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Case Management Monthly

*Best Practices
and Practical Solutions*

Investigate gray areas to improve patient status assignment

Not every patient status decision is difficult. Some are quite obvious.

"I don't think a hospital has ever received a request for a medical necessity review of a patient in the ICU intubated on a dopamine drip," said **Ralph Wuebker, MD, MBA**, vice president of audit, compliance, and education for Executive Health Resources, during the April 5 HCPro, Inc., audio conference, "Short Stays: A Data-Driven Approach to Medical Necessity."

But Recovery Audit Contractors and Medicare Administrative Contractors (MAC) are not concerned with simple patient status decisions. They focus on the cases that fall into the gray area of patient status.

Facilities that do not have a strong Medicare admission review process will struggle to get these cases correct and defend them should they come under scrutiny, Wuebker said.

Calculate observation rate

Facilities can look at admission statistics to get an idea of how well they are sorting out the gray-area cases. One key analytic is the Medicare medical observation rate. Divide your facility's observation cases by the total number of observation and inpatient cases to get your observation rate. For example, 30 observation cases out of 1,000 combined cases would mean a 3% observation rate. The national average observation rate is between 8% and 12%, according to Wuebker.

Facilities that feel they have a strong inpatient admission screening process but still have a high observation

rate may need to look closely at their data, Wuebker said. Calculating observation rate according to payer may reveal that commercial payers are driving up the overall observation rate. That's because many commercial payers are modifying their contracts to state that any hospital stay shorter than 24–48 hours is automatically an observation case.

Outpatient surgeries can also drive up the observation rate, so you may want to separate the medical observation cases from the surgical cases.

After completing those calculations, if your facility's Medicare medical observation rate is still outside the national average, it may be a sign that you need to revamp your inpatient review process.

Evaluate patient screening process

According to Wuebker, the following are common processes that cause incorrect patient status assignment:

- ▶ Decisions based solely on physician order
- ▶ Decision based solely on screening criteria
- ▶ Decisions based on screening criteria with RN case manager judgment
- ▶ Decisions based on screening criteria with attending or on-site physician advisor opinion

Admission decisions based solely on a physician order can frequently lead to an overuse of inpatient and observation services depending on the medical staff's regulation knowledge and bias, Wuebker said.

Most facilities have a solid Medicare review process that involves some type of review of the physicians' orders, according to Wuebker. In many hospitals, screening criteria are applied to each case by a utilization review (UR) nurse or case manager to see whether the physician made the correct decision.

Process problems tend to come up following this point. If a case does not meet first-level screening criteria, a facility must refer the case to a second-level physician review, Wuebker said.

Questions? Comments? Ideas?

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Some hospitals will simply return to the attending physician and ask him or her to either switch the patient to inpatient or provide additional documentation that supports the inpatient admission.

Doing so can be a problem, however, depending on the physician's personality.

Some physicians are curmudgeons who refuse to listen, while others claim not to have the time to respond to case manager questions.

"I would argue the most popular but most dangerous physician is the 'pleaser,'" Wuebker said. These physicians do whatever the case manager asks, but may have a hard time defending an admission decision should an auditor review the case. "Because the nurse said so" does not have very good regulatory underpinning, he noted.

Relying on case manager judgment is not permissible and is a dangerous practice, Wuebker said. The regulations are very clear that the decision to admit a patient is solely the physician's responsibility.

Chapter 1, Section 10 of the *Medicare Benefit Policy Manual* states:

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, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Of course, basing admission decisions solely on screening criteria is also a violation of Medicare regulations.

Special Edition MLN Matters article SE1037 states that "CMS considers the use of screening criteria as only one tool that should be utilized by contractors to assist them in making an inpatient hospital claim determination."

Instill best practices

Consider the following admission screening best practices:

- **Use appropriate screening criteria.** Ensure that your screening criteria are nationally accepted,

evidence based, and approved by your fiscal intermediary, MAC, and Quality Improvement Organization.

- **Apply screening criteria to 100% of Medicare cases.** Refer cases that require a second-level physician review to a physician advisor.
- **Ensure that UR staff members stick to the screening criteria.** UR staff who go outside the screening criteria to assign patient status are in violation of the *Conditions of Participation*.
- **Regularly educate the UR staff on proper screening criteria application.** Facilities with high UR staff turnover must make sure they properly train new staff members.
- **Have more than one physician on staff who is capable of performing a second-level review.** Train physician advisors in Medicare rules, screening criteria, and evidence-based practice so that there is a consistent standard for all cases. Individual physician judgment should not play a role, Wuebker said. ■