WHEN IS A HOSPITAL STAY NOT A HOSPITAL STAY?
WHEN THE PATIENT RECEIVES "OBSERVATION SERVICES"

The Center for Medicare Advocacy (the Center) has heard repeatedly about beneficiaries throughout the country whose entire stay in a hospital is classified by the hospital as “outpatient observation,” despite the fact that the individual stays overnight in the hospital – often in the same room as people who are considered inpatients. Indeed one of our clients was billed to Medicare as “observation status” although she was in the hospital for 14 days!

In some instances, the beneficiaries' physicians order their admission, but the hospital retroactively reverses the decision. As a consequence of the classification of a hospital stay as outpatient observation (or of the reclassification of a hospital stay from inpatient care, covered by Medicare Part A, to outpatient care, covered by Medicare Part B), beneficiaries are charged for various services they received in the acute care hospital, including their prescription medications. They are also liable for the cost of their entire subsequent skilled nursing facility (SNF) care, having never satisfied the statutory three-day hospital stay requirement for Medicare coverage.

How the Centers for Medicare & Medicaid Services (CMS) Defines Observation Status

Neither the Medicare statute nor the Medicare regulations authorize or define hospital observation status. The concept comes entirely from CMS policy, and the only definition appears in various CMS manuals, where observation services are defined 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.\(^1\)

The CMS policy further provides that, in most cases, a beneficiary may not remain in observation status for more than 24 or 48 hours.\(^2\)

Even if a physician orders a hospital inpatient admission, CMS has authorized hospital utilization review (UR) committees to change the patient’s status from inpatient to outpatient “observation status” since 2004. According to CMS such a retroactive change may be made, however, only if

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\(^1\) Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6; same language in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.

\(^2\) Id.
(1) the change is made while the patient is in the hospital; (2) the hospital has not submitted a claim to Medicare for the inpatient admission; (3) a physician concurs with the UR committee's decision; and (4) the physician's concurrence is documented in the patient's medical record. CMS explains that retroactive reclassifications should occur infrequently, "such as a late-night weekend admission when no case manager is on duty to offer guidance." Although CMS anticipated in 2004 that reclassifications would be made less frequently over time, the Center has been hearing more about this practice in recent years.

**Important Consequences of Observation Services and Status**

The most expensive consequences for a beneficiary receiving observation services, rather than inpatient care, may be the cost of post-acute services in a skilled nursing facility. In addition, however, a beneficiary may be required to pay for services in the hospital that would otherwise be covered in a Part A stay.

- **Lack of Access to Medicare-Covered Skilled Nursing Facility Care**

  “Observation status” has financial consequences for a beneficiary. While s/he may avoid paying a Part A hospital deductible ($1,068 per spell of illness in 2009), any subsequent skilled nursing facility (SNF) stay will be denied Medicare coverage for lack of the requisite three day prior hospitalization. The beneficiary will have to pay at the private rate, which is about $327/day in 2009 in the State of Connecticut. Private nursing home rates often reflect only room and board costs; many other services may be charged separately.

- **Prescription Drug Coverage**

  Prescription drugs, paid under Medicare Part A during an inpatient stay, must be covered by Part D for beneficiaries receiving observation services on an outpatient basis. The hospital pharmacy is not likely to be in the Part D plan’s network, so the beneficiary will be charged the out-of-network price for necessary drugs. Moreover, some drugs used by the hospital may not be on the plan’s formulary. Non-formulary drugs may not be covered at all, especially, as is usually the case, if the beneficiary made no arrangements with the Part D plan in advance.

- **Substantial Outpatient Payment Liability**

  Under the Outpatient Prospective Payment System (OPPS), a beneficiary’s coinsurance with respect to outpatient hospital services is calculated for each Ambulatory Payment Classification

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Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital’s existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

Question and Answer 3.

5 *Id.*
(APC), based on 20% of the national median APC calculation. This is a different calculation from the usual 20% co-payment amount calculation under Medicare Part B. Under OPPS, the 20% co-payment amount could be quite large. Section 204 of the Balanced Budget Refinement Act of 1999 (BBRA) provides that no single APC coinsurance amount can be greater than the hospital inpatient deductible in a given year. However, hospitals may charge more than one APC per beneficiary outpatient department encounter, depending on the services provided.

Does CMS Require any Notice to Beneficiaries about His/Her Observation Status?

When a beneficiary is placed in observation status by the attending physician, a hospital may be required to give the patient an Advance Beneficiary Notice (ABN) of non-coverage in order to shift liability to the beneficiary. A critical issue for CMS is whether the service meets the requirements of a Part B-covered service. If the service is a Part B service, but it "falls outside of a timeframe for receipt of a particular benefit," then the hospital must give the beneficiary an ABN. If the service is not a Part B service, an ABN is not required to shift liability to the beneficiary; the hospital may voluntarily give the patient such notice. Although the precise application of these principles to observation services has not been addressed in any administrative or court decision, the Center believes that placement of a beneficiary in observation status should lead to the requirement that the hospital give the patient an ABN.

Under the Medicare Act, when a determination is made that a service was not medically necessary and that Medicare will not pay for it, payment will nevertheless be made if the beneficiary did not know, and could not reasonably be expected to know, that payment would not be made. A beneficiary is presumed not to know "that services are not covered unless the evidence indicates that written notice was given to the beneficiary [bold font in original]." A provider must inform a beneficiary when services are not medically necessary; its failure to do so will relieve the beneficiary of responsibility of paying for the service.

If a hospital UR committee determines that a patient's inpatient stay is not medically necessary and should be reclassified as outpatient observation, CMS explicitly requires that the beneficiary be notified promptly in writing. The notice is necessary so that the beneficiary "is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible."

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9 Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6.C.
12 Hospital ABNs are discussed in CMS, “Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare,” Transmittal 594, Change Request 3903 (June 24, 2005), which will be put in the Medicare Claims Processing Manual, Chapter 30, §80. This Transmittal includes 10 different forms for Hospital –Issued Notices of Non-coverage (HINNs), none of which addresses observation services.
14 Id. Question 8.
What Notice Must a Skilled Nursing Facility (SNF) Give a Beneficiary?

SNFs that believe that Medicare coverage will be denied for a technical reason, such as a lack of the three-day qualifying hospital stay, may give the resident a Notice of Exclusion of Medicare Benefits (NEMB). Use of the notice by SNFs is optional.

The NEMB-SNF informs the beneficiary that, in the view of the SNF, Medicare will not pay for the resident's care. The form offers the beneficiary three options:

- Option 1: Checking "Yes" means that the beneficiary wants to receive the services and wants Medicare to make a decision about coverage. This option requires the SNF to submit the claim, with supporting evidence, to Medicare. If Medicare denies payment, the beneficiary agrees "to be personally and fully responsible for payment."
- Option 2: Checking "Yes" means that the beneficiary wants to receive the services, but does not want the claim to be submitted to Medicare.
- Option 3: Checking "No" means that the beneficiary does not want to receive the services and that no claim will be sent to Medicare.

To Summarize:

- The Center for Medicare Advocacy believes that hospitals must give beneficiaries an Advance Beneficiary Notice when they are placed in observation status, so that their hospital care will not be billed as inpatient stays to Part A.
- CMS explicitly requires hospitals to give written notice to a beneficiary when the hospital's utilization review committee reverses an attending physician's determination to admit a patient as an inpatient.
- CMS has prepared a form that SNFs may use for technical denials of coverage, including failure to meet the three-day stay requirement, but use of the NEMB-SNF is optional for SNFs.

Notice Concerns

In the Center's experience, hospitals and SNFs are not giving beneficiaries notice of non-coverage. Hospitals are not complying with the notice requirements and are not giving patients an ABN when beneficiaries are assigned to observation status in the hospital regardless of the length of that status.

The Center anticipates that more beneficiaries may be placed in observation status next year as the Recovery Audit Contractor (RAC) program moves from demonstration status to a permanent, nationwide program. RAC was authorized by §306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) to detect and correct improper payments in the traditional Medicare program, both overpayments and underpayments. The review of the three-year demonstration program found that RAC contractors, who were paid on a contingency basis, identified $1.03 billion in improper payments, $992.7 million (96%) in overpayments and

$37.8 million (4%) in underpayments. Most of the overpayments (85%) were collected for inpatient hospitals stays. The review also reported that only 14% of providers appealed and only 4.6% of RAC overpayment determinations were overturned on appeal.\textsuperscript{17}

The Center for Medicare Advocacy would like to hear your experiences as we work on solutions to these Observation Status issues. In the meantime, the Center suggests that:

- Beneficiaries appeal from hospital and SNF notices that they do receive, and from the quarterly Medicare Summary Notice describing all Medicare claims for a designated period of time, so that the Medicare program can make an initial determination of coverage.
- Beneficiaries who do not receive a notice from the hospital should file a request with the Medicare Administrative Contractor, asking that the contractor review the information and determine whether they met the inpatient criteria.
- Beneficiaries should appeal denials of Medicare coverage for the subsequent SNF stay at the same time as they appeal their observation status in the hospital.
- Beneficiaries who are billed for prescription drugs during their hospital stay should use their Part D plan's process for submitting claims from an out-of-network pharmacy (assuming the hospitals' pharmacies do not participate in Part D plans, as most do not).

Conclusion

The observation status issue raises concerns about provider reimbursement, fraud, beneficiary cost-sharing, beneficiary notice, and access to medications and care. We will continue to untangle these issues as we advocate for proper care and coverage for Medicare beneficiaries.