

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-14

Subject: Analysis of Place-of-Service Code for Observation Services
(Resolution 119-A-13)

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee A
(Gary L. Bryant, MD, Chair)

1 At the 2013 Annual Meeting, the House of Delegates referred Resolution 119, “Place-of-Service
2 Code for Observation Services,” which was introduced by the Pennsylvania Delegation. Resolution
3 119-A-13 asked:

4
5 That our American Medical Association (AMA) conduct a study that examines the impact on
6 patient cost-sharing, physician payment, physician administrative cost and the quality of care if
7 a specific place-of-service code is created for observation services;

8
9 That our AMA consult with the American Hospital Association and other stakeholders in this
10 study on place-of-service code for observation services; and

11
12 That, based on the findings of the study, our AMA, and other interested stakeholders petition
13 the Centers for Medicare & Medicaid Services (CMS) to recognize a new place-of-service code
14 for observation services.

15
16 This report provides background on Medicare hospital admission policy and the use of observation
17 status; describes the impact of related Medicare policy on patient cost-sharing, physician payment
18 and physician administrative costs; examines the probable impact of a specific place-of-service
19 code for observation services; highlights AMA advocacy addressing observation care; summarizes
20 relevant AMA policy; and presents policy recommendations.

21
22 **BACKGROUND**

23
24 The Medicare program defines observation care as “a well-defined set of specific, clinically
25 appropriate services, which include ongoing short-term treatment, assessment and reassessment
26 before a decision can be made regarding whether patients will require further treatment as hospital
27 inpatients or if they are able to be discharged from the hospital.”¹ The original intent of observation
28 status was to identify patients, typically but not necessarily presenting in the emergency
29 department, who require treatment and monitoring while the physician decides to formally admit or
30 discharge. Patients receiving observation care are classified and registered as hospital outpatients,²
31 and can be treated in designated observation units or other areas of the hospital.

32
33 Physicians have had longstanding concerns about patients inappropriately assigned to observation
34 status, which is paid by Medicare Part B but differs from traditional outpatient care. AMA policy
35 designates a hospital stay of 24 hours as a guideline for an inpatient admission, noting that it is not

1 unusual for observation services to extend a few hours beyond 24 hours or for patients to be
2 admitted as inpatients within 24 hours.

3
4 The preamble of Resolution 119-A-13 cites the following concerns with Medicare coverage and
5 observation status: observation can extend beyond 24 hours; observation services are classified as
6 “outpatient hospital” and covered under Medicare Part B; if a patient status is reclassified as
7 “observation” rather than “admitted,” it can result in unanticipated costs and copayments for the
8 patient as well as additional administrative costs for the physician; it is not reasonable to expect
9 patients to distinguish between inpatient and observation status; and the focus of recovery audit
10 contractors (RACs) on observation care, coupled with the CMS’s focus on hospital readmissions,
11 has led hospitals to shift their admission practices to more observation care.

12
13 As noted in Resolution 119-A-13, MedPAC reports that Medicare observation claims have
14 increased more than 26 percent in a recent two-year period. Lengthier stays in observation status
15 that are essentially indistinguishable from inpatient stays have also become more common. In
16 2012, Medicare patients reportedly had 1.5 million observation stays, more than 92 percent of
17 which spanned a night or more in the hospital. Over 600,000 patients had hospital stays lasting
18 three or more observation days.³ Medicare patients had 1.1 million short (less than two nights)
19 inpatient stays in 2012 that were frequently for the same reasons as observation stays, such as chest
20 or back pain. These short-duration inpatient stays cost the Medicare program more than
21 observation stays because they were paid for by Medicare Part A.⁴

22
23 More frequent and lengthy observation stays can financially overwhelm hospital patients who are
24 unaware of their status. Because their care is paid for by Medicare Part B instead of Part A, these
25 patients are responsible for Part B copayments for each service as well as any self-administered
26 drugs. Because Medicare requires patients to have an inpatient hospital stay of three or more
27 consecutive days to be eligible for skilled nursing facility (SNF) coverage, patients whose care is
28 designated under observation status must forego post-hospital SNF care or pay for it themselves.

29
30 The AMA has also voiced concerns about RACs flagging short hospital stays and disqualifying
31 them from Medicare Part A payment. Disputes with RACs over short stay determinations have led
32 some hospitals to prospectively screen admissions using InterQual criteria, which enable them to
33 change patients’ status from “admitted” to “observation” to prevent RAC denials of their claims.

34 35 IMPACT OF SPECIFIC PLACE-OF-SERVICE CODE FOR OBSERVATION SERVICES

36
37 Observation services are identified on Medicare claims using one of two revenue codes (0760 or
38 0762) as well as Healthcare Common Procedure Coding System (HCPCS) codes.⁵ Resolution
39 119-A-13 asks the AMA to study the impact of a specific place-of-service code for observation
40 services.

41
42 Place-of-service codes are two-digit modifiers, taken from CMS’s national place-of-service code
43 set, that are placed on claims to specify the setting in which services are rendered. Place-of-service
44 code 21 is used when a patient receives care as a hospital inpatient, whereas place-of-service code
45 22 documents outpatient care. There is no place-of-service code for hospital observation services
46 because patients in this status are presumed to be outpatients whose place-of-service code is 22.
47 Because observation care is already identified on Medicare claims using codes unique to this status,
48 the Council does not believe that a new place-of-service code would remedy the observation care
49 problems outlined in Resolution 119-A-13 and in this report.

1 Medicare Part A generally pays for hospital services if patients are formally admitted or are
 2 receiving services designated by CMS as “inpatient only.” Section 1814(a) of the Social Security
 3 Act requires physician certification of medical necessity that services be required as an inpatient as
 4 a condition of Medicare Part A payment.⁶ A physician order for hospital inpatient admission is also
 5 required before a patient’s status is considered inpatient. Care provided while a decision is made
 6 regarding medical necessity for inpatient admission—before completion of an inpatient admission
 7 order—is regarded as outpatient and therefore paid by Medicare Part B. Lacking the required
 8 hospital admission orders and certifications, current law dictates that observation services are
 9 ineligible for Medicare Part A coverage.

10
 11 The Council’s analysis concludes that if CMS were to formally approve a new place-of-service
 12 code for observation status, these services would continue to be paid under Medicare Part B.
 13 Patients would still be classified as outpatients and therefore responsible for Medicare Part B
 14 copayments, self-administered drugs and the expenses associated with post-hospital SNF stays.
 15 Furthermore, a specific place-of-service code would neither decrease the administrative costs
 16 incurred by physicians charged with determining patient status, nor simplify observation status
 17 billing issues that can be confusing for both patients and physicians.

18
 19 **TWO-MIDNIGHT RULE**

20
 21 In 2013, CMS ruled that RACs will be instructed to “presume that hospital inpatient admissions are
 22 reasonable and necessary for patients who require more than one Medicare utilization day (defined
 23 by encounters crossing two midnights) in the hospital receiving medically necessary services after
 24 inpatient admission.⁷” Stays spanning less than two midnights will generally be considered
 25 outpatient and therefore paid for by Medicare Part B.⁸

26
 27 Under the rule, the hospital stay of Patient A, who is hospitalized for chest pain from 11 pm on
 28 Sunday to 4 am Tuesday (for a total of 29 hours), would be presumed by Medicare contractors to
 29 be an inpatient stay. The patient would be covered by Medicare Part A and responsible for a one-
 30 time deductible for those services received after an order for inpatient services is made by a
 31 physician. Patient B, who presents with chest pain at the hospital two hours after Patient A—at 1 am
 32 Monday—and is discharged at 10 pm Tuesday (for a total stay of 45 hours) would be presumed by
 33 the RAC to be an outpatient. Patient B would therefore be responsible for 20 percent copayments
 34 for each individual service provided during his stay as well as the costs of any self-administered
 35 medications.

36
 37 The AMA continues to advocate that hospital stays should be considered inpatient if the physician
 38 determines that an inpatient stay is warranted, with the use of 24 hours as a guideline. Advocacy by
 39 the AMA and other stakeholders highlighting concerns with the two-midnight policy—including a
 40 joint letter to CMS from the AMA and the American Hospital Association (AHA)—led CMS to
 41 delay enforcement of the policy. Per the recent passage of H.R. 4302, RAC post-payment inpatient
 42 hospital claims reviews have been suspended through March 2015.

43
 44 The new rule also stipulates the requirements for physician orders, the timing of these orders and
 45 the relationship between admission orders and physician certifications of medical necessity for
 46 inpatient services.⁹ The AMA has submitted comments to CMS outlining our many concerns, and
 47 has asked CMS to consider the effects of this policy on patients’ access to care. The AMA has also
 48 facilitated discussions between CMS and national medical specialty societies to better understand
 49 concerns with the new policy. The AMA continues to vigorously oppose the new hospital
 50 admission policy which, at the time of this writing, has not been repealed.

1 RELEVANT AMA POLICY

2
3 The AMA has extensive policy on hospital admission criteria, the use of observation status and
4 patient eligibility for SNF care. Policy D-160.932 directs the AMA to ask CMS to repeal
5 Medicare's two-midnight rule. Policy H-280.977 calls for deleting the three-day prior
6 hospitalization requirement for provision of SNF benefits under Medicare. Similar policies direct
7 the AMA to: advocate for Medicare Part A coverage for a patient's direct admission to a SNF if
8 directed by their physician and if the patient's condition meets SNF criteria (Policy D-280.988);
9 advocate that patients be subject to the same cost-sharing requirements whether they are admitted
10 to a hospital as an inpatient or for observation services (Policy H-185.941); continue to monitor
11 problems with patient readmissions to hospital and SNFs and recoding of inpatient admissions as
12 observation care and advocate for appropriate regulatory and legislative action (Policy D-280.989);
13 support payment from all third party payers for physicians' services to patients who are
14 appropriately managed in short stay units (Policy H-385.970); and recommend that the Department
15 of Health and Human Services define a subset of patients for whom elimination of the three-day
16 prior hospitalization requirement for eligibility of the Medicare SNF benefit would avert
17 hospitalization and generate cost savings.

18
19 Responsibility for hospital admissions is addressed in Policy H-320.965, which provides that the
20 determination of the medical necessity for hospital admission should be made only by a doctor of
21 medicine or a doctor of osteopathy licensed in the same jurisdiction as the treating physician. At its
22 April 2014 meeting, in response to Resolution 227-I-13, which had been referred for decision, the
23 AMA Board of Trustees established policy that specifically supports that upon admission of any
24 patient to a hospital for inpatient services, the admitting/attending physician should have access to
25 information to help the physician plan appropriately for the services that will be required to care for
26 that particular patient. Policy H-160.907 supports rescission of the requirement that physicians
27 certify the estimated time patients need to be hospitalized as a condition of payment for inpatient
28 services.

29
30 Policy H-160.944 supports a 24-hour threshold for defining observation care and directs the AMA
31 to develop policy and model legislation to ensure that, after initial approval of inpatient admission
32 by insurers, there should be no retrospective reassignment to observation care status; insurers'
33 observation care policies should include an administrative appeal process to deal with denials
34 within 60 days; and written educational materials should be made available to subscribers
35 highlighting differences between inpatient and observation care. This policy also directs the AMA
36 to work with appropriate organizations to assure that both patients and physicians are treated fairly
37 in the process of delineating the hospital admission status of patients, and to ensure that the process
38 is transparent and administratively simple.

39
40 The AMA also has extensive policy addressing problems with RACs (Policy D-330.943) and
41 hospital reclassification of patient admission status based on screening criteria used by proprietary
42 databases, so that admitting physicians and patients are notified of such reclassifications and
43 physicians can substitute their medical judgment for that of the software program
44 (Policy D-330.921).

45
46 AMA ADVOCACY

47
48 In conversations with Administration officials and in numerous letters to CMS, the AMA has
49 repeatedly requested that CMS develop a hospital admission policy that addresses physician and
50 patient concerns with observation care. The AMA continues to advocate that CMS rescind its
51 three-day inpatient stay requirement for coverage of SNF care or, in the absence of such change,

1 allow observation care days to count toward the three-day stay requirement. On numerous
2 occasions, the AMA has proposed that CMS convene workshops with all affected stakeholders,
3 including physicians, patients and hospitals, to discuss comprehensive solutions that address the
4 inappropriate use of observation services. Furthermore, the AMA has repeatedly asked CMS to:

- 5
- 6 • Revise its policy regarding changes to a patient’s admission status to require the concurrence of
- 7 the admitting or treating physician;
- 8 • Preclude Medicare contractor recoupment from physicians for admissions decisions or where
- 9 there are discrepancies between hospital and physician claims;
- 10 • Preclude Medicare contractor claim denials that do not have the concurrence of a practicing
- 11 physician in the same specialty as the admitting or treating physician; and
- 12 • Require meaningful physician input into the development of claims edit software.
- 13

14 In response to Resolution 119-A-13, AMA staff consulted with the AHA regarding the probable
15 impact of a specific place-of-service code on patient cost-sharing and patient eligibility for
16 Medicare-covered SNF care, and whether implementation of a short stay outlier would be an
17 appropriate vehicle to remedy the rise in observation care. A short stay outlier is used by CMS as
18 an adjustment to the payment rate for long-term care hospital stays that are generally much shorter
19 than average. At this time, it appears that development of a short stay outlier may be a more
20 impactful solution. The AMA and the AHA have asked CMS to explore whether allowing similar
21 adjustments for inpatient care would foster more appropriate patient lengths of stay.

22

23 The AMA strongly supports the “Improving Access to Medicare Coverage Act of 2013,” which has
24 been introduced in both Houses of Congress (H.R. 1179; S. 569) and would require the time period
25 of outpatient observation stays to count toward the three-day inpatient requirement for Medicare
26 coverage of SNF services. Consistent with Policy H-160.944, model state legislation to require fair
27 and equitable reimbursement from all third party payers for physicians’ services to patients who are
28 appropriately managed in observation or short stay units is also available.

29

30 Recently, the AMA filed an amicus brief in the appeal of *Bagnall v. Sebelius*, a case concerning
31 Medicare patients who did not meet the requirements for post-hospital SNF care because they were
32 assigned to observation care while hospitalized. The AMA is also asking CMS to address patients’
33 unanticipated post-hospital SNF costs.

34

35 DISCUSSION

36

37 The Council shares the concerns raised in Resolution 119-A-13 that increased use of observation
38 status saddles patients with unanticipated expenses, and can be an administrative nightmare for
39 physicians. The Council studied the probable impact of an “observation” place-of-service code by
40 reviewing hospital admission policy, observation care trends, and coding and billing practices. The
41 Council also met with CMS officials to discuss relevant federal policy, including the two-midnight
42 rule.

43

44 With limited exceptions, hospital inpatient admission requirements as outlined in federal statute
45 and regulations preclude observation services from being covered by Medicare Part A. A new
46 place-of-service code would not affect Medicare Part A/B determinations; rather, observation
47 patients would continue to be classified, treated and registered as hospital outpatients. Nor does the
48 Council believe that current revenue and HCPCS codes for observation services would be
49 enhanced by a specific place-of-service code. Observation services with a new place-of-service
50 code would continue to be paid under Medicare Part B. As outpatients, patients would still be
51 responsible for Medicare Part B cost-sharing expenses as well as post-hospital SNF care.

1 Accordingly, the Council concludes that an observation specific place-of-service code will not
2 impact patient cost-sharing, physician administrative costs or quality of care.

3
4 The Council is very concerned about the inappropriate use of hospital observation status and the
5 increased duration of observation stays, trends that deviate from the original intent of observation
6 care and shift more hospital costs to patients. At the time that this report was written, enforcement
7 of the two-midnight rule is on hold and CMS guidance is being closely monitored. The Council
8 recommends that the AMA continue to advocate that the CMS explore payment solutions that will
9 reduce the inappropriate use of hospital observation status. Through the reaffirmation of Policy
10 D-160.932, the Council also recommends that the AMA continue to advocate for repeal of two-
11 midnight rule. In an effort to protect patients, the Council recommends reaffirmation of Policy
12 H-320.965, which addresses responsibility for hospital admissions; Policy H-160.944, which
13 supports physician decision making in inpatient claims review; Policy H-185.941, which advocates
14 that patients be subject to the same cost-sharing requirements regardless of whether they are
15 admitted as hospital inpatients or for observation services; and Policy D-280.988, which envisions
16 Medicare Part A coverage for a patient's direct admission to a SNF.

17 18 RECOMMENDATIONS

19
20 The Council recommends that the following be adopted in lieu of Resolution 119-A-13, and that
21 the remainder of the report be filed:

- 22
23 1. That our American Medical Association (AMA) continue to advocate that the Centers for
24 Medicare & Medicaid Services explore payment solutions to reduce the inappropriate use
25 of hospital observation status. (Directive to Take Action)
- 26
27 2. That our AMA reaffirm Policy D-160.932, which directs the AMA to petition the Centers
28 for Medicare & Medicaid Services to repeal the August 2013 rules regarding Hospital
29 Inpatient Admission Order and Certification (Two-Midnight Rule). (Reaffirm HOD
30 Policy)
- 31
32 3. That our AMA reaffirm Policy H-320.965, which provides that the determination of the
33 medical necessity for hospital admission should be made only by a doctor of medicine or a
34 doctor of osteopathy licensed in the same jurisdiction as the treating physician. (Reaffirm
35 HOD Policy)
- 36
37 4. That our AMA reaffirm Policy H-160.944, which supports a 24-hour guideline for defining
38 observation care, which is flexible pursuant to physician discretion, and directs the AMA
39 to work with appropriate organizations to assure that both patients and physicians are
40 treated fairly during the hospital admission process and to ensure that the process is
41 transparent and administratively simple. (Reaffirm HOD Policy)
- 42
43 5. That our AMA reaffirm Policy D-280.988, which supports Medicare Part A coverage for a
44 patient's direct admission to a skilled nursing facility if directed by their physician and if
45 the patient's condition meets skilled nursing criteria. (Reaffirm HOD Policy)
- 46
47 6. That our AMA reaffirm Policy H-185.941, which advocates that patients be subject to the
48 same cost-sharing requirements whether they are admitted to a hospital as inpatients, or for
49 observation services. (Reaffirm HOD Policy)

- 1 7. That our AMA advocate with Centers for Medicare & Medicaid Services that the status of
2 any observation patient who remains confined at a hospital for more than 24 hours be
3 changed automatically to inpatient, and if they had spent a midnight in observation status,
4 that midnight would be counted toward the three-day prior hospitalization requirement for
5 Medicare coverage of skilled nursing facility care. (Directive to Take Action)

Fiscal Note: Less than \$500

REFERENCES

¹ Medicare Benefit Policy Manual: Chapter 6 – Hospital services covered under Part B. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Revised July 1, 2009.

² Ibid.

³ Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries. Department of Health and Human Services, Office of Inspector General. July 29, 2013.

⁴ Ibid.

⁵ Medicare Claims Policy Manual: Chapter 4 – Part B hospital (including inpatient hospital Part B and OPPS). Department of Health and Human Services, Centers for Medicare & Medicaid Services. Revised December 27, 2013.

⁶ Hospital Inpatient Admission Order and Certification. Department of Health and Human Services, Centers for Medicare & Medicaid Services. January 30, 2014.

⁷ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Federal Register* vol. 78, no. 160: 50746. August 19, 2013.

⁸ Ibid.

⁹ Ibid.