Observation vs. Inpatient: How to Get it Right

November 5, 2013
Learning Objectives

- Understand how the Inpatient Prospective Payment System (IPPS) Final Rule impacts your facility
- Integrate leading practice processes related to observation into your organization
- Identify leading practice utilization management elements
- Compare your internal organizational statistics to industry averages and benchmarks related to inpatients and observation patients
- Find out how a Chicago hospital is dealing with inpatient and observation processes
- Develop action items based upon this presentation that can be incorporated into your organization and revenue cycles which can allow you to get the patient’s status correct
“Let’s see, let’s see...we’ll put you in...Observation.”
Advocate Good Samaritan Hospital
Involvement with Patient Status Determination

- Point of Patient Entry
- Order Placement and Accuracy
- Clinical Care
- RAC Program
- Physician Documentation
- Utilization Management
- Charge Capture
Utilization Management

<table>
<thead>
<tr>
<th>Does your organization have…?</th>
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<td>An appropriate staffing model?</td>
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<td>Adequate prioritization of encounters?</td>
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<td>Specific UM expertise for necessary clinical areas?</td>
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<td>Coverage during peak hours of admission and holidays?</td>
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<td>Differentiation of duties related to case management vs. utilization management?</td>
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<td>Complete physician documentation is within the record in order to allow for the status to be accurate?</td>
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<td>An alert to UM when patients have a discharge order written but have not been reviewed by UM?</td>
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<td>Use of standard criteria (i.e. MCG, Inerqual)?</td>
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<td>Utilization Management present in the Emergency Department?</td>
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Physician Role in Status Determinations

- Physicians need to understand criteria being applied by UM
- Collaboration is Key
- Emergency physicians must choose bed type with objective purpose
- The use of second level reviewers is formalized
- Tools should be used to assist with status placement
- Each patient encounter should be independently reviewed and evaluated
IPPS Final Rule – Two Midnight Rule

**Physician Documentation is the Driving Factor**

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<tr>
<th>Potential Issue</th>
<th>2014 IPPS Final Rule Impact</th>
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<td>1. Physician documentation may be insufficient preventing patients from becoming inpatient status</td>
<td>Physician documentation must include why they expect the patient to require care spanning more than 2 midnights, the reasons for hospitalization for inpatient treatment, the diagnosis, estimated time expected in the hospital and plans for post discharge care.</td>
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<td>2. Physician orders for status may not be real time or may not be entered into the patient's record</td>
<td>The physician order must be furnished at or before the time of the inpatient admission. In addition, orders must be very clear for the status that the physician has selected for the patient.</td>
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<td>3. Documentation in the record supported inpatient status however observation status was submitted</td>
<td>Review cases as close to time of admission as possible. Inpatient admissions expected to span 2 midnights but did not – may require additional review</td>
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<td>4. Timing between initial order assignment and Clinical Care Management review is at times over 24 hours</td>
<td>If a facility makes a patient IP from Observation later in their stay, there is an increased risk of auditing and may impact the 3 day stay requirement for SNFs.</td>
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<td>5. Physicians may make order revisions late in the patient's stay</td>
<td>Inpatient admission begins at time of order for inpatient services. If observation patients are made inpatient late in the stay, this may not be paid or at least may be reviewed for medical necessity.</td>
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<td>6. Education for physicians is currently not structured or provided on a consistent basis</td>
<td>Clarity of the physician order, certification and supporting documentation are required to support the patient's status. Documentation is evaluated in conjunction with the order and certification.</td>
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<td>7. The system does not notify Utilization Management when a patient is about to be discharged and an order has not been reviewed</td>
<td>OP to IP corrections must take place during hospitalization. An order for inpatient cannot be revised once a patient is discharged.</td>
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<td>8. Utilization Management does not have coverage at all times and is not reviewing every patient encounter</td>
<td>“Use of Condition Code 44 or Part B inpatient billing pursuant to hospital self-audit is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols.”</td>
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Observation Patient Throughput

**Leading Practice Processes**

1. Emergency Department and Attending physician collaboration
2. Designated observation unit
3. Specially trained clinical staff for observation patients and staff who is aware of a patient’s status
4. Adequate documentation to support medical necessity
5. Nursing staff who will monitor patient condition and make appropriate calls to physicians when a status change is necessary
6. Transfer of inpatients to other units
Charge Capture

✓ Nursing staff appropriately document to support medical necessity for each hour of observation
✓ Start and stop times for all infusions and injections are documented appropriately
✓ If a physician performs a bed-side procedure without the nursing staff assisting, there is communication of the performance of that procedure to the nursing staff in order to document its performance in the record
✓ Appropriate charge capture processes in place to charge for each medically necessary hour of observation and all procedures
✓ Carve out of time when patients are off the unit or receiving another modality of care requiring monitoring
Dealing with the Payers

- Appropriate use of condition code 44
- Billing for hours over 48 as non-covered
- Commercial contract language that appropriately reimburses for observation care
- Charges for hourly observation care total at least the charge for the room and board rate for one day of inpatient stay
- If commercial payers reimburse for a lesser status, this is rejected when unwarranted
RAC Denials for Inpatient Medical Necessity

- RAC activity should be monitored and procedures in place to appeal encounters when deemed appropriate.
- Informal appeals period is utilized.
- Hospitals should not place patients in observation for fear of RAC or denials.
- Resubmission for Part B payment.
- Timely filing restrictions.
Observation as a % of Inpatient Admissions

The Unique Alternative to the Big Four®

Average 29.75%
Short Stay Volume (< 48 Hours) as a % of Total Inpatient Volume

Average 8.7%
Observation as a % of Total IP and Observation Discharges

Average 23.7%
Survey Questions and Results

- How aware are your clinicians of a patient’s status?
- Where are your observation patients being cared for?
- How aware are your physicians (those who choose a patient’s status) with the criteria for selecting inpatient or observation?
- What statusing criteria are is your UM department utilizing?
- What tools are being used by your physicians to assist with status placement?
- Where are your utilization management nursing staff stationed during peak admission hours?
- How are RAC denials related to one-day-stays handled?
- How do you think the new IPPS rule regarding two midnights will affect your organization and are you preparing for any significant changes in process?
- Who is performing second level reviews for those encounters that do not meet inpatient criteria based upon Interqual/Milliman guidelines?
- What physician types are placing patient orders for status?
- What is your average turn around time between initial status placement and confirmation of the patient’s order?
- What is your average length of stay for observation patient encounters?
- What is the percentage of observation patients compared to inpatient discharges?
1. How aware are your clinicians of a patient’s status?

- Extremely aware/superior documentation (2)
- Somewhat aware/Documentation is sometimes accurate (9)
- Only aware if told/Documenting the same on each patient (2)
- Entirely unaware/Documenting the same on each patient (zero responses)

2. Where are your observation patients being cared for?

- Designated Observation Unit (zero responses)
- Wherever there is an available bed (9)
- Sometimes in a designated area, others where there is an available bed (4)
- Other (zero responses)
3. How aware are your physicians (those who choose a patient’s status) with the criteria for selecting inpatient or observation?

4. What statusing criteria are is your UM department utilizing?
5. What tools are being used by your physicians to assist with status placement?

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<td>1.</td>
<td>eRecord tool, reference cards, care management team as resource</td>
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<td>2.</td>
<td>Case Managers are a reference for the physicians</td>
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<td>3.</td>
<td>Varies across system from none to support tools built into our CPOE system for hospital with CPOE.</td>
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<td>4.</td>
<td>Case management and EHR</td>
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<td>5.</td>
<td>Case management</td>
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<tr>
<td>6.</td>
<td>Case management</td>
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<td>7.</td>
<td>Electronic Criteria tool</td>
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<td>8.</td>
<td>None</td>
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<td>9.</td>
<td>Case Management pre-admission and admission review and recommendation, E.H.R. Physician peer-to-peer, Physicians have access to InterQual (desktop icon) on PCs in E.D., inpatient units, and in physician offices (if requested).</td>
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<td>10.</td>
<td>No response given</td>
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<td>11.</td>
<td>Coaching by UM nurses</td>
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<td>12.</td>
<td>CDI reference tool</td>
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<td>13.</td>
<td>Outside education</td>
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6. Where are your utilization management nursing staff stationed during peak admission hours?

- Working off-site (2)
- On inpatient units (12)
- Within the Emergency Department (7)
- There is no coverage during peak admission times (2)
7. How are RAC denials related to one-day-stays handled?

- All are appealed (2)
- A review is conducted and a determination made on whether to appeal (3)
- We submit for Part B payment (1)
- Review is conducted and resubmit when appropriate (7)
- We have no RAC denials related to one day stays (zero responses)

8. How do you think the new IPPS rule regarding two midnights will affect your organization and are you preparing for any significant changes in process?

1. Significantly. We have made changes to our processes to assist physicians with documentation of requirements.
2. About a negative $25 million in revenue
3. Significant increase in OBV cases Education and Modification of the electronic record admit orders.
4. Expect it to increase our use of observation status. We are working on physician and staff education related to this process.
5. Currently evaluating - heavily managed so process isn't expected to change radically.
6. Evaluating
7. Unsure
8. We anticipate there will be a significant organizational impact. We are working to make changes in the EHR relating to physician documentation prompts regarding certification of the need for inpatient status. UR process changes are being planned. Further clarification from CMH is expected to provided more direction regarding the continued role of medical necessity in the UR process.
9. Education, Incorporating additional investigation (of outpatient services) into the daily Utilization Management review process, thorough review of outpatient diagnostic and E.D. services prior to Observation or Admission, entering accurate start times in E.D. and/or outpatient diagnostic areas, identifying ED and diagnostic evaluation start times, verifying physician documentation meets all components to certify the admission is medically necessary.
10. No response
11. Will increase observation. We are asking physicians to document more
12. Increase in OBS status Physician Adviser providing guidance for physician staff Inpatient Certification form in use
13. No response
9. Who is performing second level reviews for those encounters that do not meet inpatient criteria based upon Interqual/Milliman guidelines?

10. What physician types are placing patient orders for status?
11. What is your average turn-around time between initial status placement and confirmation of the patient’s order?

- 0 – 6 hours (3)
- 6 – 12 hours (1)
- 12 – 24 hours (9)
- 24 hours or more (zero responses)

12. What is your average length of stay for observation patient encounters?

- 12 hours or less (zero responses)
- 13 – 24 hours (3)
- 24 – 32 hours (6)
- 32 hours or more (4)
13. What is the percentage of observation patients compared to inpatient discharges?
Thank you!

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