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Observation Services Training Handbook

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About the Reviewer

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Blondo received a bachelor of science degree in behavioral science with a psychology emphasis from Southern Adventist University in Collegedale, Tennessee, and a master’s degree in social work from the University of Maryland in Baltimore. She resides in Clarksville, Maryland, with her husband, Rick. She has a lifelong love of learning and sharing her passion in case management with others.
Chapter 1

Medicare Definition of Observation Services

When a patient comes into the hospital, it’s not always clear right away whether he or she will be ready to go home after treatment in the emergency department (ED) or if a longer stay as an admitted inpatient is needed. Some symptoms, for example, a severe headache and blurred vision, could be evidence a patient is having a stroke, or it could be a migraine headache. Sometimes no definitive diagnosis can yet be made, and the physician needs to rule out the diagnosis of a stroke so the patient can safely be discharged home. If time is needed to monitor how the symptoms will progress or resolve, perform tests, and interpret results, the physician may opt to place the patient in observation care.

The Centers for Medicare & Medicaid Services (CMS) defines observation care as 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” (CMS, Medicare Benefit Policy Manual, Chapter 6, 2015).

Essentially, observation is used for that period of time when the patient is in limbo—waiting for the provider to complete tests, interpret results, and observe and interpret symptoms to
determine whether they have progressed or evolved. All this allows the provider time to make a decision about the direction of care.

Because observation patients are by definition in flux, CMS doesn’t want them receiving observation services for any longer than necessary. So it encourages physicians to make certain that observation care is provided for the least amount of time possible.

The *Medicare Claims Processing Manual*, Chapter 4–Part B Hospital (2016) also states that “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.”

To expedite the process, CMS also calls on physicians to continually monitor and assess patients who are receiving observation services to make sure that the services continue to be medically necessary. The purpose of observation services is to determine whether the patient has improved enough to be discharged, needs additional monitoring and treatment with the expectation of a rapid resolution of symptoms, or needs to be admitted for inpatient treatment due to the severity of illness and need for treatment that can be provided only in the hospital environment.

It’s important to note that observation cannot be used as a replacement for custodial care and that the physician must be certain to document why he or she thinks it’s risky to discharge the patient to a lower level of care instead of keeping him or her in observation. Including a patient’s prior history and comorbidities in the medical record is essential. Observation services are provided by medical professionals to observe symptoms to determine
whether they improve or worsen. Custodial care involves assisting with activities of daily living and includes services that do not require skilled or licensed medical providers.

If the patient cannot be discharged to the community due to social reasons, the physician should consult with the hospital case manager, who may be able to assist with community referrals. If the patient cannot be discharged to the community due to social reasons, the patient status can be “outpatient in a bed” or simply “outpatient” based on your hospital’s policy, but the patient should not remain in observation at that time.

**A Complicated Decision**

While this definition about which patients qualify for observation services may seem fairly straightforward at first glance, the complexity of individual patient cases often muddies the waters. A patient’s condition may be unclear or may change quickly. Two patients with the same symptoms may warrant two different status decisions.

For example, two patients may come into the ED with a complaint of chest pain, and one may ultimately be admitted as an inpatient, while the other is provided with observation services. Most often, a complaint of chest pain warrants observation care, as is the case for patients with dehydration or syncope. But if a patient with chest pain also has an elevated troponin level that remains high during all three sets of cardiac enzyme testing, he or she might need to be admitted as an inpatient.

**The 2-Midnight Standard**

Adding to the complexity of patient status decisions is CMS’ 2-midnight rule, which went into effect October 1, 2013. CMS’ goal in introducing this standard was to clarify hospital admission
guidelines and counteract what many saw as a troublesome trend—an increasing number of patients receiving observation services over a longer period of time. However, some interpreted the 2-midnight rule as overriding physician judgment for medical necessity. CMS stated the following:

_The decision to admit the beneficiary as an inpatient is a complex medical decision made by the physician in consideration of various factors, including the beneficiary’s age, disease processes, comorbidities, and the potential impact of sending the beneficiary home. It is up to the physician to make the complex medical determination of whether the beneficiary’s risk of morbidity or mortality dictates the need to remain at the hospital because the risk of an adverse event would otherwise be unacceptable under reasonable standards of care, or whether the beneficiary may be discharged._

—CMS, Frequently Asked Questions, FAQ9240

Improper use of observation services can be a costly problem for some patients. In some cases, patients assigned to observation services for an extended length of time face higher out-of-pocket costs than they would have during an inpatient stay. Although many patients fear large bills when assigned to observation instead of inpatient status, a 2012 analysis by the U.S. Department of Health and Human Services Office of Inspector General found that only 6% of the patients in observation care actually paid more than the amount equal to an inpatient deductible under Medicare Part A that year. The study found that, on average, patients paid almost two times more for a short inpatient stay than for an observation stay when hospitalized for the same reason (Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, 2013). However, of greater concern is that observation services do not currently count toward
CMS’ three-day stay requirement to receive reimbursement for a postacute stay in a skilled nursing facility (SNF). Under current Medicare rules, a SNF stay is covered only if the patient has spent three consecutive inpatient days in a hospital. If, for example, a patient spends one day receiving observation services and two days as an inpatient, he or she wouldn’t qualify for SNF reimbursement. An exception is if the patient has a Medicare Advantage plan under Medicare Part C. Some secondary insurances, particularly managed care plans, will consider covering SNF care even if the patient does not qualify under his or her Medicare SNF benefits.

Note that changes are in the works for this requirement. CMS waived the three-day requirement starting in 2017 for some Medicare beneficiaries in certain accountable care organizations (80 Federal Register 130, 2015). A rule change started in April 2016, the second year of the Comprehensive Care for Joint Replacement program (which is still under review), to waive the three-day SNF rule for beneficiaries to transfer to a SNF rated three stars or higher on the CMS Nursing Home Compare website (American Hospital Association, 2016). CMS is also waiving the three-day hospital stay rule for patients in hospitals under the Bundled Payment for Care Improvement program (BPCI) and for SNFs that score well on its Nursing Home Compare five-star rating system (American Hospital Association, 2016). But in the meantime, the three-day inpatient stay requirement remains an issue.

Clarifying Status Decisions

In hopes of making status decisions easier, the 2-midnight rule dictates time thresholds for observation and inpatient services.

In order to qualify for inpatient status, the physician needs to use his or her clinical judgment to not only verify that the patient
meets medical necessity criteria for an inpatient admission but that he or she will likely also need two midnights of care at the time he or she is admitted. If the physician does not expect the patient will need two midnights of care, the physician—with some exceptions—should place the patient on observation status.

CMS stated that only in rare instances should an inpatient stay last 24 hours or less. Organizations that do not comply with the 2-midnight rule may face denials and penalties.

On October 1, 2015, Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIO) took over the role of education and enforcement for the 2-midnight rule, a job that was formerly the domain of Medicare Administrative Contractors, who are still in charge of reviewing claims submitted prior to September 30, 2015, and will still be doing follow-up audits on hospitals with high error rates.

KEPRO and Livanta are the two BFCC-QIOs currently conducting short-inpatient-stay reviews to ensure hospitals are complying with the regulation.

The fiscal year 2016 outpatient prospective payment system final rule became effective January 1, 2016, and allows hospitals to bill for inpatient services in some circumstances “if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care despite an expected length of stay that is less than two midnights.” The documentation should include the severity of the symptoms, the “medical predictability” of an adverse event occurrence, and the need for diagnostic studies not usually requiring a 24-hour-or-more hospital stay (Federal Register, 2015).

An exception to the 2-midnight rule, which warrants an inpatient admission, includes patients admitted to the hospital for a procedure on the inpatient-only list. Another exception is a patient
Medicare Definition of Observation Services

newly placed on mechanical ventilation but anticipated to be discharged in fewer than two midnights, which is an example of a “rare and unusual exception” (CMS, 2013).

Depending on their role at the organization, case managers and other staff members may ensure that patient status determinations are correct and also provide education and documentation support to physicians while working closely with their physician advisor or physician advisor service. This requires a careful review using nationally approved clinical criteria, such as InterQual or MCG (formerly Milliman Care Guidelines), and a good understanding of medical necessity and documentation requirements. It also makes it necessary to understand the difference between noncovered and nonreportable observation services, which we will discuss in the next chapter.

References


Chapter 1


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