Understanding and selecting inpatient vs. observation – How to decide

Novitas, in concert with CMS, is continuing to focus on lowering the Comprehensive Error Rate Testing (CERT) claims paid error rate. Currently, one area of concern identified in the CERT data is one-day inpatient admissions and outpatient observation services. Specifically, recent CERT errors have identified a significant issue related to the submission of claims for one day inpatient admissions. These errors indicate observation services would have sufficed.

The following definitions and guidelines are provided to assist you in making future determinations regarding whether a claim is properly submitted as an inpatient admission or outpatient observation care.

Inpatient services defined

“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 require hospital care that is expected to span at least two midnights 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.”

[CMS IOM Pub. 100-02 Benefit Policy Manual, Chapter 1, section 10](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf)

CMS gives further guidance for inpatient

“Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.”

[CMS IOM Pub. 100-08 Program Integrity Manual, Chapter 6, section 6.5.2(A)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf)

Physicians are recommended to use a 24-hour period as a benchmark when making a determination on an inpatient admission. However, admissions are not deemed covered, or non-covered, solely on the basis of the length of time the patient actually spends in the hospital. Additionally, when a patient presents for a minor surgical procedure, or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients, regardless of the hour the patient presented to the hospital and if that patient remained in the facility over the midnight census.

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 by-laws and admissions policies, and the relative appropriateness of treatment in each setting. In general, the decision to admit a patient should be primarily based on the severity of illness and intensity of services rendered. Medical necessity at the time of admission to the hospital must be clearly documented in the medical record.

Without accompanying medical conditions, factors that would only cause the beneficiary, or beneficiary’s family, inconvenience in terms of time and money do not justify a continued hospital stay. This includes, but is not limited to, continued hospitalization when the patient’s condition warranted a discharge to home or when the patient could have been discharged for nursing home placement. Failure to discharge the patient when appropriate will result in a delayed discharge and will be subject to medical necessity denials.

Observation services defined

“Observation care is 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. 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.

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.”

[CMS IOM Pub. 100-04 Claims Processing Manual, Chapter 4, section 290.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf)

Observation care should be utilized until it is determined that the patient can either be discharged or admitted as an inpatient.

Observation services must be patient specific and not part of the facility’s standard operating procedures. For example, post-procedural recovery and monitoring would not be billable as observation. In certain instances, specific clinical situations may arise and additional outpatient services, or an inpatient admission, may be medically necessary. However, this would have to be outside the standard recovery and monitoring periods for the procedure rendered.

Observation services are not considered medically necessary when the patient’s current medical condition does not warrant observation, or when there is not an expectation of significant deterioration in the patient’s medical condition in the near future.

Observation services generally are not expected to exceed 48 hours in duration. Observation services greater than 48 hours in duration are seen as rare and exceptional cases. If medically necessary, Medicare will cover up to 72 hours of observation services. Observation services rendered beyond 72 hours is considered medically unlikely and will be denied as such. The appeals process must be followed to have observation services exceeding 72 hours to be considered for payment. A patient in observation status is either:

* Admitted as an inpatient based on the patient’s condition or;
* An outpatient and released when the physician determines observation is no longer medically necessary

A physician’s order is required when placing a patient in observation. Lack of documentation can lead to claim errors and payment retractions. A lack of documentation for an inpatient admission does not warrant retroactive observation billing. An order to admit the patient as an inpatient is also required when billing for an inpatient stay. Again, lack of documentation that clearly indicates the order for admission is grounds for a claim error and payment retraction. For example, and 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. It is imperative that there is a continued focus on lowering the CERT rate and facility involvement is a key component to this goal.

Providers are reminded that observation services are provided on an outpatient basis and should be billed according to observation billing guidelines, which state that all hours of observation should be submitted on a single line with the date of service being the date the order for observation was written. Orders for observation services are not considered to be valid inpatient admission levels of care orders. When billing observation services, Novitas Solutions expects the charges associated with those services to be billed as outpatient level of care services. Providers are encouraged to participate in educational opportunities offered by Provider Outreach & Education. Training and educational materials are focused on addressing topics that assist providers in understanding Medicare policies.

Who can prevent inappropriate inpatient admissions?

In reviewing charts of recent Novitas CERT errors, two types of providers are identified as being able to prevent an inappropriate inpatient admission: emergency room providers and attending providers

Emergency room providers

In some cases, the emergency room (ER) provider is writing the order to admit to inpatient services. Review of the documentation has identified that this is often within the first 24 hours of the patient arriving in the emergency room and prior to any diagnostic testing being ordered, or if diagnostic testing is being ordered, the order for the inpatient admission is written prior to the results being obtained.

Emergency room providers need to be aware that observation services are an option to assess the patients’ condition and provide sufficient time for diagnostic testing and receipt of the test results to be sure that an inpatient admission is warranted per CMS guidance.

Attending providers

Once the attending provider has assessed the patient after admission from the emergency room and determines, based on results of the physical exam, patient signs and symptoms, including resolution of those signs and symptoms, and receipt of negative diagnostic testing results, the inpatient admission is not necessary, what can the provider do at this point?

When it is determined that a patient was admitted erroneously, the condition code 44 policy may be invoked. All the requirements set forth in the condition code 44 policy must be met in order to change the status from inpatient to outpatient.

These requirements are included below:

* The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
* The hospital has not submitted a claim to Medicare for the inpatient admission;
* A physician concurs with the utilization review committee’s decision; and
* The physician’s concurrence with the utilization.

The hospital may not bill observation charges retroactively to cover the time the patient was admitted as an inpatient in the hospital. Medicare does not permit retroactive orders or inference of physician orders. If observation is ordered upon the determination that the patient should no longer receive inpatient treatment, Medicare coverage begins when observation services are initiated in accordance with the physician’s order.

In condition code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter.

Regardless of what point the provider encounters the patient, whether it is the emergency room provider performing the initial exam and treatment or the attending provider, the provider needs to be sure that an inpatient admission is the most appropriate level of care following CMS guidelines.

If it is not signed, it is not complete

Is your documentation completed? Will it stand up in a medical record review?

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

Do not add late signatures to the medical record, beyond the short delay that occurs during the transcription process.

Do not send draft or preliminary copies of your records. The records need to be properly authenticated by the author, complete with a legible signature, signature attestation or group signature log.

If there is no signature or the signature is illegible the signature authentication process may be used. A signature attestation statement or signature log may be used for any unsigned or illegible signatures. The attestation statement is signed and dated by the author of the medical record entry and contains sufficient information to identify the beneficiary.

Did you know an illegible signature or provider’s initials are permitted? The signature or initials must be directly above a typed or printed name. A signature log that matches the signature on the documentation can also be submitted with medical records.

For a signature to be valid, the following criteria must be met:

* Services that are provided or ordered must be authenticated by the ordering practitioner
* Signatures are handwritten, electronic, or stamped (stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of inability to sign due to a disability)
* Signatures are legible

Remember, if it’s not signed, it’s not complete.

For full guidelines, exceptions, and examples of acceptable signatures, please see the references below.

References

* [CMS IOM Pub. 100-08 Medicare Program Integrity Manual, Chapter 3, section 3.3.2.4](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)
* [Medicare Learning Network (MLN) Matters Article, MM6698 - Signature Guidelines for Medical Review Purposes](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf)

Case examples of denied inpatient stays

The following are examples of one-day inpatient admissions in which the documentation did not support the inpatient admission and observation care would have been the more appropriate billing.

All examples are from CERT error reports and denied as inpatient one-day stays by the CERT contractor.

1. Patient was admitted with abdominal pain. A computerized axial tomography (CAT) scan of the abdomen was performed and showed no obstruction. The patient was given Lactulose and IV fluids were ordered, but there is no documentation that they were given. The patient was discharged in stable condition in less than 24 hours. This was denied as not a reasonable and necessary inpatient admission and these services could have been accomplished as outpatient observation services.
2. Patient was an elective admission for transurethral destruction of bladder lesion with no complications post-operatively. The patient was discharged in less than 24 hours. This was denied as not reasonable and necessary as an inpatient procedure since the services could have been accomplished as an outpatient procedure.
3. Two examples involved patients who were admitted with complaints of chest pain. In both cases the patient was admitted to “rule out myocardial Infarction.” Both were placed on telemetry monitoring and serial electrocardiograms and cardiac enzymes were performed. In both cases, the patient findings were normal sinus rhythm and cardiac enzymes were negative. Both were discharged in less than 24 hours. In both cases, the inpatient one-day stay was denied as not reasonable and necessary as these services should have been provided as outpatient observation services.
4. A patient was admitted with the physician’s order of “observation level of care.” At the time of discharge, the utilization review (UR) department asked the physician to change the admission to inpatient. This was changed while the physician was writing discharge orders for this hospital stay. The inpatient stay was less than 24 hours, and the documentation did not support an inpatient admission. In this case the physician was incorrect on changing the order to inpatient admission. Per [CMS IOM Pub. 100-02 Benefit Policy Manual, Chapter 6, section 20.6B](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf) “when a physician orders that a patient receive observation care, the patient’s status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released or be admitted as an inpatient.” The UR department was incorrect in this instance to request that the physician change the admission order.
5. An 81-year-old patient was admitted after being “pushed by someone at the nursing facility” and fracturing her right humerus. The patient’s past medical history included previous right shoulder replacement multiple years ago. An orthopedic consult recommended surgery for reasonable function of the shoulder; however, discussion with the family resulted in the decision to not pursue surgery. The patient was placed on oral medications and was stable. The ER documentation indicated that this was a “social admission” pending rehabilitation placement as the patient “did not want to go back to the same facility.” The documentation does not support that this inpatient admission was medically reasonable and necessary. CMS does not allow payment for services for the convenience of the patient, provider, or supplier.

References

* [CMS IOM Publication 100-04, Claims Processing Manual, Chapter 4, §290](https://www.cms.gov/files/document/chapter-4-part-b-hospital-including-inpatient-hospital-part-b-and-opps-0)
* [CMS IOM Publication 100-02, Benefit Policy Manual, Chapter 6, §20.6](http://www.cms.gov/manuals/Downloads/bp102c06.pdf)
* [CMS IOM Publication 100-04, Claims Processing Manual, Chapter 1, §50.3](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf)
* [CMS IOM Publication 100-07, Appendices Table of Contents, Appendix A, §482.30(d)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf)
* [CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, §6.5](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c06.pdf)
* CERT Center ([JH](https://www.novitas-solutions.com/webcenter/portal/CERT_JH))([JL](https://www.novitas-solutions.com/webcenter/portal/CERT_JL))