Hospitals should ensure that their policies and procedures address two areas of inpatient billing targeted by the Department of Health and Human Services Office of Inspector General ("OIG"): (1) inpatients with one-day lengths of stay; and (2) inpatients who are readmitted shortly after having been discharged from a prior inpatient stay (often referred to as the “combined admissions” issue). These two topics have been included in the OIG’s work plan since 2000, and they are coming under increasing scrutiny.

One-Day Length of Stays
Although not formally designated as a national project, the OIG as well as a number of Quality Improvement Organizations (“QIOs”)1 are examining hospitals with high numbers of inpatients who were admitted and discharged on the same day. Because hospitals receive the full DRG payment for Medicare regardless whether the inpatient was present for one day or many days, and because reimbursement generally is higher for inpatients than for outpatients, the government is concerned that hospitals are depicting patients on their UB-92 claims forms as inpatients (e.g., indicating bill type 111) who actually should be depicted as outpatients (e.g., indicating bill type 131). An OIG report from 2001 found that the number of one-day inpatient stays increased 57 percent from 1990 to 1997. In 1990, 6.8 percent of Medicare inpatients were one-day stays, whereas that percentage had increased to 10.7 percent by 1997.2 The OIG views this trend as evidence that hospitals are manipulating Medicare billing by depicting outpatients as inpatients.

Neither the Medicare Act nor Medicare regulations define the term “inpatient.” The Medicare Hospital Manual ("MHM") and the Medicare Intermediary Manual ("MIM") (collectively, the “Manuals”) provide the following definition of inpatient:

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a bed overnight. MHM § 210; MIM § 3101.

This definition of “inpatient” is maddeningly circular — it provides that an “inpatient” is one who has been admitted for purposes of receiving “inpatient hospital services” and provides further that a person is “generally” “considered an inpatient” if he has been “formally admitted as an inpatient.” The definition is also vague — it provides that a patient is generally deemed an inpatient if admitted “with the expectation that he will remain at least overnight and occupy a bed,” but leaves it vague as to whose expectation is relevant. A later passage in the Manuals indicates

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1 QIOs were formerly known as Peer Review Organizations ("PROs").
that the relevant factor is the physician’s intention at the time of the admission as they note that “the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors.” Id.

The Manuals further provide that a patient’s inpatient or outpatient admission status cannot be based solely on the length of time spent in the hospital. See id. Moreover, while the OIG has advocated that CMS adopt a “bright line” rule that would require an overnight stay for an inpatient admission, CMS has advised the OIG that it has rejected this recommendation, favoring case-by-case determinations.3 Finally, the Manuals direct QIOs to evaluate the inpatient/outpatient status of a patient based on information available at the time of admission, and not based on the entire record post-discharge. See MHM §210; MIM §3101.

Many fiscal intermediaries (“FIs”) and QIOs have reportedly adopted billing standards that are more stringent than these rules.4 To varying degrees, they have reportedly moved toward a blanket rule that, absent certain special circumstances (such as a patient death or a patient decision to leave the hospital against medical advice), one-day cases cannot be billed as inpatients. Such positions seemingly contradict the Medicare authority summarized above. Nonetheless, to avoid running afoul of their QIOs and fiscal intermediaries, many hospitals have decided that it is most prudent to follow the “extra-regulatory” pronouncements even though the pronouncements appear inconsistent with the Manuals. Hospitals whose FI or QIO has narrowly interpreted the requirements for inpatient billing should consider whether to appeal certain “test cases” where the FI or QIO appears to have overreached.

In addition to FI and QIO review activity, the OIG has commenced one-day stay enforcement initiatives in several states, including Pennsylvania, Ohio, Oregon, New Jersey, and Indiana.5 In some instances, the Department of Justice and the OIG have treated one-day stay inpatient billing issues as Medicare fraud, launching investigations under the False Claims Act. In New Jersey, for example, four hospitals and health systems have entered into False Claims Act settlements. Settlement amounts have ranged from $450,000 to $2,000,000, and the settlement agreements have contained corporate integrity obligations. Hospitals that come under a fraud investigation should understand that many challenged cases may be defended, depending on the particular facts and circumstances. In some cases, the government has taken positions in fraud investigations that appear to contradict the Manual guidance summarized above.

**Combined Admissions**

In the combined admissions area, the OIG is targeting claims for inpatients who are discharged from the hospital and subsequently readmitted within a short period of time. The government’s concern regarding subsequent readmissions is that the patient was discharged from the first admission prematurely, and that the two admissions should be combined into a single UB-92. The OIG’s 2002 Work Plan does not state, however, the timeframe the OIG considers when it reviews subsequent readmissions. Rather, the 2002 Work Plan states that the OIG plans to review “claims for beneficiaries who were discharged and subsequently readmitted relatively soon to the same or another acute care prospective payment system hospital.” (emphasis

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3 See OIG, 2001 Red Book at 12.
4 Ultimately, QIOs have the authority to review all inpatient claims on a case-by-case basis to determine whether the admission was medically necessary. See MIM § 3101; MHM § 210. QIOs have also included one-day stays as part of their Payment Error Prevention Program (PEPP). See, e.g., www.tmf.org/pepp/1daystay.html.
added) In its formal audit reports on this subject, the OIG has focused on readmissions that occurred on the same day of discharge. QIOs have implemented varying review standards, ranging from three days to 30 days post-discharge. The PRO Manual states that a PRO should review readmissions occurring “less than 31 calendar days” after the prior discharge. PRO Manual § 4240.

As in the area of one-day stays, guidance on how to bill for subsequent readmissions is unclear. No Medicare regulation or manual provision expressly prohibits a hospital from billing for two separate admissions when the readmission occurred shortly after the first discharge (assuming the hospital is acting in good faith). The Medicare Act permits the Secretary to deny payment for inpatient claims when it determines, based upon information supplied to a QIO, that “a hospital, in order to circumvent the [prospective] payment method . . . has taken an action that results in the admission of individuals . . . unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices.” 42 U.S.C. § 1395ww(f)(2). Of course, the decision whether to admit or discharge a patient is the responsibility of the attending physician, not the hospital. Although hospitals have a financial incentive to reduce lengths of stay through improved efficiency — and the government has encouraged reduced lengths of stay — it is presumably an uncommon circumstance in which the hospital will have “taken an action” causing the premature discharge and repeat admission of a particular patient.

CMS’ PRO Manual directs QIOs to review “unnecessary readmissions and transfers” for the purpose of determining when a hospital has “circumvented the Prospective Payment System through unnecessary admissions, readmissions, or other inappropriate medical practices.” PRO Manual § 196(A). The PRO Manual states that the type of action that circumvents the PPS is the “readmission of a patient to a hospital for care that could have been provided during the first admission” and declares that such action “occurs when a patient is readmitted to a hospital for care that, pursuant to professionally recognized standards of health care, could have been provided during the first admission.” Id. at § 196.1(B).

Thus, while the Medicare Act provides for denying claims when the hospital has “taken an action” causing a premature discharge, the PRO Manual has framed the inquiry more broadly to be whether the patient was discharged prematurely even if the hospital took no action to cause the premature discharge. Accordingly, the standard set forth in the PRO Manual appears to contradict the Medicare Act.

Nonetheless, as with one-day length of stay inpatients, many hospitals have determined that it is more prudent to adopt a conservative approach toward combining claims for inpatients readmitted shortly after a previous discharge. Some hospitals have undertaken to review readmissions to determine whether to combine the two admissions in a single claim to Medicare on grounds that, with the benefit of hindsight, the previous discharge may have been premature.

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7 The Texas Medical Foundation has published audit procedures for readmissions that occur within three days of discharge. See “Audit Tool for Admission and DRG Review,” available at http://www.tmf.org. Idaho’s PRO, PRO-West, has reviewed admissions within seven days of discharge. See PRO-West, PEPP Talk (Jan. 2000) at 2. The Medical Association of Georgia elected to review readmissions within 10 days of discharge, see Medical Association of Georgia, MAG-Health Policy News (June 2000) (available at http://www.mag.org), and the Michigan Peer Review organization has reviewed readmissions within two weeks of discharge. See Michigan Peer Review Organization, PEPP Talk (Fall 2001) at 2. Finally, Island Peer Review Organization, the PRO for New York, elected to review readmissions within 30 days of discharge. See “Aggregate Project Report: Readmission Within 30 Days to the Same Hospital,” available at http://www.ipro.org.

8 Again, this directive misses the fact that admission and discharge decisions are the responsibility of the physician, not the hospital.
Conclusions and Recommendations

In light of the OIG’s recent emphasis on inpatient admissions, providers should take the following steps to help ensure the accuracy of their billing:

- Verify that written policies and procedures appropriately address one-day stays and combined admissions;
- Educate physicians and medical records staff regarding inpatient admission criteria, discharge policy, the importance of documentation to memorialize decision-making, and other topics related to inpatient admissions;
- Ensure that hospital information systems have the flexibility needed to implement policies and procedures regarding one-day stays and readmissions;
- Include one-day stays and subsequent re-admissions in the compliance program’s claims monitoring schedule; and
- Consider appealing initial decisions of FIs or QIOs for “test cases” that appear to contradict regulatory guidance.

Finally, in the event of a government audit, hospitals should keep in mind that admission and discharge decisions are ultimately the physician’s. Hospitals should not automatically accept an “error rate” asserted by the government, but should consider conducting a separate analysis of the disputed claims. Due to the ambiguity of the Medicare rules and clinical complexity, and the government’s tendency to overreach, these cases can often be effectively defended.

Further Information

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