HOSPITAL IN PATIENT VS. OBSERVATION GUIDELINES

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Learning Objectives:
- What two main components help determine inpatient versus observation hospital status?
- Does the Two-Midnight rule apply to all insurers?

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OBSERVATION VS INPATIENT
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WHY SHOULD WE CARE?
- **Compliance** – conforming to a rule, such as a specification, policy, standard or law
- Medicare conditions of participation
  - If Medicare rules and regulations are not followed, then you are not able to bill for Medicare services
  - Medicare is 39% / Medicare Advantage 20%
  - Payor source for the Boswell population
  - Bread and butter for Geriatric physicians
- Serious **financial** implications for patients, providers and hospital
- Many commercial insurers follow Medicare guideline trends

TWO STANDARDS
- For determination of observation vs inpatient status
  - **MEDICAL NECESSITY/SEVERITY OF ILLNESS**
    - How sick is the patient?
    - What is the risk to the patient?
    - Must think in terms of ACUTEly
  - **INTENSITY OF SERVICE**
    - Medications (po, IV, IV drips)
    - Nurse assessment/monitoring requirements
    - Procedures/Treatments required (urgent/emergent)
    - Think what is the sense of urgency...
INPATIENT VS. OBSERVATION

- Inpatient care is required only if the patient’s medical condition, safety, or health would be significantly and directly threatened if care was provided at a lower setting such as outpatient.
- Inpatient admissions are not necessarily justified on the basis of length of time in the hospital or based on hospital setting (ex: med/surg, tele, vs ICU).

INPT VS OBS (continued)

- Furthermore, factors that would cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or to travel to a doctors office, or may cause the beneficiary to worry, DO NOT JUSTIFY A CONTINUED HOSPITAL STAY.
  - Biopsy for incidentiloma, etc.
  - Family not available to take care of the patient till later

WHAT’S THE DIFFERENCE

- Observation “status” considers the patient to still be an OUTPATIENT.
  - Insurers will often require the patient to pay a 20% copay versus the entire hospitalization being covered.
  - Billing by hospitals is often “by the hour” instead of by “DRG” or hospital day.
  - As a Medicare A/B patient (not the advantage plans), if needing a skilled nursing facility stay to be covered
    - Observation does NOT count in the 3 night minimum hospitalization stay needed for SNF approval (must be under an INPATIENT status).
THE DIFFERENCE (continued)

- Inpatient “status”
  - 3 night stay as an INPATIENT will qualify for skilled nursing facility if needed
  - Hospital bills by DRG or hospital day

IN HOSPITAL PHYSICIAN JOB REQUIREMENTS

- Insurers, patients, and hospital leaders today are “strongly encouraging” physicians to:
  - see a large number of patients
  - work them up in a timely and efficient manner
  - make sure they are discharged without being readmitted within 30 days for any reason

*** Of note: If a patient was discharged as an inpatient and comes back to a hospital within 30 days as Observation “status” only, it does not count as a Re-Admission.

WHAT DOES A PHYSICIAN DO?

- In the hospital setting, the physicians will work with case managers, social workers, and physician advisors
- This team of people help you the physician navigate through the complex almost daily changes in CMS rules and regulations in regards to compliance in patient care and documentation
- Educate you the physician on what needs to be done to be compliant with commercial and government insurers
CASE MANAGEMENT

• Nurse case managers and social workers in hospitals are assigned to one or more units
  • Nurse case managers, will use their clinical skills as well as Milliman or Interqual Criteria (standard recognized guidelines) to help determine if a patient will meet inpatient or observation status and can advise the physician
  • Nurse case managers and social workers work with nursing, patients, ancillary staff, and physicians to ensure that the patient has
    › efficient throughput
    › appropriate status placement
    › discharge planning

PHYSICIAN ADVISORS

• Perform Medical Necessity Reviews
• Reviewing the documentation in a patient’s chart (usually concurrently)
  › Including history and physician, vitals, labs, imaging, EKG’s, consultant's notes, nursing notes
  › To determine if the patient is appropriately statused as inpatient or observation
  › Because technically if the patient is placed in the wrong status, this is considered 'fraud'
• This work helps in the prevention of denials as well as fighting denials that insurers will file
  › If denied, could result in no hospital payment at all
  › Doctor's billing is not affected (for now but 2015 to 2016 will change)

REMEMBER

• The clinical judgement of the physician is not being questioned
• The documentation is being scrutinized to make sure it clearly paints the clinical picture of the patient
  • Also helps with improving patient billing
    › Why not get paid for all your hard work?
  • Improves documentation for medico-legal purposes
    › "If it wasn't documented, then it never happened"
PEER TO PEER DISCUSSION

- Payer (Insurance) company medical director may request peer to peer discussion
- Discuss the case with case manager, physician advisor if needed before calling back
- Always call back
- If you disagree, just acknowledge the disagreement of opinion politely
- Document the conversation in the medical record with your position and why you took that position
- Inform the case manager or physician advisor about the outcome of your discussion

The Next Section Applies to Medicare Patients only

CMS Issues 2014 IPPS Final Rule Revising Criteria Related To Patient Status Effective October 1, 2013
WHAT’S NEW?
• CMS has now stated that an inpatient admission is only appropriate and payable under Medicare A when:
  • The patient is formally admitted to the hospital after an order for inpatient admission by a physician or other qualified practitioner eligible to admit is written
  • The admitting physician expects, at the time of issuing the order, that the patient will require a stay lasting two midnights ("the two-midnight benchmark")

WHAT’S NEW? (continued)
• In addition:
  • The physician certifies through appropriate documentation, prior to the patient’s discharge, that the services are required to be provided on an inpatient basis
  • To justify medical necessity, the physician order and appropriate documentation must be present in the medical record

INPATIENT ONLY PROCEDURES
• Are excluded from the two-midnight benchmark
• Therefore, they qualify as inpatient regardless of the patient’s length of stay
What if the physician cannot reliably predict that the patient’s stay will encompass two midnights?

- When it is difficult to make a reasonable prediction regarding the two-midnight benchmark, the physician should not admit the patient but should place the patient in observation as an outpatient. The physician should continue to treat the patient as an outpatient and then admit as an inpatient if and when additional information suggests a longer stay or when the passing of a second midnight is anticipated.
- The physician may consider the time a patient spent after arriving at the hospital receiving outpatient services (observation services, ED treatment time, etc.) in determining if the two-midnight benchmark will be met.

Tips/Tools

- Ruling Out...Remember OBS
- Medicare INPATIENT ONLY procedure list is exempt from the 2 Midnight Rule (or benchmark)
- Medicare 3 night stay rule for skilled nursing facilities
  - Monitored closely by Medicare
  - Only counts if the patient is placed under INPATIENT STATUS

ADMISSION QUICK TIPS

- GI symptoms: MUST be NPO for few hours at least except Liver and Renal issues in addition to other criteria.
- GI bleeding: H&H at least every 8hours, Hgb <8 or platelets <60000 or INR> 2.0 or orthostatic.
- Failed out patient treatment
- Pulmonary / Cardiac patients:
  - Pulse Ox less then 96%
  - Using accessory muscles of resp.
- Arrhythmias requiring IV drip/ cardioversion / AICD firing twice in 24 hours
- SBP <90 or HR >100 (persistent and unresolved)
- Positive troph with documented Myocardial ischemia
- Worsening Renal failure (> 2X increase in creat. or decreased GFR by 50% )
- Elevated WBC >10000, HR >100, Temp >100.4F (SIRS criteria)
- Infection in immunocompromised patient requiring IV antibiotics.
- Asthma: PCO2 >46 or PO2 <60, PEF 26-39%, failure to respond in 24 hr OBS
QUICK TIPS (continued)

- Sodium < 124 or > 150
- K < 2.5 or > 6.0 (and symptomatic or with acute EKG changes)
- TIA with persistent Neuro symptoms, abnormal CT head/carotid imaging/ echo/ persistent HTN > 180/110 (not initial in ED)
  - also depends on what medical treatment given
- Neuro-checks more frequent then every 4 hours
- Vasoactive drips
- New onset seizures- start anticonvulsants and 2 seizures in 24 hours and perform EEG and Q4 hr Neuro-checks and seizure precautions OR seizures due to alcohol withdrawal OR pregnant.
- Renal colic and Obstructive uropathy with fever / increased creat / unable to tolerate PO meds.

CAVEATS

- Each insurance company has a utilization department that reviews patient cases either concurrently while in the hospital or retroactively to make sure they are billed correctly by the hospital under the correct obs or inpatient status
- Each insurance company uses their set of guidelines (ex: Milliman or Interqual) for the initial review
- The better you are at documenting and explaining the clinical picture of the patient and how truly “acutely ill or sick” the patient is, the better the chance to meet inpatient criteria
- Clinical medicine trumps “guidelines”, however if it is not documented... “it never happened.”

CASE EXAMPLE #1

- HPI
  - The patient is a pleasant 77-year-old white female with poorly controlled high blood pressure over the last 3 years. She says she will have spells which typically happen in the morning where she will feel a burning sensation starting in her toes going up to her head. She says she gets this feeling when her blood pressure is high. Last evening, she felt that feeling, checked her blood pressure and she had a systolic of 240. She also had some left-sided chest pain with some palpitations associated with this. No shortness breath or diaphoresis. She has some nausea. No radiation of the pain. At this time, she is asymptomatic. Blood pressures in the emergency room come down to 138/72. She is on p.r.n. clonidine at home; she has to take it usually at least 4 times a week.
• **PMH**
  1. Hypertension. Per records, she had a renal MRA, which is normal in 06/2013.
  2. Hyperlipidemia.
  3. History of chest pain. She had a negative nuclear stress test and echocardiogram in 08/2013.
• **SH**
  She uses tobacco, but she says she does not inhale. No alcohol, no illicit drug use, no ambulatory aids. She drives.

• **Meds**
  • Metoprolol 25 mg twice a day.
  • Losartan 50 mg twice a day.
  • P.r.n. clonidine for systolic pressure above 170

• **Physical Examination**
  • Vital signs: Afebrile, heart rate 62, respirations in the teens, O2 sat 96% on room air, blood pressure most recently 138/72.
  • General: The patient is alert, pleasant, in no apparent distress. She is oriented x4.
  • HEENT: Head is normocephalic. No apparent trauma. Pupils equal, round, reactive to light. Conjunctiva are pink. Extraocular movements intact. Oral cavity is pink, moist. No obvious patholgy.
  • Neck: Supple, without JVD, carotid bruits, thyromegaly or adenopathy. No supraclavicular adenopathy.
  • Lungs: Clear to auscultation bilaterally. Normal effort.
  • Heart: Regular rhythm. Okay Sr. Sa.
  • Abdomen: Soft, positive bowel sounds, nontender, nondistended, no hepatosplenomegaly or masses appreciated.
  • Extremities: Without cyanosis, clubbing. There is trace lower extremity edema. Good peripheral pulses.
  • Neurologic: Cranial nerves II through XII are intact. She has good and equal upper and lower extremity strength.
• EKG- NSR, hr 72, no acute ischemic changes
• Labs are unremarkable. Troponin is < 0.02.
• Single view CXR- no acute cardiopulmonary disease

• IMPRESSION
  • 1. Hypertensive urgency with history of difficult-to-control blood pressure.
  • 2. Chest pain, likely as a result of uncontrolled hypertension with benign workups as above.
  • 3. Hyperlipidemia per records, unclear current treatment.
  • 4. History of breast cancer.
  • 5. History of cervical cancer.

• PLAN
  • Cardiac enzymes.
  • P.r.n. blood pressure medications.
  • Continuation of her home blood pressure medications.
  • Check orthostatics.
  • Nephrology consultation to see if she needs a secondary workup for her hypertension and if they want to adjust her medications
  • Cardiology consultation
Meds
- Aspirin 81 mg, PO, DAILY
- carvedilol (Coreg) 12.5 mg, PO, BID
- Enoxaparin 40 mg, 0.4 mL, SubQ, Q24H 03/07/14 15:52
- Spironolactone 25 mg, PO, DAILY
- hydrALAZINE 50 mg, PO, Q6H, PRN
- morphine 2 mg, 1 mL, IV Push, Q5MIN, PRN: Chest pain
- nitroglycerin (Nitrostat) 0.4 mg, SL, Q5MIN, PRN: Chest pain
- ondansetron (Zofran ODT dissolve) 4 mg, PO, Q6H, PRN: Nausea and Vomiting

Question
- INPATIENT OR OBS?
- Is there MEDICAL NECESSITY?
- Is there INTENSITY OF SERVICE?

CASE EXAMPLE #2
- HPI
  - The patient is a 74-year-old female who was brought into the emergency room after sustaining a syncopal episode. She apparently got up to walk and suddenly fell and lost consciousness. She apparently felt lightheaded before falling. Her husband had a hard time getting her up and they called EMS. She did not have any injury to her head. She apparently regained consciousness fairly quickly. No history of any chest pain or shortness of breath. She uses oxygen at home 3 L per nasal cannula. There is no history of fever or chills. She denies any palpitations. No history of any abdominal pain, no history of any vomiting or diarrhea. She apparently has been eating okay.
CASE EXAMPLES (Continued)

- **PMH**
  - Significant for metastatic lung cancer diagnosed in 2012 with brain metastases, status post resection and stereotactic radiotherapy. She has been getting chemotherapy every 3 weeks. She was apparently found to have some small lesions in her brain after resection. Her other medical problems include HTN, COPD, GERD, hypothyroidism, and dementia.
- **PSH**
  - Significant for hysterectomy, tonsillectomy, craniotomy and excision of metastatic lesion. She has a chemotherapy port.
- **SH**
  - Tobacco-quit in 1997, 35 pack‐yr smoking hx; occas. ETOH

**PHYSICAL EXAMINATION:**

**GENERAL:** She is a pleasant female resting in bed. She has some memory impairment and her daughter and husband help with history.

**VITAL SIGNS:** Blood pressure is 135/68, pulse is 92 per minute, oxygen saturation is 95% on 2 L nasal cannula.

**HEENT:** She has pallor, no icterus.

**NECK:** No JVD.

**HEART:** She has normal S1, S2, no gallop.

**LUNGS:** She has diminished breath sounds on the right side. No crackles or wheezing on the left side.

**ABDOMEN:** Soft, nontender. There is no hepatomegaly.

**EXTREMITIES:** There is no pedal edema.

**SKIN:** Revealed skin tears on her left forearm and also on the left ankle and foot area.

**NEUROLOGIC:** She is alert and pleasantly confused. There are no focal deficits. She is generally weak.

**EKG:** sinus tachycardia, hr 102, RBBB, no acute ST-T changes

**Single view CXR:** No pneumothorax. Cardiac silhouette is obscured. No definite failure. Stable left chest port with tip probably in the left. The cephalic vein. There is complete opacification of right hemithorax which appears worse than the prior study. Question of cut off in the right mainstem bronchus.

**Labs:**
- WBC 13.8  
- Hb 9.9/Hct 31
- Na 132  
- K 3.4  
- Cl 9.4  
- Mg 1.3
- CPK 29  
- Trop < 0.02
IMPRESSION
1. Syncope, likely from orthostatic hypotension.
2. Electrolyte imbalance.
3. Dehydration.
4. Metastatic lung cancer with history of right lung collapse and metastasis to brain, undergoing chemotherapy.
5. Chronic obstructive pulmonary disease and smoking.
7. Dementia secondary to metastatic disease and stereotactic radiotherapy to the brain.
8. Hyperlipidemia.
10. Anemia, likely secondary to chemotherapy and underlying malignancy.

PLAN
We will hydrate her with normal saline. We will replace her electrolytes. We will continue dexamethasone at the same dose. We will recheck her orthostatic vital signs after hydration. We will have physical therapy, occupational therapy evaluate her

albuterol 2.5 mg, 3 mL, SVN, BID
metoprolol (metoprolol tartrate IR) 25 mg, PO, BID
Sodium Chloride 0.9% 1,000 mL 80 mL/hr, IV
morphine 2 mg, 1 mL, IV Push, Q4H, PRN: Pain
ondansetron (Zofran) 4 mg, 2 mL, IV Push, Q6H, PRN: Nausea and Vomiting

INPATIENT OR OBS?
Is there MEDICAL NECESSITY?
Is there INTENSITY OF SERVICE?
What if?
- What if we added:
  - Carotid dopplers
  - Echocardiogram
  - MRI of the brain
  - Neurology consultation
  - Cardiology consultation

FYI
- Acute cholelithiasis
- OBS
- TIA
- OBS
- Chest pain
- OBS

Questions?
- What are the two main standards to meet inpatient status?
- Does the 2 midnight rule apply for all insurers?