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ARE YOU IN OR ARE YOU OUT? INPATIENT ADMISSION STATUS IS A KEY RISK AREA FOR MEDICARE PROVIDERS

In the continually evolving world of Medicare coverage and payment rules, hospital compliance personnel must look broadly to identify potential risk areas to be addressed within their organization. Based on the facts alleged in two recent False Claims Act *qui tam* cases, with one of those cases currently proceeding through the federal courts, hospitals should evaluate their inpatient admission criteria and review process to ensure that they comply with all applicable payment rules.

BACKGROUND

The Medicare program generally recognizes two admission statuses for hospital patients: outpatient and inpatient. Outpatient status is the default; a patient is presumed to be an outpatient unless a physician orders that they be admitted for inpatient care. An inpatient admission is appropriate when the treating physician expects that the patient will need hospital care in accordance with the two-midnight benchmark. Additionally, outpatient observation status is a bridge between outpatient and inpatient and is appropriate when the treating physician needs more time to assess the patient before determining whether an inpatient admission is appropriate.

A hospital patient's admission status can greatly impact the payments that the hospital can expect from Medicare. Generally speaking, Medicare pays more for services provided to an inpatient than it would if the same services were provided to an outpatient. Medicare considers outpatient observation to be a separately payable outpatient service (although the payment may be bundled into an outpatient APC for other outpatient services).

Ultimately, it is the treating physician's responsibility to determine whether a patient should be admitted as an inpatient. The Medicare program relies on physicians and hospitals to make determinations as to a patient's outpatient, outpatient observation and inpatient status, and physicians and hospitals are required to charge Medicare only for medically necessary services. Many hospitals engage second-level physician review organizations as part of the utilization process to assist in reviewing patient status determinations and advising treating physicians as to the patient's eligibility for inpatient admission.

In the two cases discussed below, whistleblowers allege that a hospital system in one case and a second-level review organization in the other filed claims for inpatient services that they knew did not satisfy inpatient-status requirements in Medicare program guidance.

OUTPATIENT V. INPATIENT SERVICES

On March 19, 2018, a federal judge denied a second-level review organization's ("Organization") motion to dismiss a *qui tam* relator's ("First Relator") claims that the Organization intentionally caused its clients to claim inpatient reimbursement for outpatient services.[1] According to the First Relator, the Organization evaluated patients based on proprietary internal criteria that did not align with Medicare guidance. The First Relator further alleged that the Organization would recommend that its clients' physicians order inpatient admission knowing that the patients did not meet Medicare guidelines. The First Relator claimed that he raised these concerns with the Organization and that the Organization failed to correct its practices.

No final outcome has been reached in this case, but several of the Organization's client hospitals have successfully argued for their dismissal. However, their success in doing so was based largely on their particular circumstances, and there is no guarantee that other client hospitals will be successful.

ELECTIVE V. URGENT

On April 12, 2018, a hospital system based in the western United States ("System") agreed to settle a False Claims Act case alleging that the System hospitals intentionally submitted false claims for short-stay inpatient hospital services.[2] According to the relator in this case ("Second Relator"), officials at the System's hospitals miscategorized elective claims as "urgent" on Medicare claim forms. The Second Relator further alleged that System hospitals submitted inpatient claims for a significant number of "zero day stays," (i.e., stays for which the patient was admitted and discharged on the same day). Finally, the Second Relator alleged that the System improperly admitted patients to outpatient observation status following surgical procedures in contravention of Medicare rules.

The federal government intervened in this case. Under the settlement agreement, the System will pay over $18 million, with more than $3 million going to the Second Relator. Additionally, the System agreed to a five-year corporate integrity agreement. It is noteworthy that the Second Relator has also successfully prosecuted two other claims under the False Claims Act.

PRACTICAL TAKEAWAYS

Regardless of a hospital's or health system's size, there is no one-size-fits-all solution to Medicare compliance. However, a robust compliance program can help hospitals protect against whistleblower suits based on alleged false claims. Hospital executives and compliance officers should consider whether there are opportunities to enhance their compliance programs with respect to their utilization review process and patient status determination processes. In particular, the following should be considered:

1. Education and training. Are providers and billing personnel aware of the Medicare program's inpatient admission standards? Do participants of the hospital's utilization review committee receive ongoing education regarding patient status determinations? Do hospital billing personnel understand how to calculate observation hours?
2. Auditing and monitoring. Does the hospital have a structured program for reviewing inpatient status determinations with particular emphasis on short stay inpatient admissions? Are these determinations audited to identify issues before they become broader problems? Is a business unit responsible for routinely monitoring inpatient status determinations? Due to the potential monetary impact of improper claims, hospitals should consider adding inpatient status determinations to the annual compliance work plan.
3. Communication. Has the hospital established and publicized processes for anonymously reporting compliance issues, such as a hotline or a compliance email address?
4. Investigation and Response. Does your hospital follow up on credible reports of non-compliance? Do those investigations lead to enhanced processes?

In the event that a significant compliance issue is identified, hospitals should be aware that the Federal Sentencing Guidelines call for reduced penalties for organizations that have established compliance programs but only if the program is effective. Hall Render has extensive experience in assisting clients establish, review and augment their compliance programs. Additionally, we regularly assist clients in handling compliance issues through voluntary refunds, self-disclosures and defense against whistleblower complaints and government investigations.

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[1] *Polansky v. Executive Health Resources, Inc.*
[2] *Guardiola v. Banner Health and NCMC Inc.*