Caught in the middle
Under tough scrutiny from the CMS over which patients should be admitted for care, hospitals are frustrated—and patients are fighting back

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The threat of ceaseless auditing and penalties is causing many hospitals to reclassify Medicare patients as less-costly “observation” cases, and the people receiving the care say the confusing change leaves them on the hook for medical bills that the government ought to cover.

At the center of the issue are the federal authorities and the private auditing firms that work for them as recovery audit contractors. They've made short inpatient hospital stays one of their biggest targets in the ongoing effort to put hospital expenses under a microscope, retroactively reduce reimbursements and seek damages for claims viewed as fraudulent.

Hospital officials say the investigative focus on short stays increases the pressure on them to second-guess admitting physicians’ decisions using the hindsight of medical records in cases likely to attract the scrutiny of Recovery Audit Contractors, sometimes using specialized software designed to analyze patient documents.

Fourteen seniors are suing the federal government in a class-action case in U.S. District Court in Bridgeport, Conn., saying the policy that allows healthcare providers to reclassify hospital care from inpatient to observation after being admitted is illegal and ought to be overturned.

One of those seniors is Martha Leyanna, 85, who alleges she ended up paying $10,600 out-of-pocket for 40 days of rehabilitation care after leaving Christiana Hospital in Wilmington, Del., last November. The bills came because a hospital committee overturned a doctor’s decision to admit her, declaring her under observation and leaving her ineligible to receive Medicare coverage for her skilled-nursing rehab care.

“To me, it was no different than being admitted. It was just a word they put on a piece of paper,” said Leyanna’s daughter, Mary Smith.

Hospitals say the government is forcing their decisions in cases like Leyanna’s. “It puts hospitals in a very uncomfortable position,” said Melinda Hatton, senior vice president and general counsel at the American Hospital Association. “No hospital wants a patient to be denied payment for services they really should have when they need them. But hospitals, like patients, are the ones who face a penalty when they guess wrong in the eyes of the authorities about whether something should be an admission or an observation.”

HHS’ inspector general’s office announced in its 2012 work plan that it expects to probe hospitals’ use of observation services this year, including how the practice affects Medicare beneficiaries’ out-of-pocket expenses. That report is targeted for release by the end of the year.

Meanwhile, bipartisan bills are pending in the U.S. House and Senate that would address the issue of whether Medicare should cover beneficiaries’ skilled-nursing expenses after an observation stay in a hospital, like Leyanna’s.

Current rules say Medicare’s hospitalization program won’t pay for skilled-nursing rehabilitation care without three consecutive days as an inpatient, but the House and Senate bills would count any time spent in a hospital—including
time under observation—toward the three-day rule.

“We have very broad-based support,” said U.S. Rep. Joe Courtney (D-Conn.), one of the House sponsors. “If it doesn't cost anything, this is something that should be easy, even in this Congress.”

However, it's not clear the change wouldn't cost anything. Courtney said the CMS' actuaries have preliminarily analyzed it and found the change would not increase budget costs for Medicare nursing rehab care, because those costs are already factored into the system. The increased auditing that hospitals say is driving the use of observation was never intended as a way to decrease skilled nursing costs, he said.

CMS officials declined to comment for this story on whether they have analyzed the costs or if they could make such changes administratively without requiring acts of Congress.

In a July 7, 2010 letter, acting CMS Administrator Marilyn Tavenner addressed claims by the hospital industry at the time that RAC auditing was leading to increased use of observation status. “There has been no change in CMS policy for how hospitals should approach such cases,” the 2010 letter says.

Hospitals, however, say the federal government “does not speak with one voice on this issue,” the AHA wrote in an April 27 amicus brief filed in the Connecticut class-action lawsuit against the CMS.

Federal prosecutors have been filing False Claims Act cases against hospitals under the theory that hospitals are increasing Medicare reimbursements by admitting patients who could have received more appropriate care in less-expensive outpatient settings. A prominent and ongoing example is the national investigation into the spinal reconstruction procedure kyphoplasty, which has resulted in $39 million in settlements from 40 hospitals.

Former employees of spinal surgery kit-maker Kyphon said in a whistle-blower lawsuit that the company specifically counseled hospitals on how to increase reimbursement by performing the procedures on an inpatient basis as a way to cover the cost of the tools and materials.

Kyphon, which was subsequently purchased by Medtronic, settled the case for $75 million in 2008 but denied the allegations. The U.S. attorney's office in Buffalo, N.Y., has also been filing demands for medical records with hospitals, along with lawsuits in cases across the country. Hospitals—which face the prospect of triple damages and expulsion from Medicare if found liable for False Claims Act violations—have settled the cases without admitting wrongdoing. Some have specifically denied any illegalities in interviews.

In its amicus brief in the class-action lawsuit, the AHA notes that prosecutors like those pursuing the kyphoplasty cases explicitly encourage hospitals to second-guess the medical judgment of admitting physicians based on the information accumulated in patient charts since the admission.

“The government acknowledges the value of the individual physician provider decision in initially assessing the level of care,” wrote William Hochul Jr., the U.S. attorney in Buffalo, in a request for information sent to a hospital in a kyphoplasty case, according to an exhibit in the AHA’s filing.

“The physician provider decision is the start of the analysis and not the end of the analysis. The hospital possesses an independent duty to assess the medical necessity of the site of service determination through, amongst other
regulatory authority, Condition Code 44," Hochul's demand letter says.

The abstruse-sounding Condition Code 44, it turns out, is the source of much of the animosity on the part of patients.

On Sept. 10, 2004, HHS released an addition to its CMS Online Manual System describing how hospitals could use Condition Code 44 to change inpatient admissions to outpatient observations in cases where a hospital's utilization review committee determines that patient files don't support a physician's decision to admit a patient for care. However, Medicare Part A has always required a full three-night stay as a hospital inpatient before the program will cover the kind of rehabilitation services that seniors commonly receive from a skilled-nursing facility after acute care.

A patient’s conundrum

In Martha Leyanna's case, she was in so much pain following her Nov. 16-22 stay at Christiana Hospital that she felt she had to get rehab care, even if Medicare wouldn't pay for it, her daughter Mary Smith said.

On the morning of Nov. 15, Leyanna rose from bed, flung off her sheets and blankets and then lost her balance, hitting her head on a wall and her shoulder on the nightstand. She was treated in the Christiana emergency room and released the next day, but at home, she kept grabbing at her chest and complaining about the pain, Smith said.

Leyanna returned to the ER later on the 16th and was formally admitted to the hospital to begin a series of tests to see if she had any broken bones related to her osteoporosis or any issues related to her pacemaker, according to Smith and statements in the lawsuit.

Tests failed to find the suspected crack in her sternum or any cardiac problems, and on Nov. 20, the hospital notified her that her status had been changed from inpatient to outpatient observation. All the while, she received around-the-clock care from nurses, slept in a normal hospital bed and ate hospital food, Smith said.

Christiana officials declined to comment on Leyanna’s case or the issue of observation status.

No one knows how many class-action plaintiffs could be covered by the lawsuit in which Leyanna is a member if a class is certified. Toby Edelman, senior policy attorney for the Center for Medicare Advocacy, one of two law firms representing the plaintiffs, said the number is likely well over 10,000. Edelman said the plaintiffs are seeking to overturn the CMS rule allowing observation status, along with a recovery of patients' out-of-pocket expenses since Jan. 1, 2009, and attorney's expenses.

The AHA isn't supporting either side in the litigation, but rather is hoping for an across-the-board set of rules governing observation status that prosecutors and auditors would also agree to follow during enforcement. Hatton said: "Our ideal scenario would be for CMS to come up with a process to help patients and hospitals make this judgment more clearly, and to have law enforcement agencies commit to following that process, so that hospitals and patients aren't second-guessed when they need medical care."

TAKEAWAY: As hospitals say they're being pressured to place patients in lower-cost observation status, patients are fighting back with a class-action lawsuit because they're being forced to pay out of pocket.

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