DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

JUL 29 2013

TO: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

/S/

FROM: Stuart Wright
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Memorandum Report: *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040

This memorandum report describes hospitals' use of observation stays and short inpatient stays in 2012. The Centers for Medicare & Medicaid Services (CMS) and others have raised concerns about these types of stays. To address these concerns, CMS recently proposed policy changes—through a Notice of Proposed Rulemaking (NPRM)—that, if promulgated as proposed, would substantially affect how hospitals bill for these stays.[1]

SUMMARY

When beneficiaries enter the hospital, hospital physicians often need to decide whether to admit them as inpatients or to provide observation services. Observation services are short-term treatments and assessments provided to outpatients to determine whether beneficiaries require further treatment as inpatients or can be discharged. CMS policy states that observation services are usually needed for 24 hours or less.

CMS, Members of Congress, and others have raised concerns about hospitals' use of observation stays and short inpatient stays. They are concerned about beneficiaries spending long periods of time in observation stays without being admitted as inpatients. In particular, they are concerned that beneficiaries may pay more as outpatients than if they were admitted as inpatients. Moreover, beneficiaries who are not admitted as inpatients may not qualify under Medicare for skilled nursing facility (SNF) services following discharge from the hospital. Beneficiaries who do not qualify for SNF services may choose to receive them, but are then responsible for the SNF charges. In addition, CMS is concerned about improper payments for short inpatient stays when the beneficiaries should have been treated as outpatients.

[1] See 78 Fed. Reg. 27485, 27644–27650 (May 10, 2013).

We found that Medicare beneficiaries had 1.5 million observation stays in 2012; these beneficiaries commonly spent 1 night or more in the hospital. Beneficiaries had an additional 1.4 million long outpatient stays; some of these may have been observation stays. Beneficiaries also had 1.1 million short inpatient stays, which were often for the same reasons as observation stays. On average, short inpatient stays cost Medicare and beneficiaries more than observation stays. Some hospitals were more likely to use short inpatient stays, whereas others were more likely to use observation or long outpatient stays. Beneficiaries had over 600,000 hospital stays that lasted 3 nights or more but did not qualify them for SNF services. For 4 percent of these stays, beneficiaries received SNF services for which they did not qualify; Medicare inappropriately paid $255 million for these services.

BACKGROUND

When a beneficiary enters a hospital, hospital physicians often need to decide whether to admit the beneficiary as an inpatient. The decision to admit is a complex medical judgment. It is made by the treating physician, who must consider several factors including the beneficiary's medical history, the severity of the beneficiary's symptoms, and the expected care. Physicians are also directed to consider whether beneficiaries are expected to need at least 24 hours of hospital care.[2]

During observation stays, treating physicians use short-term treatments and assessments to determine whether a beneficiary should be admitted as an inpatient or discharged.[3] During these stays, physicians may use a variety of outpatient services, such as laboratory tests, drugs, minor procedures, x-rays, and other imaging services, to inform this decision. Observation stays can occur anywhere in the hospital, including the emergency department, a separate observation unit, or an inpatient unit. According to CMS policy, the decision to admit or discharge usually can be made within 24 hours and should rarely take longer than 48 hours.[4]

Concerns About Observation Stays and Short Inpatient Stays

CMS, Members of Congress, and others have raised concerns about hospitals' use of observation stays and short inpatient stays. They are concerned about beneficiaries spending long periods of time in observation stays without being admitted as inpatients.[5] In particular, they are concerned that beneficiaries may pay more as outpatients than if they were admitted as inpatients. Moreover, beneficiaries who are not admitted as inpatients may not qualify under Medicare for SNF services following discharge from the hospital. Beneficiaries who do not qualify for SNF services may choose to receive them, but are then responsible for the SNF charges. Notably, there have been reports of

---

[2] CMS, *Medicare Benefit Policy Manual* (MBPM), Pub. No. 100-02, ch. 1, § 10.
[3] CMS, MBPM, Pub. No. 100-02, ch. 6, § 20.6.
[4] *Ibid.*
[5] See, for example, CMS, *Listening Session: Hospital Observation Beds*, Aug. 24, 2010. Transcript available at https://www.cms.gov/hospitaloutpatientpps/downloads/94244031HosptialObservationBedsListeningSession082410.pdf [sic]. Accessed on May 8, 2013. Charles Fiegl, "Lawmakers try to eliminate Medicare coverage technicality," *American Medical News*, Nov. 7, 2011. Accessed at http://www.amednews.com/article/20111107/government/311079953/7/ on May 8, 2013.

beneficiaries in observation stays who incurred bills from SNFs for tens of thousands of dollars because they did not qualify for SNF services under Medicare.[6]

CMS and others also have raised concerns about short inpatient stays, which are inpatient stays that lasted less than 2 nights. CMS found that a significant portion of payments for these stays were improper because the services should have been provided in the outpatient setting.[7] CMS contractors, such as Recovery Audit Contractors, seek to recoup these improper payments. According to hospitals and others, these recoupment efforts have contributed to a shift from short inpatient stays to extended observation stays, which are increasing.[8]

Proposed Changes to the Payment Policies for Inpatient and Outpatient Stays

To address these concerns, in April 2013, CMS proposed policy changes through an NPRM that, if promulgated as proposed, would substantially affect how hospitals bill for observation stays and short inpatient stays.[9] If these changes are implemented, CMS contractors would presume that inpatient hospital stays lasting 2 nights or longer were reasonable and necessary and would qualify for payment as inpatient stays. Conversely, CMS contractors would presume that stays lasting less than 2 nights would not qualify for payment as inpatient stays and instead would be paid for as outpatient stays.[10] In the NPRM, CMS proposed that time spent in any outpatient area of the hospital would not count towards this 2-night presumption.[11] It also solicited comments on this proposal.

CMS expected these policy changes to reduce the number of observation stays lasting 2 nights or longer and to reduce the number of short inpatient stays.[12] Overall, it expected a net shift from outpatient to inpatient stays. To offset the costs of additional inpatient stays, CMS proposed implementing an across-the-board reduction in Medicare payments for all inpatient stays.

In addition, in March 2013, CMS implemented a ruling regarding payments for inpatient services when a CMS contractor or a hospital determines that an inpatient admission was not reasonable and necessary.[13] Specifically, CMS revised its Part B inpatient billing

---

[6] See, for example, Susan Jaffe, "Medicare rules give full hospital benefits only to those with 'inpatient' status," *Washington Post*, Sept. 7, 2010: HE01. Drew Armstrong, "Medicare Fraud Effort Gives Elderly Surprise Hospital Bills," *Bloomberg*, Jul. 12, 2010. Accessed at http://www.bloomberg.com/news/2010-07-12/hospital-fraud-audits-spur-unintended-cash-penalty-to-elderly-on-medicare.html on May 8, 2013.

[7] CMS reports an improper payment rate of 36 percent in 2012 for inpatient stays lasting 1 night or less. See 78 Fed. Reg. at 27647.

[8] See, for example, American Hospital Association, letter to CMS regarding extended observation services, October 27, 2010. Accessed at http://www.aha.org/advocacy-issues/letter/2010/101027-let-pollack-cms.pdf on April 23, 2013. CMS indicated that it received similar comments from various stakeholders. See 77 Fed. Reg. 45061, 45156 (July 30, 2012).

[9] See 78 Fed. Reg. at 27644–27650.

[10] See 78 Fed. Reg. at 27645–27649.

[11] See 78 Fed. Reg. at 27648.

[12] See 78 Fed. Reg. at 27649–27650.

[13] CMS Rulings, CMS-1455-R (March 13, 2013). Simultaneously, CMS issued a proposed rule about billing inpatient services under Part B; the proposed rule differs in some ways from the ruling and, if finalized, would supersede the ruling once it is in effect. 78 Fed. Reg. 16632 (March 18, 2013).

policy to allow payment for all hospital services that were provided and would have been reasonable and necessary if the beneficiary had been treated as an outpatient. This revision substantially reduces hospitals' financial risk when admitting beneficiaries if CMS contractors later deny or recoup payments for inpatient claims. Prior to this ruling, if an inpatient claim was denied, hospitals received payment for only a limited set of services even if all the services provided would have been reasonable and necessary in the outpatient setting.

Payments for Observation Stays, Inpatient Stays, and SNF Stays

An observation stay is a type of outpatient stay. Medicare Part B pays hospitals for outpatient stays under the Outpatient Prospective Payment System (OPPS). When a hospital bills Medicare, the claim typically includes many services. For most services, Medicare pays 80 percent of the cost, while the beneficiary is responsible for the remaining 20 percent.[14] Because payments are made per service, Medicare and beneficiary payment amounts both increase as the number of services provided increases.

During both observation and other outpatient stays, beneficiaries may receive services such as laboratory tests, drugs, minor procedures, x-rays, and other imaging services. Hospitals distinguish observation stays from other outpatient stays by adding a specific code to the claim.[15] This code indicates that a hospital provided services in order to determine whether beneficiaries should be admitted as inpatients or discharged. Although hospitals typically receive a separate payment for each outpatient service, they are not always paid a separate amount for coding a claim as an observation stay.

Medicare Part A pays hospitals for inpatient stays under the Inpatient Prospective Payment System (IPPS). Each beneficiary is classified into a Medicare severity diagnosis related group (MS-DRG). These groups are based on the beneficiary's primary and secondary diagnoses, the procedures the hospital performed, and other factors.[16] Medicare pays hospitals a different payment rate for each MS-DRG.[17]

In contrast to Medicare payments for outpatient stays, Medicare payments for inpatient stays do not depend on the number of services provided or the length of stay. While the OPPS is designed to reflect the cost of caring for each individual beneficiary, the IPPS is designed to reflect the cost of caring for an average beneficiary. Likewise, beneficiary cost-sharing for inpatient stays also does not depend on the number of services provided

[14] 42 CFR § 419.40(b); CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 30.
[15] Hospitals include a revenue center code of "0760" or "0762" to identify the claim as an observation stay.
[16] Each MS-DRG generally falls into one of three severity levels, depending on the beneficiary's secondary diagnoses. For example, a beneficiary with no secondary diagnoses that increase the complexity of care would be in a low-severity MS-DRG; a beneficiary with asthma would be in a medium-severity MS-DRG; and a beneficiary with pneumonia would be in a high-severity MS-DRG.
[17] Payment rates are adjusted by a variety of facility-level factors, such as a geographic factor to account for differences in labor costs.

or the length of stay. Instead, beneficiaries are responsible for an inpatient deductible; in 2012, the deductible was $1,156.[18]

Medicare Part A pays SNFs for services under the SNF Prospective Payment System. Medicare pays SNFs a daily rate that is determined by the beneficiary's needs. Beneficiaries incur no cost-sharing during the first 20 days, after which they pay a daily copayment ($145 in 2012). To qualify for SNF services, a Medicare beneficiary must have had an inpatient hospital stay of at least 3 nights.[19] Beneficiaries may choose to receive SNF services when they do not qualify for them under Medicare, but the beneficiaries are then responsible for SNF charges.

METHODOLOGY

We based this study on an analysis of: (1) paid Medicare Part A and Part B hospital claims from the National Claims History file with dates of service in 2012 and (2) SNF Part A claims for beneficiaries who received hospital services in 2012. We excluded hospitals that are not paid under both the OPPS and the IPPS, such as long-term care hospitals, critical access hospitals, and hospitals in Maryland that are paid under different systems.

Analysis of Observation Stays. We first identified all of the Part B hospital claims that were coded as observation stays.[20] We then determined the top 10 reasons for observation stays (e.g., chest pain). Specifically, we calculated what the MS-DRG would have been if the beneficiary had been admitted by using the information on the Part B hospital claim regarding the beneficiaries' primary and secondary diagnoses, procedures, age, and gender.[21] We based our method on the MS-DRG Manual and tested the method on short inpatient claims.[22] Based on the results of the testing, we corrected the number of observation stays associated with each reason.[23] See Appendix A for descriptions of the reasons for stays included in this report.

Next, we described how the observation stays began—that is, we calculated the percentage of observation stays that began: (1) in the emergency department, (2) with an operating room procedure, and (3) in other ways, such as a scheduled clinic visit. For the

[18] Beneficiaries are responsible for paying the deductible once per benefit period, even though a benefit period may include multiple hospital stays. A benefit period ends when the beneficiary has not received Medicare-covered hospital or SNF services for 60 consecutive days.
[19] This qualifying hospital stay typically must occur within the 30 days prior to the SNF admission. See 42 CFR § 409.30.
[20] For the purposes of this report, we considered each hospital claim to be a hospital stay. We identified all claims that had a claim line item with a revenue center code of "0760" or "0762."
[21] We also identified the procedures on the non-institutional Part B claims that were provided to the beneficiary during the observation stay. We converted the Current Procedural Terminology procedure codes to procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification using information from MediRegs and other sources.
[22] *Medicare Severity Grouper with Medicare Code Editor Software, Installation and User's Manual*, October 2012. Manual appendixes accessed at http://www.codingupdates.com/wp-content/uploads/ on May 31, 2013.
[23] The tests showed that the method somewhat underestimated certain MS-DRGs and overestimated others.

observation stays that began with an operating room procedure, we determined the most common procedure.[24] For all observation stays, we calculated the length of stay and determined which of the top 10 reasons were most likely to lead to an observation stay that lasted 2 nights or longer. Throughout this report, a 0-night hospital stay means a stay that began and ended on the same calendar day; a 1-night hospital stay spans 2 calendar days; a 2-night stay spans 3 calendar days; etc.

We determined total Medicare and beneficiary payments for all observation stays. In addition, we determined average Medicare and beneficiary payments per stay for all stays, and we estimated average payments for each of the most common reasons for stays.[25] We also calculated the percentage of all observation stays that included charges for self-administered drugs, which are not covered by Medicare during outpatient stays, and the average payment per observation stay including these charges.

We also determined the number of Part A hospital claims in which the beneficiaries began as outpatients, received observation services, and were eventually admitted as inpatients; we refer to these stays as inpatient stays, rather than observation stays.

Analysis of Outpatient Stays That Lasted at Least 1 Night but Were Not Coded as Observation Stays. We identified all Part B hospital claims that lasted at least 1 night and were not coded as observation stays.[26] We refer to these claims as long outpatient stays.[27] As with observation stays, we determined: (1) the top 10 reasons for these stays, (2) the percentage of these stays that began in the emergency department, and (3) the length of stay.

Next, we identified the number of observation stays and the number of long outpatient stays for each hospital. We calculated the percentage of these stays that were observation stays and the remaining percentage that were long outpatient stays to assess the variation in hospitals' use of these stays.

Analysis of Short Inpatient Stays. We identified all Part A hospital claims that were 1 night or less; we refer to these claims as short inpatient stays.[28] We calculated the percentage of these stays that lasted 1 night and the percentage that lasted less than

[24] We considered an outpatient procedure to be an operating room procedure if it would have led to a surgical MS-DRG if the beneficiary had been admitted. Most MS-DRGs are considered either medical or surgical.

[25] These averages are estimates because of the method we used for determining the reasons for observation stays.

[26] We did not include claims for repetitive and recurring services, such as physical therapy and chemotherapy. The dates on these claims may indicate, for example, a 30-day stay; however, the beneficiaries did not spend the night; instead they returned periodically (e.g., once a week) for the same services.

[27] While these claims did not include a claim line item with a revenue center code of "0760" or "0762," they may have included observation services—that is, services to determine whether the beneficiary should have been admitted as an inpatient or discharged.

[28] We excluded short inpatient stays in which the beneficiary died, was transferred to another acute-care facility, had an inpatient-only procedure, or left against medical advice.

1 night. We also calculated the percentage that included emergency department services before the beneficiary was admitted.

In addition, we determined the top 10 reasons for short inpatient stays.[29] We also calculated total and average Medicare and beneficiary payments for short inpatient stays and average payments for each of the most common reasons for short inpatient stays.

Comparisons Between Short Inpatient Stays and Observation Stays. We compared short inpatient and observation stays in several ways. First, we compared the most common reasons for the two types of stays. We determined how many of the top 10 reasons for each type of stay overlapped and how the order differed between observation and short inpatient stays.

Second, we compared Medicare and beneficiary payments for the two types of stays. For each of the most common reasons, we determined the differences between the average Medicare and beneficiary payments for short inpatient stays and the estimated average Medicare and beneficiary payments for observation stays. Next, for all observation stays, we determined how often beneficiaries paid more than the inpatient deductible and how often they paid more than twice the inpatient deductible.

Finally, we identified the number of short inpatient stays and the number of observation and long outpatient stays for each hospital. We determined the percentage of these stays that were short inpatient stays to assess the variation in hospitals' use of these stays.

Analysis of SNF Stays for Beneficiaries Who Spent at Least 3 Nights in the Hospital But Did Not Qualify for SNF Services. We first identified all hospital stays from 2012 in which beneficiaries spent at least 3 nights in the hospital but had fewer than 3 nights as inpatients. A beneficiary with a hospital stay that is fewer than 3 inpatient nights does not qualify for Medicare SNF services. These stays included observation and long outpatient stays; they also included short and 2-night inpatient stays when the beneficiary spent at least 1 night as an outpatient prior to admission. We calculated the number and percentage of each type of these stays.

Next, we determined the number of these hospitals stays in which the beneficiary received SNF services after the hospital stay. Specifically, we identified all SNF services that began within 30 days of the discharge from the hospital stay.[30] To verify that these SNF services did not have another hospital stay that qualified the beneficiary for SNF services, we matched the hospital dates reported by the SNF to all inpatient claims for each beneficiary and included only the SNF services that were not associated with 3 inpatient nights.

[29] We used the MS-DRG on the Part A claim to determine the reason for the stay.

[30] Typically, for beneficiaries to qualify for SNF services, these services must be provided within 30 days of the hospital stay. In addition, SNFs must report the dates of the hospital stay on their claims, unless the beneficiary did not have a qualifying hospital stay. We included only SNF services in which the reported hospital dates (1) matched at least one day of the hospital stay or (2) were blank and the Medicare payments were zero, indicating that the beneficiary did not have a qualifying hospital stay.

We then determined the percentage of these hospital stays in which Medicare paid SNFs inappropriately for services. We also determined the percentage of stays in which Medicare did not pay and the beneficiary was fully liable for the SNF charges. For the hospital stays in which Medicare paid for SNF services, we calculated the total and average Medicare payments and beneficiary copayments. Similarly, for the hospital stays in which the beneficiary was liable for SNF charges, we calculated the total and average charges.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

Medicare Beneficiaries Had 1.5 Million Observation Stays in 2012

Hospitals provided observation services to Medicare beneficiaries in 1,511,875 stays. During these observation stays, hospitals provided short-term treatments and assessments and determined that the beneficiaries did not need to be admitted as inpatients. For another 601,880 stays, hospitals provided observation services to beneficiaries who were then admitted to the hospital as inpatients.[31]

Beneficiaries in observation stays were most often treated for chest pain. During stays for chest pain, beneficiaries most commonly received electrocardiograms, chest x-rays, and other laboratory tests, such as troponin tests. The second most common reason for an observation stay was digestive disorders. During stays for digestive disorders, hospitals commonly provided various laboratory tests, most frequently a complete blood count. Notably, as shown in Table 1, many of the common reasons for observation stays—like chest pain—were related to symptoms, rather than to a specific procedure or underlying condition. For example, the third and fourth most common reasons were fainting and "signs and symptoms," which includes general pain or malaise.

Table 1: Most Common Reasons for Observation Stays, 2012

Most Common Reasons for Observation Stays	Number of Observation Stays	Percentage of Observation Stays
Chest pain	340,484	22.5%
Digestive disorders	93,091	6.2%
Fainting	81,349	5.4%
Signs and symptoms	47,439	3.1%
Nutritional disorders	39,227	2.6%
Dizziness	34,455	2.3%
Irregular heartbeat	31,390	2.1%
Circulatory disorders	31,163	2.1%
Respiratory signs and symptoms	24,715	1.6%
Medical back problems	23,846	1.6%

Source: Office of Inspector General (OIG) analysis of CMS data, 2013.

Typically, observation stays began with the beneficiary being treated in the emergency department. Seventy-eight percent of observation stays began this way, while another 9 percent began with the beneficiary having an operating room procedure. The most common operating room procedure was coronary stent insertion. The remaining observation stays began in other ways, such as with scheduled clinic visits, minor procedures, or laboratory and imaging services.

[31] We considered these stays to be inpatient stays, rather than observation stays.

Beneficiaries in Observation Stays Commonly Spent 1 Night or More in the Hospital
In 92 percent of observation stays, beneficiaries spent at least 1 night (2 calendar days) in the hospital. As shown in Table 2, in 55 percent of observation stays, beneficiaries spent 1 night in the hospital; in 26 percent of stays, beneficiaries spent 2 nights; and in 11 percent of stays, beneficiaries spent at least 3 nights.

Table 2: Number and Percentage of Observation Stays by Length of Stay, 2012

Length of Stay	Number of Observation Stays	Percentage of All Observation Stays
0 nights (1 calendar day)	126,264	8%
1 night	833,583	55%
2 nights	385,830	26%
At least 3 nights	166,198	11%
Total	**1,511,875**	**100%**

Source: OIG analysis of CMS data, 2013.

Some beneficiaries were more likely than others to have longer observation stays. Among the most common reasons for observation stays, medical back problems were the most likely to result in beneficiaries' having stays lasting 2 nights or longer, followed by signs and symptoms. Chest pain was the least likely to result in stays lasting 2 nights or longer. See Appendix B for the percentage of stays lasting 2 nights or longer for the most common reasons for observation stays.

Beneficiaries Had an Additional 1.4 Million Long Outpatient Stays; Some of These Stays May Have Been Observation Stays
Medicare beneficiaries had 1,386,090 outpatient stays that lasted at least 1 night, but were not coded as observation stays. We refer to these as long outpatient stays. As shown in Table 3, for 94 percent of these stays, beneficiaries spent 1 night in the hospital. For the remaining 6 percent, beneficiaries spent 2 or more nights in the hospital.

Table 3: Number and Percentage of Long Outpatient Stays, by Length of Stay, 2012

Length of Stay	Number of Stays	Percentage of Stays
1 night	1,298,178	94%
At least 2 nights	87,912	6%
Total	1,386,090	**100%**

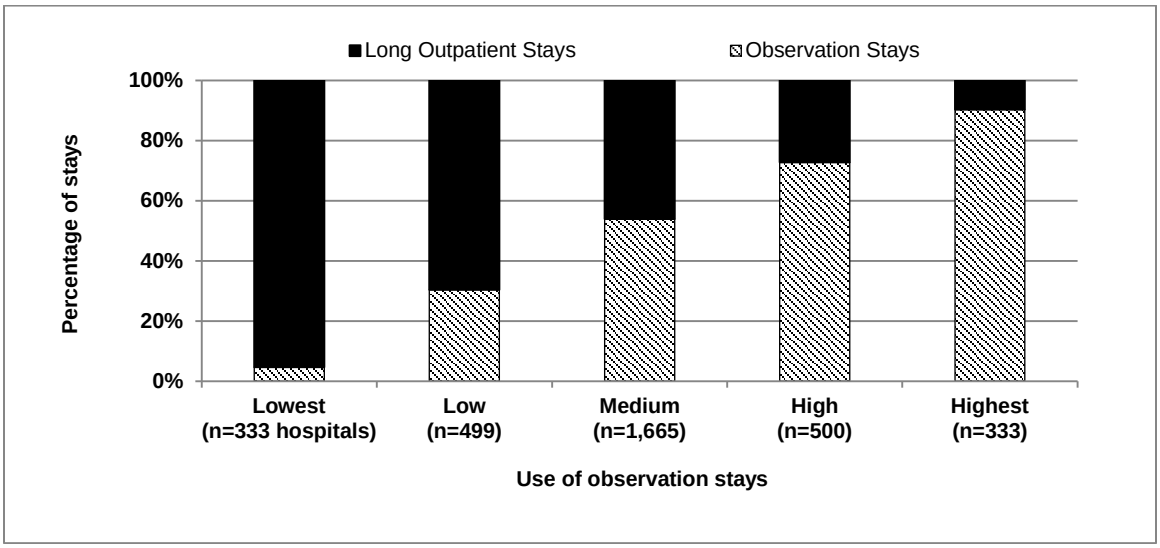
Source: OIG analysis of CMS data, 2013.

For some of these stays, hospitals may have provided observation services without coding the claims as observation stays. Because hospitals are not always paid a separate amount for coding claims as observation stays, they may have provided observation services—i.e., services to determine whether a beneficiary should have been admitted or discharged—without appropriately coding these claims.

Long outpatient stays had similar characteristics to observation stays. Like beneficiaries in observation stays, those in most long outpatient stays (63 percent) began their stays in the emergency department. Also like beneficiaries in observation stays, those in long outpatient stays were most commonly treated for chest pain and digestive disorders. See Appendix C for the top 10 reasons for long outpatient stays.

Additionally, hospitals varied widely in their use of observation stays and long outpatient stays. Nationally, 52 percent of these stays were observation stays, while the remaining 48 percent were long outpatient stays. As shown in Figure 1, for some hospitals, less than 5 percent of their stays were observation stays, while for others, over 90 percent of their stays were observation stays. This variation may reflect differences in how often hospitals code claims as observation stays when observation services are provided.

Figure 1: Variation in the Use of Observation and Long Outpatient Stays Among Hospitals, 2012



Source: OIG analysis of CMS data, 2013.

Medicare Beneficiaries Had 1.1 Million Short Inpatient Stays in 2012; These Stays Were Often for the Same Reasons as Observation Stays

In 2012, Medicare beneficiaries had 1,146,925 short inpatient stays—that is, inpatient stays lasting less than 2 nights. For 90 percent of these stays, beneficiaries spent 1 night in the hospital, while beneficiaries spent less than 1 night for the remaining 10 percent of stays. Like beneficiaries in observation stays, those in most short inpatient stays (67 percent) were first treated in the emergency department.

Short inpatient stays were often for the same reasons as observation stays. Similar to beneficiaries in observation stays, those in short inpatient stays were most commonly treated for chest pain. Additionally, 6 of the 10 most common reasons for short inpatient stays were also among the 10 most common reasons for observation stays. See Table 4 for the top reasons for short inpatient and observation stays and Appendix D for more detailed information on the most common reasons for short inpatient stays.

Table 4: Most Common Reasons for Observation and Short Inpatient Stays, 2012

Top Reasons for Stays*	Rank	
	Observation Stays	Short Inpatient Stays
Chest pain	1	1
Digestive disorders	2	4
Fainting	3	5
Signs and symptoms	4	21
Nutritional disorders	5	8
Dizziness	6	28
Irregular heartbeat	7	3
Circulatory disorders	8	6
Respiratory signs and symptoms	9	45
Medical back problems	10	35
Loss of blood flow to the brain	11	7
Red blood cell disorders	13	9
Coronary stent insertion	15	2
Irregular heartbeat (medium severity)	21	10

*This list includes the top 10 reasons for observation stays and the top 10 reasons for short inpatient stays.
Source: OIG analysis of CMS data, 2013.

On Average, Medicare Paid Nearly Three Times More for a Short Inpatient Stay Than an Observation Stay and Beneficiaries Paid Almost Two Times More

In total, Medicare paid $5.9 billion for short inpatient stays, an average of $5,142 per stay. In contrast, it paid $2.6 billion for observation stays, an average of $1,741 per stay. For each of the most common reasons for the stays, the average payment was always higher for short inpatient stays than for observation stays. As shown in Table 5, the average payment difference was lowest for chest pain, with Medicare paying $870 more for a short inpatient stay than for an observation stay, and was highest for red blood cell disorders, with Medicare paying $2,801 more for a short inpatient stay.

Beneficiaries also paid more for short inpatient stays than for observation stays. Beneficiaries paid a total of $831 million for short inpatient stays, an average of $725 per stay. In contrast, they paid a total of $606 million for observation stays, an average of $401 per stay.[32] Beneficiaries typically paid more for short inpatient stays than for observation stays when they were treated for the same reason, although there were some

[32] These payments for observation stays do not include charges for self-administered drugs, which are not covered by Medicare. When these charges are added, beneficiaries paid an average of $528 per observation stay. Fifty-one percent of observation stays included these charges. Hospitals may not always bill beneficiaries for these charges. For inpatient stays, beneficiaries are not charged for self-administered drugs.

exceptions. For all but two of the most common reasons, beneficiaries paid more for short inpatient stays, with these stays costing an average of $359 to $572 more than observation stays. For the two exceptions—coronary stent insertions and circulatory disorders—beneficiaries paid more, on average, for observation stays than for short inpatient stays. For these stays, the difference in average payments was $817 and $167, respectively. See Table 5.

Table 5: Differences Between Average Payments* for Short Inpatient Stays and Observation Stays, by the Most Common Reasons for Treatment, 2012

Top Reasons for Observation or Short Inpatient Stays**	Difference in Average Medicare Payments	Difference in Average Beneficiary Payments
Red blood cell disorders	$2,801	$373
Irregular heartbeat (medium severity)	$2,444	$457
Circulatory disorders	$2,312	-$167
Coronary stent insertion	$2,267	-$817
Medical back problems	$2,085	$404
Digestive disorders	$2,047	$425
Nutritional disorders	$1,977	$474
Fainting	$1,890	$417
Signs and symptoms	$1,854	$359
Respiratory signs and symptoms	$1,792	$396
Loss of blood flow to the brain	$1,677	$415
Dizziness	$1,320	$466
Irregular heartbeat	$943	$572
Chest pain	$870	$419

*Average payments for observation stays are estimates because each reason is estimated based on information from the Part B hospital claim.

**This list includes the top 10 reasons both for observation and short inpatient stays.

Source: OIG analysis of CMS data, 2013.

Beneficiaries in observation stays sometimes paid more than the deductible charged to beneficiaries in inpatient stays.[33] For 6 percent of all observation stays, or 83,747 stays, beneficiaries paid more than the inpatient deductible. Notably, for 3,439 observation stays, beneficiaries paid more than two times the inpatient deductible.

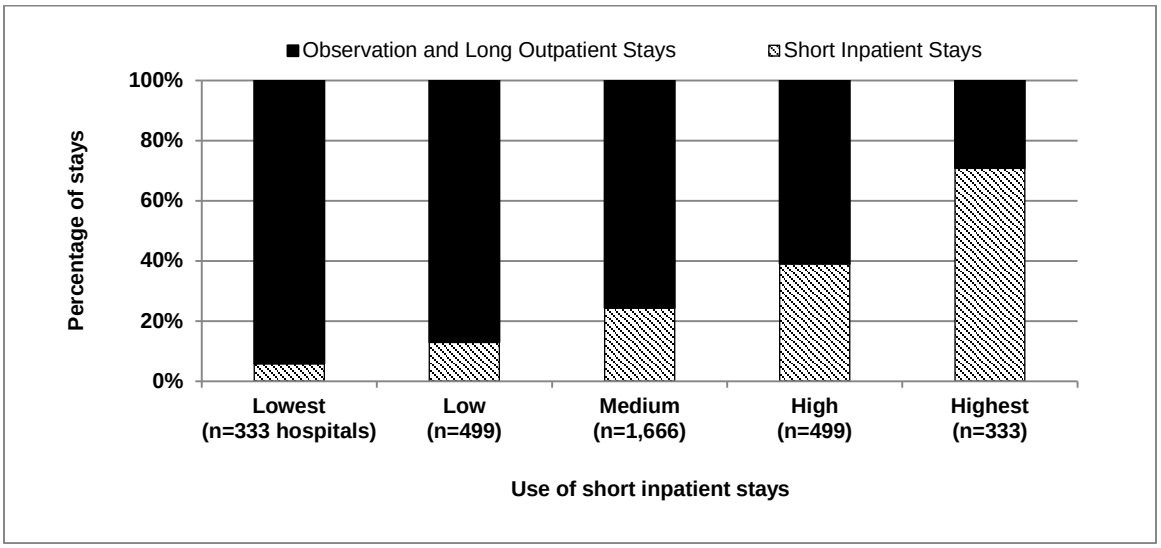
Some Hospitals Were More Likely To Use Short Inpatient Stays While Others Were More Likely To Use Observation or Long Outpatient Stays

Of the three types of stays, nationally, 28 percent were short inpatient stays, while the remaining 72 percent were either observation or long outpatient stays. However, the use of short inpatient stays varied widely among hospitals. Some hospitals used short

[33] The inpatient deductible was $1,156 in 2012. There is no cap on beneficiaries' 20-percent cost-sharing for observation stays.

inpatient stays for less than 10 percent of their stays, while others used them for over 70 percent of their stays. See Figure 2 for the variation in hospitals' use of short inpatient stays and their use of observation and long outpatient stays.

Figure 2: Variation in the Use of Short Inpatient Stays and the Use of Observation and Long Outpatient Stays Among Hospitals, 2012



Source: OIG analysis of CMS data, 2013.

Beneficiaries Had Over 600,000 Hospital Stays That Lasted 3 Nights or More, But Did Not Qualify Them for SNF Services

Beneficiaries had 617,702 hospital stays that lasted at least 3 nights, but did not include 3 inpatient nights; these beneficiaries did not qualify for SNF services under Medicare. These hospital stays included observation and long outpatient stays. They also included stays in which the beneficiary began as an outpatient and was eventually admitted into a short or 2-night inpatient stay. See Table 6 for the types of hospital stays lasting at least 3 nights without 3 inpatient nights.

Table 6: Types of Hospital Stays Lasting at Least 3 Nights but With Less Than 3 Inpatient Nights, 2012

Type of Hospital Stay	Number of Hospital Stays	Percentage of Hospital Stays
Outpatient only		
Observation	166,198	27%
Long outpatient	18,072	3%
Inpatient that began as outpatient		
Short inpatient	78,795	13%
2-night inpatient	354,637	57%
Total	**617,702**	**100%**

Source: OIG analysis of CMS data, 2013.

For 4 percent, or 25,245, of the 617,702 hospital stays, beneficiaries received SNF services following their discharge from the hospital, even though they did not qualify for these services under Medicare. For 23,148 of these hospital stays, Medicare inappropriately paid for the SNF services, for a total of $255 million. Beneficiaries paid a total of $63 million in copayments, for an average of $2,735 for the SNF services following each hospital stay. For the remaining 2,097 hospital stays, Medicare did not pay for the SNF services and the beneficiary was fully liable for the SNF charges. These charges totaled $22 million, for an average of $10,503.

CONCLUSION

In 2012, Medicare beneficiaries had 1.5 million observation stays; these beneficiaries commonly spent 1 night or more in the hospital. Beneficiaries had an additional 1.4 million long outpatient stays; some of these may have been observation stays. Beneficiaries also had 1.1 million short inpatient stays, which were often for the same reasons as observation stays. On average, short inpatient stays cost Medicare and beneficiaries more than observation stays. Some hospitals were more likely to use short inpatient stays, whereas others were more likely to use observation or long outpatient stays. Additionally, beneficiaries had over 600,000 hospital stays that lasted 3 nights or more but did not qualify them for SNF services. For 4 percent of these stays, beneficiaries received SNF services for which they did not qualify; Medicare inappropriately paid $255 million for these services.

CMS recently proposed policy changes—through an NPRM—that, if promulgated as proposed, would substantially affect how hospitals bill for observation stays, long outpatient stays, and short inpatient stays. Our results may be useful to CMS as it considers policy changes. Our results indicate that under the policies proposed in the NPRM, the number of short inpatient stays would be significantly reduced; however, the number of observation and long outpatient stays may not be reduced if outpatient nights are not counted towards the 2-night presumption. Our results further indicate that, under the policies proposed in the NPRM, some hospitals would likely follow the provisions and continue to bill these as outpatient stays; other hospitals—given strong financial incentives and few barriers—would likely not follow the provisions and would admit beneficiaries as inpatients as soon as possible to meet the 2-night presumption.

Lastly, our results raise concerns about SNF services for beneficiaries in observation stays, long outpatient stays, and short inpatient stays. CMS should consider how to ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for SNF services. Allowing nights spent as an outpatient to count toward the 3 nights needed to qualify for SNF services may require additional statutory authority. Ensuring that controls are in place so that Medicare does not inappropriately pay when beneficiaries do not qualify for SNF services is also critical. We will refer to CMS in a separate memorandum the SNFs that received $255 million in inappropriate payments so that CMS can look into recoupment.

In addition, OIG plans to conduct future work on hospitals' use of these stays. We also plan to conduct future work on inappropriate Medicare payments for SNF services for beneficiaries who do not have a 3-night qualifying hospital stay. We may issue formal recommendations to CMS in these future reports.

This memorandum report is being issued directly in final form because it contains no formal recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-12-00040 in all correspondence.

APPENDIX A

Descriptions of Reasons for Stay*

Reason	Description
Chest pain	Chest pain
Circulatory disorders	Circulatory disorders except acute myocardial infarction, with cardiac catheterization
Coronary stent insertion	Percutaneous cardiovascular procedures with stent
Digestive disorders	Esophagitis, gastroenteritis, and miscellaneous digestive disorders
Dizziness	Dysequilibrium
Fainting	Syncope and collapse
Headaches	Headaches
Injuries to the skin or tissue	Trauma to the skin, subcutaneous tissue, and breast
Irregular heartbeat	Cardiac arrhythmia and conduction disorders
Irregular heartbeat (medium severity)	Cardiac arrhythmia and conduction disorders (medium severity)
Kidney and urinary tract infections	Kidney and urinary tract infections
Loss of blood flow to the brain	Transient ischemia
Musculoskeletal signs and symptoms	Signs and symptoms of musculoskeletal system and connective tissue (e.g. muscle inflammation, joint pain)
Nutritional disorders	Nutritional and miscellaneous metabolic disorders (e.g. vitamin deficiency)
Red blood cell disorders	Red blood cell disorders (e.g. anemia, sickle-cell disease)
Respiratory signs and symptoms	Respiratory signs and symptoms (e.g. coughing, shortness of breath)
Signs and symptoms	Signs and symptoms (e.g. general pain, malaise)

*Unless noted otherwise, throughout this report, all of the reasons for stays were for beneficiaries at the low severity level—i.e., without secondary diagnoses that can increase the complexity of care.

Source: OIG, 2013.

APPENDIX B

Percentage of Observation Stays Lasting 2 Nights of Longer, 2012

Most Common Reasons For Observation Stays	Percentage of Observation Stays Lasting 2 Nights or Longer
Medical back problems	54.5%
Signs and symptoms	47.9%
Nutritional disorders	47.2%
Digestive disorders	46.7%
Circulatory disorders	45.2%
Dizziness	39.3%
Fainting	38.3%
Respiratory signs and symptoms	33.2%
Irregular heartbeat	24.8%
Chest pain	24.1%

Source: OIG analysis of CMS data, 2013.

APPENDIX C

Most Common Reasons for Long Outpatient Stays, 2012

Most Common Reasons for Long Outpatient Stays	Number of Long Outpatient Stays	Percentage of Long Outpatient Stays
Digestive disorders	121,721	8.8%
Chest pain	57,078	4.1%
Coronary stent insertion	54,723	3.9%
Injuries to the skin or tissue	49,384	3.6%
Kidney and urinary tract infections	37,183	2.7%
Medical back problems	31,418	2.3%
Signs and symptoms	29,712	2.1%
Circulatory disorders	28,853	2.1%
Musculoskeletal signs and symptoms	28,024	2.0%
Headaches	25,010	1.8%

Source: OIG analysis of CMS data, 2013.

APPENDIX D

Most Common Reasons for Short Inpatient Stays, 2012

Most Common Reasons for Short Inpatient Stays	Number of Short Inpatient Stays	Percentage of Short Inpatient Stays
Chest pain	49,716	4.3%
Coronary stent insertion	45,658	4.0%
Irregular heartbeat	38,961	3.4%
Digestive disorders	37,649	3.3%
Fainting	32,656	2.8%
Circulatory disorders	29,515	2.6%
Loss of blood flow to the brain	25,355	2.2%
Nutritional disorders	24,624	2.1%
Red blood cell disorders	20,977	1.8%
Irregular heartbeat (medium severity)	20,064	1.7%

Source: OIG analysis of CMS data, 2013.