. Nurses (including care managers) are not legally qualified to make that decision, which is outside their “scope of practice.”<sup>15</sup> “In no case may a non-physician make a final determination that a patient’s stay is not medically necessary or appropriate.”<sup>16</sup>

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 outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting.<sup>17</sup> The MBPM sets forth the following factors that should be considered by the physician in determining whether to admit a patient as an inpatient:

- 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.<sup>18</sup>

In some cases, the choice between inpatient admission and observation services is clear. However, given that the dividing line between the two types of services is a physician’s expectation of whether the patient will need acute hospital services for longer

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<sup>13</sup> *In Hospital Observation Struggle, Uncertain Outcomes May Justify Inpatient Admissions*, Report on Medicare Compliance, Oct. 23, 2006.

<sup>14</sup> *Id.*

<sup>15</sup> See, e.g., *Medicare Claims Processing Manual*, *supra* note 8, at Ch. 1, § 50.3.1; Georgia Medicaid Hosp. Manual 901.1 (requiring admissions by doctors); 42 C.F.R. § 482.12(c)(2) (“Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital”); Highmark LCD, *supra* note 5 (“The determination of an inpatient or outpatient status for any given patient is specifically reserved to the *admitting physician*.”).

<sup>16</sup> Ctrs. for Medicare & Medicaid Servs., *Medicare State Operations Manual*, app. A-0656, available at <http://cms.hhs.gov/manuals/IOM/list.asp> (follow “100-07” hyperlink).

<sup>17</sup> MBPM, *supra* note 1, Chap. 1, §10.

<sup>18</sup> MBPM, *supra* note 1, Chap. 1, §10.

than a 24-hour period, it is likely that for many cases, the choice between the two is not as obvious.<sup>19</sup> If a physician wrongly chooses observation services rather than inpatient admission, the decision can also be subject to scrutiny.<sup>20</sup> The difficulty in distinguishing between inpatient and observation status is undoubtedly why there has been so much confusion on the part of hospitals and physicians in this area.<sup>21</sup>

One of the problems with having the physicians make the admission decision is that the physicians drive the admission decision, but they do not have financial repercussions if Medicare determines the inpatient stay was not medically necessary. This is because the physicians are paid the same for their services even if Medicare denies the hospital's claim. Due to this disconnect, hospitals are making significant efforts to educate physicians on both the differences between an inpatient and observation status and the documentation required in the orders to make the patient status more clear. Further, hospitals are encouraging their physicians to communicate early in the patient stay with the utilization review nurse or care manager about the patient's level of care. CMS created Condition Code 44<sup>22</sup> which allows the hospital to change the patient's status from inpatient to observation after the patient has been admitted but before the patient is discharged from the hospital. Even though Condition Code 44 may help to

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<sup>19</sup> *RAC Denials for Unnecessary Admissions are Overturned; Process is Questioned*, Report on Medicare Compliance (June 23, 2008) (noting admission decisions are not always black and white).

<sup>20</sup> See, e.g., Dep't of Health & Human Servs., Office of Inspector General, *Review of Hospital Observation Beds* (May 2002), available at <http://oig.hhs.gov/oas/reports/region7/70102631.pdf>.

<sup>21</sup> Recent guidance from Trailblazer demonstrates hospitals are still confused as to where to draw the line between inpatient and outpatient observation status. The Trailblazer report provides the following guidance:

- Outpatient observation is still an alternative to inpatient admission.
- An order simply documented as “admit” will be treated as an inpatient admission. A clearly worded order such as “inpatient admission” or “place patient in outpatient observation” will ensure appropriate patient care and prevent hospital billing errors.
- Medicare coverage for observation services is limited to no more than 48 hours unless the A/B MAC grants an exception.
- An outpatient observation patient may be progressed to inpatient status when it is determined the patient's condition requires an inpatient level of care.
- An inpatient admission cannot be converted to outpatient observation.
- Documentation must support the level of care provided (inpatient admission versus outpatient observation).
- Ensure the documentation addresses problems identified in the history and physical, treatment initiated, patient's response to treatment, major changes in the patient's condition and action taken, status of unresolved problems, discharge planning and follow-up.

Trailblazer Health Enters., *supra* note 4.

<sup>22</sup> *Ctrs. for Medicare & Medicaid Servs.*, MLN Matters No. SE0622, *Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: “Inpatient Admission Changed to Outpatient,”* (March 22, 2006), available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0622.pdf>; see also *Ctrs. for Medicare & Medicaid Servs.*, Pub. 100-04, Transmittal 1803, Change Request 6626, *October 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)* (Aug. 28, 2009), available at <http://www.cms.hhs.gov/Transmittals/downloads/R1803CP.pdf>.

catch errors prior to discharge, it is better to assign the correct patient status when the patient presents at the hospital (often in the emergency room), which is often a result of early communication between the utilization review nurses, the emergency room physician, and the treating physician.<sup>23</sup>

#### **IV. Focus on Short Stay Inpatient Admissions**

Short stay hospital admissions have been a target of OIG audits at least since 2000 when the issue appeared on the OIG Work Plan. In addition to appearing on the OIG Work Plan, one-day hospital stays have also been a focus of Medicare's Program for Evaluating Payment Patterns Electronic Reports ("PEPPER reports").<sup>24</sup> Recently, the issue of medical necessity has been highlighted with the implementation of the RACs. Medical necessity denials represented 40% of the recovery dollars in the RAC pilot program through March 27, 2008, resulting in \$391.3 million.<sup>25</sup> Most of these were short stay inpatient denials. Medical necessity reviews continue to be a key issue for the RACs in 2010.

#### **V. Short Stay Admission Enforcement Actions**

In May 1989, the OIG issued a report addressing unnecessary short stay hospital admissions.<sup>26</sup> The study examined short stays of one, two or three days in order to determine the extent of short stays, whether the short-stay patients were being admitted and discharged appropriately, and whether the quality of care they received was adequate.<sup>27</sup>

In the early 2000s, there were several hospital settlements under the False Claims Act as a result of short stay admissions. In 2002, according to the OIG, approximately ten percent of all Medicare patients admitted to hospitals are released the following day.<sup>28</sup> The OIG announced its review would concentrate on the adequacy of controls to detect and deny inappropriate payments for one-day stays and the CMS program integrity studies in this area.<sup>29</sup>

In November 2005, Saint Barnabas Health Care System in New Jersey agreed to pay the federal government nearly \$3.9 million to settle claims it overcharged Medicare

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<sup>23</sup> *In Hospital Observation Struggle, Uncertain Outcomes May Justify Inpatient Admissions*, Report on Medicare Compliance, Oct. 23, 2006, at 1.

<sup>24</sup> PEPPER reports are electronic data reports containing hospital-specific data for target areas - specific DRGs that have been identified as high risk for payment errors.

<sup>25</sup> Ctrs. for Medicare & Medicaid Servs., *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration* (June 2008), available at [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf) (numbers self-reported by the Claim RACs).

<sup>26</sup> Richard P. Kusserow, *National DRG Validation Study: Short Hospitalizations*, May 1989, available at <http://oig.hhs.gov/oei/reports/oai-05-88-00730.pdf>.

<sup>27</sup> *Id.*

<sup>28</sup> Dep't of Health & Human Servs., *HHS/OIG Fiscal Year 2002 Work Plan*, Centers for Medicare and Medicaid Services (2002), available at <http://oig.hhs.gov/publications/docs/workplan/2002/cms.pdf>.

<sup>29</sup> *Id.*

for inpatient services when patients received same-day treatment. The health system settled the claims “for services to Medicare patients that reflected a higher level of service than was actually performed.”<sup>30</sup> Specifically, the Saint Barnabas settlement agreement states the health system settled claims for billing outpatient services as inpatient services in violation of Sections 210 and 230.1 of the Medicare Hospital Manual.<sup>31</sup>

Saint Joseph’s Health System in Atlanta settled False Claims Act allegations with the federal government in December 2007.<sup>32</sup> The hospital paid \$26 million to settle claims that it improperly admitted patients to the hospital that did not meet medical necessity for inpatient admission.<sup>33</sup> The government’s investigation of Saint Joseph’s focused on the medical necessity for claims submitted for short inpatient stays, specifically zero-day and one-day stays, two-day and three-day inpatient stays when the hospital’s reimbursement exceeded the billed charges, and three-day stays followed by a discharge to a skilled nursing facility. The government also reviewed reimbursement for one-day inpatient stays regarding ESRD patients receiving urgent dialysis after missing scheduled maintenance dialysis as a result of needing to repair blocked or non-functioning access sites. The government contended that the hospital received more reimbursement by admitting the patients as inpatients, rather than treating them in observation status which would generally result in a lower reimbursement than inpatient admission. The government’s investigation was based upon a complaint filed under the *qui tam* provisions of the False Claims Act by a former utilization review nurse at the hospital.

In May 2008, Medtronic Spine LLC, the successor to Kyphon Inc., agreed to pay the United States \$75 million to settle allegations regarding submitting false claims to Medicare.<sup>34</sup> The allegations related to submission of claims for the kyphoplasty procedure, which is a minimally-invasive surgery used to treat painful, progressive fractures of the spine. The government allegations included that Kyphon billed Medicare for kyphoplasty procedures performed on an inpatient basis instead of the more appropriate outpatient setting. This conduct led to Medicare reimbursing more for the inpatient hospital stays than it would have for outpatient claims. The civil settlement with the government resolved the action filed in Buffalo, New York by two former employees of the company under the *qui tam* provisions of the False Claims Act.

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<sup>30</sup> Margaret F. Bonafide, *Hospitals pay \$3.9M; Medicare was overbilled*, Asbury Park Press (Dec. 7, 2005) at A1.

<sup>31</sup> Settlement Agreement Between United States and Saint Barnabas Healthcare System (Nov. 23, 2005), available at <http://www.justice.gov/usao/nj/press/files/pdf/SBHCS%20Settlement%20Agreement.pdf>.

<sup>32</sup> Press Release, Dep’t of Justice, *Saint Joseph’s Hospital of Atlanta to Pay U.S. \$26 Million to Settle False Claims Allegations* (Dec. 21, 2007), accessible at [http://www.justice.gov/opa/pr/2007/December/07\\_civ\\_1029.html](http://www.justice.gov/opa/pr/2007/December/07_civ_1029.html).

<sup>33</sup> *Id.*

<sup>34</sup> Press Release, Dep’t of Justice, *Medtronic Spine, Formerly Kyphon Inc., to Pay U.S. \$75 Million to Resolve Allegations of Defrauding Medicare* (May 22, 2008), accessible at <http://www.justice.gov/opa/pr/2008/May/08-civ-455.html>.

Three hospitals in the HealthEast Care System agreed to pay the United States \$2.28 million to settle allegations that the hospitals submitted false claims to Medicare in May 2009.<sup>35</sup> The settlement resolved allegations the hospitals overcharged Medicare from 2002 to 2007 each time they performed the kyphoplasty procedure.<sup>36</sup> The government alleged that the HealthEast hospitals performed the procedure on an inpatient basis in order to receive greater reimbursement from Medicare when the procedure can be safely performed on an outpatient basis.<sup>37</sup> The *qui tam* lawsuit against the HealthEast hospitals was brought under the False Claims Act.

The government settled allegations in September 2009 with six Indiana and Alabama hospitals related to similar allegations surrounding the kyphoplasty procedure.<sup>38</sup> Similar to the Medtronic and HealthEast cases cited above, the government alleged that kyphoplasty is a minimally-invasive procedure that should have been performed on an outpatient basis rather than admitting the patients as inpatients.<sup>39</sup> These six hospitals in Indiana and Alabama agreed to pay the United States more than \$8 million to settle allegations that the health care facilities submitted false claims to Medicare.<sup>40</sup>

In July 2009, Yale-New Haven Hospital in Connecticut settled claims with the government related to medically unnecessary inpatient hospital admissions.<sup>41</sup> The hospital paid \$885,953 to settle the allegations.<sup>42</sup> The allegations related to a Gamma Knife stereotactic radiosurgery procedure which is generally used to treat malignant and benign tumors, vascular abnormalities, and other neurological conditions.<sup>43</sup> The government contended that this specific procedure was non-invasive and should have been performed on an outpatient basis without general anesthesia rather than admitting the patients as inpatients.<sup>44</sup> The hospital received a letter from the Medicare QIO in Connecticut regarding an inpatient admission for the Gamma Knife procedure.<sup>45</sup> Specifically, the QIO letter notified the hospital that the inpatient stay for this procedure was not medically necessary.<sup>46</sup> After reviewing the claims for the Gamma Knife procedure, in September 2006, Yale-New Haven voluntarily notified the QIO and the OIG of improper billing and refunded Medicare \$2,356,702 for these procedures.<sup>47</sup> The hospital later determined that it had overcharged Medicare for inpatient hospital stays

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<sup>35</sup> Press Release, Dep't of Justice, *Minnesota Hospitals to Pay U.S. \$2.28 Million to Settle False Claims Act Allegations* (May 21, 2009), available at <http://www.justice.gov/opa/pr/2009/May/09-civ-497.html>.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> Press Release, Dep't of Justice, *Indiana and Alabama Hospitals to Pay U.S. Over \$8 Million to Settle False Claims Act Allegations* (Sept. 9, 2009), available at [http://www.justice.gov/usao/nyw/press/press\\_releases/HospitalPress.pdf](http://www.justice.gov/usao/nyw/press/press_releases/HospitalPress.pdf).

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> U.S. Attorney's Office, Dist. of Conn., *Yale-New Haven Hospital Enters into Federal Civil Settlement Agreement* (July 1, 2009), available at <http://www.justice.gov/usao/ct/Press2009/20090701-1.html>.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

related to the Gamma Knife procedure for an earlier time period as well and therefore reimbursed Medicare an additional \$885,953 to cover this earlier date range.<sup>48</sup>

In January 2010, Wheaton Community Hospital in Minnesota agreed to pay \$846,461 to settle allegations that their “hospital admission practices violated the False Claims Act.”<sup>49</sup> The government allegations focused on inpatient hospital stays that the government contended were not reasonable or necessary.<sup>50</sup> Specifically, the government alleged that the hospital “admitted some patients and kept others admitted to acute care when doing so was not medically necessary.”<sup>51</sup> The hospital then billed Medicare for the inpatient hospital admissions that were not medically necessary. The investigation of the Wheaton Community Hospital began with a lawsuit filed in federal court in Minnesota under the *qui tam* provisions of the False Claims Act. The whistleblower in this case was a physician who formerly practiced at the hospital.

## VI. Role of the Quality Improvement Organizations

As a result of the Deficit Reduction Act of 1984, QIOs, formerly known as Peer Review Organizations, became the guardians of medical necessity determinations. QIOs have the authority to review services furnished to Medicare beneficiaries and make determinations concerning the medical necessity, quality, and appropriateness of the services.<sup>52</sup> In the case of hospitals providing inpatient services, one of the purposes of the QIO reviews includes determining “the appropriateness of admissions and discharges.”<sup>53</sup> In particular, the role of the QIO is to determine “[w]hether those services furnished or proposed to be furnished on an inpatient basis could be effectively furnished on an outpatient basis, or in an inpatient health care facility of a different type.”<sup>54</sup> The MBPM sets forth the following guidance on the QIO reviews:

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary....In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission

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<sup>48</sup> *Id.*

<sup>49</sup> Press Release, Dep’t of Justice, *Minnesota Hospital to Pay U.S. to Resolve Allegations of False Claims Involving Unnecessary Admissions* (Jan. 4, 2010), available at <http://www.justice.gov/opa/pr/2010/January/10-civ-001.html>.

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> 42 U.S.C. § 1320c-3; *see also* 42 C.F.R. § 476.70.

<sup>53</sup> 42 U.S.C. § 1395cc(a)(1)(F); *see also* 42 C.F.R. § 476.71(a)(3), (6), (8).

<sup>54</sup> Ctrs. for Medicare & Medicaid Servs., Quality Improvement Organization Manual, Ch. 1 § 1005, available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp?listpage22> (follow “100-10” hyperlink).

information would support a finding that an admission was medically necessary.<sup>55</sup>

In 1999, the QIO began its Sixth Scope of Work which included a review of one-day stays generally and for chest pain specifically. The goal of the program was to reduce national and state payment errors for PPS hospitals. High error rates were common and QIOs required some providers to implement Quality Improvement Plans. QIOs focused on auditing hospitals for short stays, concentrating on medical necessity.

In the early 2000's, the QIOs initiated the Seventh Scope of Work with the goal of reducing national and state payment errors, and reducing variation among medical necessity decisions. After performing reviews of inpatient admissions, most hospitals reported high error rates ranging from 30-50 percent or higher for inpatient admissions.<sup>56</sup> Under the QIOs Eighth Scope of Work, many QIOs continued to tackle the issue of inappropriate one-day stays.<sup>57</sup> Currently, QIOs are working on the Ninth Scope of Work but have returned to focusing on quality initiatives and improvement. The current QIO focus on quality of care coincided with the initiation of the RACs, government contractors that will focus on auditing hospitals to identify inappropriate payments.

## VII. Examples of Recent State QIO Reviews of Short Stay Admissions

The work performed by the following QIOs serve as examples for the kind of short stay admissions projects that many QIOs have undertaken. The following is a non-exhaustive list of the types of short stay projects and programs implemented by the QIOs.

**Michigan:** During the Eighth Scope of Work, MPRO, the QIO in Michigan, created a program to “try to get to the bottom of this payment error and facilitate hospital networking to help reduce its prevalence.”<sup>58</sup> In July 2006, reimbursement for one-day stays in Michigan had increased 60% since 2000.<sup>59</sup> MPRO undertook a study of one-day stays under the Hospital Payment Monitoring Program (“HPMP”).<sup>60</sup> As of January 2008, Michigan hospitals had driven down their rate of inappropriate one-day stays.<sup>61</sup> To improve the one-day stay problem, MPRO focused on 16 hospitals at higher risk for one-day stays.<sup>62</sup> Some of the strategies that the MPRO used to educate and improve the short stay admissions problem included holding monthly educational calls with the 16 hospitals organized by the MPRO, implementing a standard quality-improvement approach called “rapid-cycle” allowing hospitals to quickly implement interventions to solve problems

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<sup>55</sup> MBPM, *supra* note 1, at Chap. 1 § 10.

<sup>56</sup> Dennis Barry, AHLA/HCCA Fraud and Compliance Forum, *Inpatient Short Stays and Medical Necessity*, (Sept. 25-27, 2006).

<sup>57</sup> *As Errors for One-day Stays Climb, QIOs Launch Projects Aimed at Observations*, Report on Medicare Compliance, July 3, 2006, at 1.

<sup>58</sup> *Id.* at 5.

<sup>59</sup> *Id.* at 1.

<sup>60</sup> *Id.*

<sup>61</sup> *Mich. Hospitals Focus Efforts to Improve One-Day Stay Admissions*, Report on Medicare Compliance, Jan. 28, 2008, at 6.

<sup>62</sup> *Id.*

and drive down errors, educating physicians and patients about the differences in patient status, and installing case managers in the emergency department.<sup>63</sup>

**New Mexico:** In a June 2008 publication, the QIO in New Mexico, New Mexico Medical Review Association (“NMMRA”), announced it planned to lead a six-state study that involved utilizing a case management protocol for assigning bed status when a patient presents at the hospital in an effort to reduce short stay hospital admissions. New Mexico worked in collaboration with QIOs in Arizona, Nevada, Oregon, Utah, and Washington on this project. The QIO in each of these states recruited three hospitals to adopt the case management protocol for the study. The participating hospitals were educated on the differences between inpatient and observation levels of care when admitting a patient. NMMRA’s goal was to have a 20% reduction or more in the number of unnecessary admissions in the hospitals participating in the project.<sup>64</sup>

**Missouri:** In February 2006, Primaris, the QIO in Missouri, notified 20 hospitals within the state that they had been identified through the HPMP as having a high proportion of inpatient one-day stays. The OIG suggested those hospitals may also have a higher proportion of unnecessary admissions. Primaris launched a One-Day Stay Project to assist the 20 hospitals identify and reduce inappropriate short stay admissions. The Primaris One-Day Stay project identified errors in 66% of all one-day admissions resulting in a payment error of \$23 million in Missouri alone.<sup>65</sup>

**Georgia:** Georgia Medical Care Foundation (“GMCF”), the QIO in Georgia, issued a HPMP Special Projects Report which found a large number of one-day hospital stays for congestive heart failure are avoidable. GMCF conducted a study and evaluated the diagnosis and treatment of CHF patients to determine whether those patients could have been treated on an outpatient basis. GMCF performed a records review on 11 hospitals included within the study. The baseline error rate for admissions was 26.9%. GMCF staff held meetings with the hospitals who had error rates of over 10% to develop quality improvement plans to improve upon these error rates.<sup>66</sup>

**New Jersey:** Healthcare Quality Strategies, Inc. (“HQSI”), the QIO in New Jersey, implemented a short stay project with 15 hospitals that had a high proportion of short stay admissions for nine targeted DRGs.<sup>67</sup> HQSI reviewed cases at the 15 hospitals using InterQual criteria. At the end of the project, “assuming a sustained level of improvement, the estimated savings to the Medicare Trust fund for one year following

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<sup>63</sup> *Id.*

<sup>64</sup> *New Mexico Health Care Providers and NMMRA Working Together to Improve the Quality of Care*, New Mexico Medical Review Association Bulletin, April 2008, at 1, 8, available at [http://www.nmmra.org/resources/About/137\\_1304.pdf](http://www.nmmra.org/resources/About/137_1304.pdf).

<sup>65</sup> *Battling the Unseen Over-Utilization: One Day Stays*, Quality Today (Primaris Healthcare Bus. Solutions, Columbia, Mo.), Summer 2006, at 1, available at [http://www.primaris.org/documents/qualitytoday/QT\\_2006summer.pdf](http://www.primaris.org/documents/qualitytoday/QT_2006summer.pdf).

<sup>66</sup> Ga. Med. Care Found., *Hospital Payment Monitoring Program, Special Projects Report*, available at [http://www.gmcf.org/medicare\\_beneficiaries/media/DRG127.Project.pdf](http://www.gmcf.org/medicare_beneficiaries/media/DRG127.Project.pdf).

<sup>67</sup> Ya-ping Sun, Medicare Patient Mgmt., *Reducing Medically Inappropriate Admissions*, Medicare Patient Mgmt., Jan.-Feb. 2008, at 27.

conclusion of the project is approximately \$11.3 million.”<sup>68</sup> As a result of the study, the 15 hospitals had significant improvement in understanding the issues regarding assigning the appropriate patient status. Factors key to this improvement included use of InterQual criteria and educating physicians and the utilization review and case management staff regarding observation versus inpatient status.<sup>69</sup>

**Arizona and Florida:** Health Services Advisory Group (“HSAG”), the QIO in Arizona, and Florida’s Medicare Quality Improvement Organization (“FMQAI”), the QIO in Florida, designed and implemented projects to reduce unnecessary hospital admissions for Medicare patients with chest pain (DRG 143). Both projects utilized the Case Management Protocol, successfully used in a 2004 CMS project conducted in Florida and later included in HSAG’s current special study, the Case Management Assessment Protocol Special Study. For the 11 Arizona hospitals included in this project, the rate for inappropriate one-day admissions for DRG 143 was reduced 42 percent from baseline to re-measurement and the absolute number for DRG 143 one-day admissions was reduced by 90 percent.<sup>70</sup> In Florida, FMQAI focused on chest pain admissions at 10 hospitals. The “participating hospitals reduced their inappropriate [DRG 143] admissions by 37%, with a projected decrease annually of 67%.”<sup>71</sup>

**Massachusetts:** In 2006, Masspro, the QIO in Massachusetts, identified through PEPPER reports that UMass Memorial Medical Center (“UMass”) had a high percentage of one-day inpatient stays.<sup>72</sup> Masspro worked together with UMass to understand why the numbers of one-day stays were high. Masspro and UMass identified communications breakdowns between the points of entry at the hospital as one of the causes of the high percentage of one-day stays. Through “onsite meetings, educational sessions, and Masspro’s sharing of best practices from other (de-identified) hospitals,” UMass was able to improve its percentage of one-day stays.<sup>73</sup> UMass and Masspro developed a quality improvement project that included the following: (1) Utilization Review Committee established a sub-committee to specifically address the issue of one-day inpatient stays, and (2) UMass developed reports that kept the hospital staff focused on improving communications regarding admission decisions (the reports were also provided to the Utilization Review Committee on a monthly basis).<sup>74</sup> In addition, UMass developed education sessions (including one-on-one physician education regarding the appropriate levels of care for patient status). The project resulted in an overall reduction in the number of one-day stay admissions. “Prior to the implementation of these initiatives,

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<sup>68</sup> *Id.* at 29.

<sup>69</sup> *Id.* at 30-31.

<sup>70</sup> Health Services Advisory Group Special Studies, *accessible at* <http://www.hsag.com/services/special/paststudies.aspx> (last visited Feb. 5, 2010).

<sup>71</sup> *Compliance to the Case Management Protocol Reduces Unnecessary Hospital Admissions*, Press Release, FMQAI (Sept. 10, 2009), *available at* <http://www.fmqai.com/library/attachment-library/CMAPRelease0910F.pdf>.

<sup>72</sup> Masspro, *UMass Memorial Medical Center and Masspro Work Together to Improve One-Day Stay Rates and Compliance with Medicare Regulations*, *available at* [http://www.masspro.org/REPS/MECA/HPMP/docs/casestudies/CS\\_review\\_services.pdf](http://www.masspro.org/REPS/MECA/HPMP/docs/casestudies/CS_review_services.pdf).

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

UMass ranked among the top five providers for one-day stays related to a number of DRGs. Following the implementation of the initiatives, UMass' ranking has moved in a positive direction, falling below the top 20 one-day stay providers.”<sup>75</sup>

### **VIII. Recommended Action**

- Education and ongoing training for the emergency room physicians, treating physicians, and utilization review/care management nurses regarding the differences between inpatient and observation status as well as Condition Code 44.
- Use of up-to-date InterQual (or other screening criteria) guidelines by the utilization review/care management nurses.
- Early communication among members of the treating team including physicians and utilization review/care management nurses.
- Ensure hospital has an up-to-date Utilization Review Plan and a Utilization Review Committee that meets and reviews short stay admissions and unnecessary admissions. Develop a plan of action if these reviews reveal a high percentage of one-day stays or unnecessary admissions.
- Emphasize importance of clear documentation in physician admission orders (*e.g.*, physician order to “admit” is not clear; physician order should specify inpatient, outpatient, and observation and should include the admitting diagnosis).
- Use of physician advisors when disagreements occur between the physicians and utilization review/care management nurses regarding patient status.
- Involvement of utilization review staff, coding/billing department, Health Information Management department, finance department, and compliance team regarding compliance with Medicare rules and regulations.

### **IX. RACs Focus on Medical Necessity**

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed HHS to conduct a three-year demonstration project with the RACs. After the demonstration project, the project shifted to a nationwide program. Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires the expansion of the program to all fifty states by no later than 2010.

As noted above, during the demonstration project, medical necessity denials represented 40% of the recovery dollars in the pilot program through March 27, 2008,

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<sup>75</sup> *Id.*

resulting in \$391.3 million recovery dollars.<sup>76</sup> Most of these were short stay inpatient denials. Another 8% of the recovery dollars in the pilot program through March 27, 2008 represented no or insufficient documentation which may also implicate medical necessity issues.<sup>77</sup>

Medical necessity reviews will continue to be a key issue for the RACs in 2010. Hospitals should be prepared for RAC requests for medical records for complex medical necessity reviews and should implement a process for responding to the RAC requests.

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<sup>76</sup> *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, *supra* note 25 (June 2008), accessible at [http://www.cms.hhs.gov/RAC/Downloads/RAC\\_Demonstration\\_Evaluation\\_Report.pdf](http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf) (numbers self-reported by the Claim RACs).

<sup>77</sup> *Id.*