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Report on Medicare Compliance Volume 31, Number 24. July 11, 2022 Outpatient in a Bed 'Isn't Real,' but May Generate Compliant Revenue for Hospitals

By Nina Youngstrom

A patient who has been at Self Regional Healthcare in South Carolina for 132 days and counting is one of many across the country who doesn't meet the Medicare definition of inpatient or outpatient but is stuck there just the same. Although he was a bit dehydrated and not eating well, the patient has no acute medical needs. It's just a matter of family members unwilling or unable to take him home.

"He wouldn't make it past the observation stay," said Phillip Baker, M.D., assistant vice president and chief medical revenue officer. Like many similar patients, no long-term care placement is available or approved yet. In South Carolina, Medicaid on average takes six months to approve people for nursing home coverage, assuming they qualify. As a result, some of them wind up as "outpatient in a bed," a term that isn't in any Medicare manuals. It's a catch-all phrase for capturing some compliant revenue for patients who may require some outpatient medical care initially but stay in the hospital longer than medically necessary, said Ronald Hirsch, M.D., vice president of R1 RCM.

Outpatients in a bed get there in various ways. "The biggest problem is we all have these patients, and the family drops them on our doorstep because they can't take care of them anymore, and they don't have acute medical needs," Baker said. Maybe the patients are dehydrated or have altered mental status and there's something the hospital can do to help for a day or two, and Medicare will reimburse the hospital for observation, but there's a limit. "You bill observation by the hour, and once you reach eight hours, you get [a comprehensive ambulatory payment classification, or C-APC] payment around $2,300. You don't get additional reimbursement for the additional time they occupy a bed," Baker said.

At six hours of meetings one day this week, Baker said two hours were devoted to patients in the hospital for seven or more days, and 60 people made the cut. "About a dozen are just being housed," he noted. "There's no place to send them. They need long-term placement."

This is a persistent problem for hospitals, Hirsch said at a June 9 webinar sponsored by RACmonitor.com.[1] "There's a mistaken impression patients in the hospital always need to be in the hospital," he said. "If I walked through a hospital on any given day, I could find five to 10% of patients who don't need to be there."

It's time for hospitals to figure out how to charge compliantly for patients who occupy beds when they don't need to be there, Hirsch said. Although sometimes hospitals give away care as part of their charity care mission, they should seek every opportunity for reimbursement, he said. That requires establishing a process.

"On the inpatient side, there are ways to shift costs to patients" for noncovered or medically unnecessary care, Hirsch explained. For example, the Hospital-Issued Notice of Noncoverage (HINN) 1 informs patients if they proceed with the admission they will be financially responsible for it (e.g., a surgery that doesn't comply with a national coverage determination). When patients are stable for discharge after an appropriate admission but they resist leaving the hospital, they get the HINN 12. It informs them they will be charged if they stay. They have already received the Important Message from Medicare informing them of their right to appeal the discharge.

Some hospitals discharge inpatients and change them to outpatient in a bed in the same encounter. "Then they're able to bill for outpatient services, such as EKGs and bloodwork," Hirsch said. "But calling something outpatient in a bed is not real, and changing status like that may not be allowed." The hospital may simply be providing observation-like services, although it depends on whether that's medically necessary. Medicare's definition of observation includes the language "a well-defined set of specific, clinically appropriate services." In other words, "if you're providing a service that looks like observation but isn't clinically appropriate, then it's not observation," he said. For example, a hospital claim might include 22 hours of observation on one line plus four hours of noncovered hours during which the patient waited to be picked up by a family member, with the GA modifier indicating the hospital billed the patient for the four hours after giving them an advance beneficiary notice.

Reporting Noncovered Observation With A9270

But hospitals should move away from reporting noncovered observation on separate lines of the claim form. For one thing, the *Medicare Claims Processing Manual* states, "Observation services must also be reasonable and necessary to be covered by Medicare,"[2] and the National Uniform Billing Committee manual does the same. By definition, then, custodial-care hours in observation shouldn't be reported as G0378, the code for observation services. One Medicare administrative contractor (MAC), National Government Services, recently reinforced this in an email: "Per CMS/FISS changes implemented in 2021, G0378 may only be billed on one claim line, with only medically necessary hours of observation included." The MAC said it won't fly for a hospital to bill beneficiaries for "additional non-medically necessary hours, regardless of whether the beneficiary has signed an ABN. Observation services are reimbursed via APC and payable only for medically necessary time."

There is another way to go, courtesy of CMS. In a recent email, a CMS official said "Chapter 1 of 100-04, section 60.4.2 addresses outpatient billing procedures and liability situations. The hospitals may need to bill medically unnecessary hours on a line with A9270 with the GY modifier."[3] Hospitals would use A9270 with revenue code 760, which is for outpatient specialty services, rather than revenue code 762, the CMS official wrote in the email to consultant Valerie Rinkle.

A9270 can be used to report noncovered observation services, Hirsch said. In the absence of medically necessary observation services, hospitals could consider providing what Rinkle has called "a monitoring level of service." The hospital is generally keeping patients safe, with a nurse rounding on them and the hospital providing meals and housekeeping, Hirsch said. Hospitals still must use the modifier required to convey to CMS that they will charge patients for medically unnecessary services. Hirsch said modifier GY should be used because it's for items or services that are statutorily excluded from Medicare coverage like custodial care.

Hospital Has Arrangements With Nursing Homes

Another option for dealing with "the whole outpatient in a bed thing, which makes no sense," is to try to head off people who don't belong in the hospital at all or to place them at more appropriate places, Baker said. Self Regional Healthcare is looking to put a social worker in the emergency room to intervene when a family is dropping off one of its own because they're exasperated or tired or have vacation plans, although people will still need a medical screening exam under the Emergency Medical Treatment and Labor Act.

Self Regional Healthcare also has arrangements with nursing homes to take patients short-term when they're safe for discharge but family members are unavailable and Medicaid coverage of a nursing home bed is pending. "We have a couple of facilities we pay to house these patients" because it's more affordable than a hospital bed, Baker said. Meanwhile, the hospital works on arranging Medicaid for the patient's placement in long-term care. Because Medicaid coverage is retroactive to the day it was applied for, the facilities will get fully paid for the

patients and then reimburse the hospital. "We have to front the money. If someone doesn't get Medicaid, we lose but we lose less. We are all trying to lose less."

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1 Ronald Hirsch, "Outpatient in a Bed: Effective Utilization Review and Billing Strategies," webcast, Racmonitor.com, June 9, 2022.
2 Centers for Medicare & Medicaid Services, "Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)," § 290.1, *Medicare Claims Processing Manual*, Pub. 100-04, accessed July 8, 2022, https://go.cms.gov/3uB89An.
3 Nina Youngstrom, "Noncovered Observation Shouldn't Be Reported With G0378, But CMS Offers Another Code," *Report on Medicare Compliance* 31, no. 14 (April 18, 2022), https://bit.ly/3Irbqb6.