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Medicare Inpatient or Outpatient Observation?

Distinguishing between an inpatient admission and an outpatient observation continues to create billing problems for providers nationwide. Generally, the distinction between inpatient and extended outpatient observation represents a billing characterization rather than a difference in medical condition. The Medicare criteria and differentiation of status are not relevant to the ordering physician. As a result, physician orders for inpatient admissions and observation stays may be ambiguous.

The determination of inpatient or outpatient status for a patient is reserved to the admitting physician, subject to Medicare guidelines. The decision is to be based on the physician's expectation of the care that the patient will require. Generally, the physician should order an inpatient admission for patients who are expected to require inpatient hospital care for 24 hours or longer. Inpatient admissions are not covered when the care could be provided in a less intensive setting without significantly and directly threatening the patient's safety or health, or when the admission is for convenience. [PRO § 4110.A]

Observation services require the use of a bed and periodic monitoring to evaluate an outpatient condition or determine the need for possible inpatient admission. Observation may not be used as a substitute for a medically necessary inpatient admission, nor may it be used solely for the convenience of a patient, physician or facility. Observation generally does not exceed 24 hours.

Issues arise as to whether a patient stay is properly an inpatient or outpatient observation stay. Hospital Manual § 210, as well as other sources of Medicare authority, state that a physician's order for an inpatient admission cannot be converted to observation status (and vice versa) without a contravening order from the physician.

CMS has undertaken to provide answers and policy clarifications relating to some of the problems plaguing hospitals. One intermediary, Riverbend Government Benefits Administrator, has issued a local medical review policy on the subject of inpatient admissions and observation status, effective for services performed after June 1, 2002 (www.riverbendgba.com/vlmp/080-01.html). The impetus for the policy was the perceived misunderstanding of the relative roles of physicians and facilities in determining patient status and the distinction between inpatient and outpatient observation billing rules.

Because the physician is responsible for the admission order, the physician may modify the order at any time prior to the completion of the service (*i.e.*, prior to discharge). The modification should, however, be based on the physician's initial expectation in accordance with Hospital Manual § 210. The Riverbend policy states explicitly that "[i]t would be appropriate for a UM nurse to review a record the morning after admission and inform the physician that he always discharges his rule-out MI patients in 18 hours, so in accordance with Hospital Manual § 210, he should consider the care to be outpatient. It would not be appropriate for UM to say 'this patient left after 18 hrs. so it should be outpatient even though you thought they would be here for two days.' "

Watch for It!

CMS Administrator Tom Scully told reporters that if Congress does not act to change Medicare payment for prescription drugs based on Average Wholesale Price, CMS will do so effective January 1, 2004. Scully said the proposed cuts in the AWP-based drug reimbursement will be accompanied by some limited increase in the practice expense reimbursements to physicians that administer the drugs. The draft rule is expected this summer, in time for inclusion in the November Medicare physician fee schedule.

Watch for further consideration of "cost-effectiveness" by CMS, Medicare contractors, and Medicaid administrators in making coverage decisions and setting reimbursement levels. Most recently, CMS has raised cost-effectiveness in deciding whether to cover new colon cancer tests and discussing payment for certain prescription heartburn drugs.

The Riverbend policy also states that there may be circumstances in which the initial physician order is ambiguous. In these instances, the policy states that the physician may clarify an ambiguous order “when the order and its implementation were inconsistent.” Such clarification may be made after discharge and prior to billing. Note that this is only in cases of ambiguous orders.

Once the initial bill is submitted to Medicare, the bill can only be adjusted to correct billing errors. Therefore, the physician’s intended patient status (inpatient versus outpatient) cannot be changed.

The Riverbend policy also considers a situation in which the physician orders an outpatient observation, but a review of the medical chart indicates that an admission would be the appropriate status according to Hospital Manual § 210. In this case, the facility may not bill the inpatient admission unless the physician changed his order and admitted the patient (*i.e.*, before discharge).

Hospitals should carefully monitor their short stay patients and be mindful of the Medicare distinctions between inpatients and observation patients. This is particularly important given recent OIG scrutiny of short stays and inclusion of the issue in the last two OIG work plans.

It is important to note that the policies contained in the Riverbend local review policy relating to observation and inpatient status are not those of CMS. Significantly, intermediaries appear to have varying policies on these issues.

CMS Finalizes a Portion of the 1998 ASC Proposed Rule

On March 28, 2003, CMS issued a final rule with comment period (“Final Rule”) updating the ambulatory surgical center (“ASC”) list of covered procedures to be effective July 1, 2003. 68 Fed. Reg. 15268. This Final Rule updates and finalizes the June 12, 1998 proposed ASC rule that set forth the list of surgical procedures approved for reimbursement in the ASC setting. However, this 2003 Final Rule does *not* update payment rates or address the statutory revised ratesetting methodology based on APC groups.

CMS states that it delayed publication of this Final Rule primarily in response to public comments that requested that the ASC changes coincide with the hospital outpatient prospective payment system (“OPPS”) final rule, given that

the Medicare ASC and OPSS payments are closely linked. In other words, providers requested this concerted implementation to allow them the opportunity for comparison of the two payment systems (ASC vs. OPSS).

During the delayed implementation of the proposed rule, the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (“BIPA”) revised the ASC statutory payment requirements (SSA § 1833(i)(2)) by, in part, requiring that payment rates effective for January 1, 2003, be based on a survey of ASCs conducted after 1999. In this Final Rule, CMS acknowledges that it is out of compliance with this requirement. Although CMS has developed the survey instrument, it does not expect that the compilation of cost data upon which to base ASC payment rates will be completed for at least two years.

Therefore, this Final Rule only updates the list of ASC-approved procedures. The updated list includes many of the procedures proposed for inclusion in the June 1998 proposed rule, new CPT codes that were added to CPT from 1999 through 2003 and that are similar to the procedures on the proposed ASC list that CMS ultimately accepts as permissible, and adds and deletes other codes in response to comments from the public.

Comments are due to CMS on this Final Rule by May 27, 2003.

CMS Springs Into Action with String of Proposals

New Medicare Enrollment Policy. On April 25, 2003, CMS proposed a new regulation on Medicare enrollment, stating that the new policy would not only streamline the process but also effectively screen out unqualified providers and suppliers. Some provisions are not surprising. For example, each applicant must satisfy all federal, state, and local requirements as a provider or supplier of services. In addition, CMS plans to reject excluded or debarred individuals. The proposal also introduces a few new provisions. For instance, if an enrolled provider or supplier does not submit claims for payment for two consecutive calendar quarters, then CMS intends to deactivate the billing number of such a provider or supplier until a claim is submitted. However, CMS plans to develop exceptions for pediatricians and other providers and suppliers that do not bill Medicare regularly. Furthermore, CMS proposes to mandate a recertification by the enrolled provider or supplier every three years. CMS is accepting public comments through June 24, 2003.

New Medicare Coverage of High Technology. Currently, Medicare pays for the use of magnetic resonance angiography (“MRA”) for beneficiaries with abdominal or pelvic vascular disease only when the aortic wall is damaged. CMS announced its plans to expand Medicare coverage of MRA. CMS intends to pay for the use of MRA to evaluate renal or pelvic arteries even when the aortic wall is not damaged. In addition, CMS proposed to allow the use of catheter angiography in conjunction with MRA when medically necessary.

New Medicaid Definition of Audiologist . On April 2, 2003, CMS proposed a regulation that would harmonize the definition of an audiologist for both the Medicare and Medicaid programs. The proposal revises the qualification criteria employed by State Agencies to define and enroll audiologists in Medicaid. Specifically, the audiologist must hold a master’s or doctoral degree and satisfy all state requirements. If a state does not license or certify audiologists, then the audiologist must either obtain American Speech-Language-Hearing Association (“ASHA”) certification or complete 350 hours of supervised clinical practice in order to enroll in Medicaid. In essence, the proposal eliminates the ASHA certification as the sole enrollment criterion. However, CMS did not change the definition of a speech-language pathologist. CMS is accepting public comments through June 2, 2003.

Please contact our *Payment Matters* editors, Holley Thames Lutz (202/230-5126) or Carin Sigel (202/230-5173), for additional details or advice on these issues.

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