DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-08-16

DATE: **April 4, 2008**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Provision of Observation Services in Critical Access Hospitals (CAHs)

Memorandum Summary

- A CAH may maintain beds used solely for outpatient observation services without counting these beds toward the statutory CAH maximum of 25 inpatient beds.
- However, State Survey Agencies (SAs) must examine CAH provision of outpatient observation services carefully to assure they are consistent with the statutory limit of 25 inpatient beds that have an annual average length of stay that does not exceed 96 hours per patient.
- An advance copy of revised portions of the State Operations Manual (SOM) CAH Appendix W, addressing the assessment of observation bed services in CAHs, is attached to this memorandum.

Questions have been raised about whether or not a CAH can have beds used solely for observation without these beds being counted toward the statutory CAH maximum of 25 inpatient beds. A CAH is permitted to use beds for outpatient observation services. However, SAs must examine such arrangements carefully to determine whether the observation units are being employed appropriately, or whether they are functioning as an expansion of inpatient beds beyond the permitted statutory maximum.

A CAH provides not more than 25 inpatient beds for care that does not exceed, on an annual average basis, 96 hours per patient. (Section 1820(c)(2)(B)(iii) of the Social Security Act, codified at 42 USC 1395i-4(c)(2)(B)(iii)). (This limit does not include inpatient beds used in a CAH psychiatric or rehabilitation distinct part unit, each of which may have up to ten beds.)

There is no prohibition on a CAH's offering outpatient observation services. Medicare pays for observation status as an outpatient service, even though the patient in such status may be provided with overnight accommodation, food and nursing care. As a result, an observation bed is not considered an inpatient bed that counts toward the 25-bed limit, and the hours spent in observation status do not count toward the calculation of the CAH's annual average length of stay.

In light of the statutory limitations on both bed size and average length of stay, the Centers for Medicare & Medicaid Services (CMS) is concerned about the potential for inappropriate use of outpatient observation status as a means to circumvent these limits. CMS seeks, therefore, to ensure that CAH provision of outpatient observation services is clinically appropriate and consistent with the statutory limitations on CAH inpatient services.

We are equally concerned that Medicare beneficiaries who are inappropriately placed in an outpatient observation status may be subjected to an increased beneficiary coinsurance liability that could have been avoided, had the beneficiary been properly admitted as an inpatient. This is the case because, as CAHs are not paid under the hospital Outpatient Prospective Payment System (OPPS), the beneficiary in an observation status will be liable for a coinsurance charge equal to 20 percent of the CAH's customary charges for the services. Further, as CAHs are also not subject to the preadmission payment window, a Medicare beneficiary would be liable for the coinsurance charges for the services received on observation status even when subsequently admitted. Depending on the terms of their health insurance coverage, other CAH patients may also face similar increased and avoidable costs when inappropriately placed in an observation status.

CMS believes that the clinical needs of the patient must be the primary concern in determining what types of equipment, including beds and services, the CAH utilizes. The CAH must provide equipment and services appropriate to the patient's needs, and still remain in compliance with the statutory limitations on its services. A CAH should not place patients who need inpatient care in an observation status in order to avoid compliance with the 25-bed inpatient limit.

Attached is an advance copy of revisions to the SOM, Appendix W, which provides updated interpretive guidance concerning the CAH 25-bed limit on inpatient beds. The on-line version of the SOM will be updated to incorporate this material; the final version may differ slightly from this advance copy.

If you have any questions concerning this memorandum, please call CDR Cindy Melanson at (410) 786-0310 or via E-mail at cindy.melanson@cms.hhs.gov.

Effective Date: This policy clarification is effective immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: This information should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/
Thomas E. Hamilton

Attachment:

cc: Survey and Certification Regional Office Management

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal *Advance Copy* **Date:**

SUBJECT: Revision to Appendix W, "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs)"

I. SUMMARY OF CHANGES: Appendix W, Tag C-0211, was revised and updated to include information released in S&C-08-16, Provision of Observation Services in Critical Access Hospitals (CAHs). The revision provides CAHs the ability to utilize beds for observation services that will not count against the statutory CAH maximum of 25 inpatient beds.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: UPON ISSUANCE
IMPLEMENTATION DATE: UPON ISSUANCE

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix W Tag C-0211

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

C-0211

§485.620(a) Standard: Number of Beds

Except as permitted for CAHs having *distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.*

Interpretive Guidelines §485.620(a)

Section 1820(c)(2)(B)(iii) of the Social Security Act, codified at 42 USC 1395i-4(c)(2)(B)(iii) limits a CAH to a maximum of 25 inpatient beds that can be used for inpatient acute care or swing bed services. The statute also requires CAHs to provide inpatient acute care limited, on an annual average basis, to 96 hours per patient (See interpretive guidelines for §485.620(b))

Section 1820(c)(2)(E) of the Act also permits a CAH to operate a 10-bed psychiatric distinct part unit (DPU) and a 10-bed rehabilitation DPU, without counting these beds toward the 25-bed inpatient limit.

The limit applies to the number of inpatient beds; not to the number of inpatients on any given day. CAHs that were larger hospitals prior to converting to CAH status may not maintain more than 25 inpatient beds, plus a maximum of 10 psychiatric DPU inpatient beds and 10 rehabilitation DPU inpatient beds.

Observation Services

Observation beds are not included in the 25-bed maximum, nor in the calculation of the average annual acute care patient length of stay. This makes it essential for surveyors to determine that CAHs with observation beds are using them appropriately, and not as a means to circumvent the CAH size and length-of-stay limits.

Inappropriate use of observation services also subjects Medicare beneficiaries to an increased beneficiary coinsurance liability that could have been avoided, had the beneficiary been properly admitted as an inpatient. This is the case because, as CAHs are not paid under the hospital Outpatient Prospective Payment System (OPPS), the beneficiary in an observation status will be liable for a coinsurance charge equal to 20 percent of the CAH's customary charges for the services. Further, as CAHs are also not subject to the preadmission payment window, a Medicare beneficiary would be liable for the coinsurance charges for the observation status services even when subsequently admitted. Depending on the terms of their health insurance coverage, other CAH patients may also face similar increased and avoidable costs when inappropriately placed in an observation status.

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment, that are provided before a decision

can be made regarding whether a patient will require further treatment as an inpatient, or may be safely discharged. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after outpatient surgery, and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a clinical decision is made concerning their next placement. The CAH should ensure that once there is sufficient information to render this clinical decision, the patient should be expeditiously admitted, appropriately transferred, or discharged.

A patient may be in an observation status even though the CAH furnishes the patient overnight accommodation, food, and nursing care.

*Observation services are **NOT** appropriate*

- *As a substitute for an inpatient admission;*
- *For continuous monitoring;*
- *For medically stable patients who need diagnostic testing or outpatient procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting*
- *For patients awaiting nursing home placement;*
- *To be used as a convenience to the patient, his or her family, the CAH, or the CAH's staff;*
- *For routine prep or recovery prior to or following diagnostic or surgical services; or*
- *As a routine "stop" between the emergency department and an inpatient admission.*

*Observation services **BEGIN** and **END** with an order by a physician or other qualified licensed practitioner of the CAH.*

- *The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record. The order may not be backdated. Orders should be clear for the level of care intended, such as "admit to inpatient" or "admit for observation."*
- *Observation services end when the physician or other qualified licensed practitioner orders an inpatient admission, a transfer to another health care facility, or discharge. The inpatient stay begins on the date and time of the new order.*
- *Standing orders for observation services are not acceptable, since it is not necessary to employ observation services for every patient in a given category, e.g., every emergency department patient, in order to reach a clinical decision about the appropriate next step in the patient's care.*

Medicare generally will not pay for observation services lasting more than 48 hours. However, some States may have more stringent limits in their licensure or other regulatory requirements, e.g., 24 hours. In such cases the more stringent limit on the length of an observation stay applies to Medicare beneficiaries as well.

CAHs must provide appropriate documentation upon surveyor request to show that an observation bed is not an inpatient bed. The CAH must be able to document that it has specific clinical criteria for admission to, and discharge from, the observation service, and that these criteria are clearly distinguishable from those used for inpatient admission and discharge. CMS expects a CAH to employ the same type of clinical criteria for observation versus inpatient status for all patients, regardless of their payer status. For example, if a CAH were routinely placing only Medicare beneficiaries in a dedicated observation unit, then this would suggest that non-clinical criteria were being used in the decision to admit versus place in observation status. This would not only call the observation bed status into question, but would violate the CAH's provider agreement. (See 42 CFR section 489.53(c)(2))

CMS expects there to be a reasonable relationship between the size of the CAH's inpatient and observation operations. For example, a 10-bed observation unit in a 25-bed CAH might be disproportionately large, and the surveyor must determine whether the observation unit is actually functioning as an inpatient overflow unit. A CAH observation unit that routinely operates at a high occupancy rate could also be an indicator of the need to probe further.

Other Types of Beds

Other bed types that do not count toward the 25 inpatient bed limit include:

- *Examination or procedure tables;*
- *Stretchers;*
- *Operating room tables;*
- *Beds in a surgical recovery room used exclusively for surgical patients during recovery from anesthesia;*
- *Beds in an obstetric delivery room used exclusively for OB patients in active labor and delivery of newborn infants (do count beds in birthing rooms where the patient remains after giving birth);*
- *Newborn bassinets and isolettes used for well-baby boarders;*
- *Stretchers in emergency departments; and*
- *Inpatient beds in Medicare-certified distinct part rehabilitation or psychiatric units.*

Hospice Services

A CAH can dedicate beds to a hospice under arrangement but the beds must count as part of the maximum bed count. The computation contributing to the 96 hour annual average length of stay does not apply to hospice patients. The hospice patient can be admitted to the CAH for any care involved in their hospice treatment plan or for respite care.

Medicare does not reimburse the CAH for the hospice CAH benefit. Medicare reimburses the hospice. The CAH must negotiate payment for services from the hospice through an agreement.

Survey Procedures §485.620(a)

- *Count the number of inpatient beds the CAH maintains, excluding any DPU beds.*
- *Ask the CAH how frequently it uses observation services, and for its policies and procedures governing use of observation services.*
- *Verify that patients are never pre-registered for observation services; there should be no scheduled observation stays.*
- *Check to see if the CAH has specific clinical criteria for admission to and discharge from the observation service and that these clinical criteria are clearly distinguishable from those used for inpatient admission and discharge.*
- *If there is a separate unit of observation beds, ask the CAH for evidence of how its criteria for admission to the observation unit differ from admission criteria for an inpatient bed. Count the number of beds in the observation unit and compare them to the number of inpatient beds. The higher the proportion of observation beds, the greater is the CAH's burden to prove these are not being used as inpatient beds. Ask for the occupancy rates for the observation unit; the higher the occupancy rate, particularly if there are more than a couple of beds, the greater is the CAH's burden to prove these are not being used as inpatient beds.*
- *Review the medical records for patients who are in observation status at the time of survey. Verify that the medical record includes an order to place the patient in observation status, including the clinical reason for observation, as "Place patient in observation to rule out possible myocardial infarction (MI)."*
- *Select a sample of closed medical records for patients who were in an observation status. Verify that the medical record includes an order to place the patient in observation status, as well as a later order to admit, discharge, or transfer the patient.*
- *Verify through medical record review that observation services are not ordered as a standing order following outpatient surgery or prior to admission from the emergency department.*