

# MEDICARE COMPLIANCE

## In Hospital Observation Struggle, Uncertain Outcomes May Justify Inpatient Admissions

The tension over observation status vs. inpatient admissions is causing all sorts of compliance and revenue consequences for hospitals. Some hospitals may be putting patients in observation even when they qualify for inpatient admission to avoid accusations of unnecessary one-day stays, which deprives them of revenue and distorts their length-of-stay statistics. At the same time, hospitals are walking the line carefully to avoid inappropriate one-day stays, which drive the inpatient error rate. And there is a fundamental misunderstanding of the reason certain patients don't qualify for observation: uncertainty about their diagnosis and treatment outcome. As a result, physicians and case managers may butt heads over some admission decisions, with case managers backed by formal admission criteria, and physician judgment sometimes superseding paper guidelines — especially since Medicare doesn't mandate the use of InterQual's or other admission criteria, one expert says.

To get this problem under control, hospitals need a Medicare admission review process that involves case managers, attending physicians and physician advisers, experts say.

"It's about a consistent process and applying consistent criteria to every Medicare patient that comes into the hospital," says physician Robert Corrato, M.D., president of Executive Health Resources in Newtown Square, Pa.

One-day stays are a prime target of CMS's Hospital Payment Monitoring Program, the main vehicle to drive down payment errors on the hospital inpatient side. CMS sees a failure to use observation services appropriately as a major reason that patients wind up in the hospital for medically unnecessary one-day stays. While it may not always be that simple, hospitals are struggling to improve compliance and avoid claims denials, guided by rankings for top risk errors in "PEPPER" reports from quality improvement organizations (QIOs), which administer the Hospital Payment Monitoring Program. (PEPPER stands for Program to Evaluate Payment Patterns Electronic Report.)

The main compliance approach involves improving the way hospitals decide whether to admit patients to observation or inpatient status. "There is a process that is evolving where there is appropriate admission decision making to avoid [medically unnecessary] one-day stays that are so critical to payback issues," says Ken Blickenstaff, former head of the Indiana Medicaid fraud

control unit. "Everyone should be involved in the decision-making process — the emergency department physician, the patient's physician and case management. And it should start in the emergency room." Doing this in real-time is vital because the only way hospitals can preserve reimbursement for a medically unnecessary inpatient admission is to convert patients to observation/outpatient status and drop the bill before discharge, using condition code 44.

Developing a predictable process is designed partly to compensate for the fact that treating physicians don't understand or care about artificial reimbursement designations like observation vs. inpatient, Corrato says. They see it as one and the same thing: You hospitalize the patient to observe him. But in the Medicare reimbursement world, a fine distinction is drawn: If the patient's course of treatment and outcome are considered highly predictable by the treating physician at the time of presentation, if the patient is not unstable or at significant risk, and if that treatment can be safely delivered in an outpatient setting, then the patient may be appropriate for observation status, subject to significantly less reimbursement. By contrast, when diagnosis and outcome are unpredictable and danger is inherent, an inpatient bed may be justified, Corrato says. Whichever way the ball bounces, "the regulations are such that a physician order is required and it must be congruent with the claims status for payment to be obtained from Medicare," he says.

Getting the decision right is essential because, on average, Medicare pays about \$4,500 to \$5,000 more for a DRG than for an APC with its bundled observation fee, Corrato says. Billing one legitimate inpatient stay as an observation every day adds up to about \$1.7 million in lost revenue annually, he says. That doesn't even begin to account for the overpayment recoupment and false claims risks hospitals take if they are engaging in the opposite risky behavior: billing inpatient stays that should have been observation admissions. He adds that weekend evaluations of inpatient vs. observation account for 29% of admissions, so the process should not be abandoned after hours.

### Minefields on Path to Admit Decision

There are opportunities for mistakes along the way. Here's how the decision-making process typically plays out, Corrato says:

Sometimes the planets are in alignment, and the physician order matches the admission criteria, the patient heads for observation or an inpatient bed, and the hospital drops the bill for an APC or DRG.

Often these situations are more problematic, Corrato says. Patients come to the hospital, and the treating physician writes an order for inpatient admission. The case manager does an admission review applying InterQual (or whatever other criteria), and finds the circumstances don't justify inpatient admission. The case manager calls the doctor, explains that the order didn't survive the InterQual process, and asks the physician to change the patient to observation status. The physician agrees, and life goes on.

Sometimes, however, treating physicians insist the patient needs an inpatient admission. Maybe it's because they don't realize the patient will receive the same diagnostic tests and treatments in an observation bed, and that if the patient's diagnosis is cut and dried and the treatment is expected to take a predictable course and lead to prompt discharge, then observation is, in fact, deemed appropriate by Medicare, as indicated by InterQual. To avoid physicians' confusion and incorrect assignment of Medicare claim status, it helps to have a physician adviser from inside or outside the hospital explain the circumstances and ask them to change the order, Corrato says.

But if there are variables that make the patient's diagnosis and outcome uncertain, and if the treating physician feels the patient may be in danger, InterQual or other admission criteria take a back seat to the treating physician's judgment, Corrato says. He notes that 20% to 25% of these scenarios aren't captured by InterQual.

"The physician adviser looks at the case and determines that either 'this patient doesn't meet the level of care for an inpatient in the hospital, and they are appropriate for observation,' or the physician adviser says 'even though the case doesn't meet criteria, this falls under the 20 to 25%. I am making a utilization review decision that says this patient meets inpatient criteria,'" Corrato says.

Suppose a patient presents at the emergency department with chest pain. The treating physician knows this patient and his history — heart attacks, some stents in arteries — so an inpatient order seems wise because it's unclear what may develop. When the physician adviser reads the documentation, it will be apparent that there was a change in the patient's level and duration of pain from the chronic baseline to a more acute situation. "When there is change from a chronic baseline, there is uncertainty, and that's what's important for the change in the level of care," says Corrato.

In fact, Medicare regulations don't mandate the use of InterQual or other admission criteria before inpatient hospitalization is justified and a DRG is paid. That's a common misconception, along with the myth that time determines the medical necessity of observation (e.g., this patient needs only about 12 hours of monitoring, so the patient must qualify only for an observation bed).

### Level of MD Uncertainty Called Important

"What is important for the change in the level of care is the level of uncertainty in the physician's mind, and InterQual doesn't capture this 100%," Corrato says. "InterQual is a tool that is used for non-clinicians to make determinations of medical necessity." So when a conflict arises, the physician adviser (1) after reading documentation and consulting with the case manager, decides there is support for the inpatient admission; (2) explains to the attending physician why the order must be changed from inpatient to observation; or (3) counsels the attending physician on improving documentation to support the case for inpatient admission, Corrato says.

He says that hospitals that lack an effective Medicare admission review process may experience more than a few down sides. Executive Health Resources has audited thousands of hospital one-day stay and observation status charts, and found that anywhere from 40% to 50% of patients put in observation actually qualified for inpatient admission. That translates into a big revenue loss for the hospitals, he adds.

Typical scenarios in which observation patients may warrant admission as inpatients: (1) A patient who has failed intense outpatient therapy (e.g., for asthma, nausea/vomiting); (2) a patient who comes in for an emergent procedure that is done normally as an outpatient (e.g. cardiac cath); (3) unstable angina (the word is not used by the physician, but the history clearly supports this diagnosis); and (4) patients with multiple comorbid conditions whose baseline makes some outpatient workups too dangerous.

A side effect, Corrato says, of using observation when one-day stays are appropriate is the hospitals "artificially elevated their length of stay." The reason: fear of being ranked in the 99th percentile of one-day stays in the PEP-PPER reports for their state, he says.

Blickenstaff, a principal in the consulting firm BlickenWolf LLC, says part of the problem is that admission orders are written too fast. Attending physicians write an order to admit to inpatient without having the intimate knowledge the emergency department physician and case manager have, which is why he thinks getting everyone together in the ED is so crucial.

Contact Corrato at rcorrato@ehrdocs.com and Blickenstaff at ken@blickenwolf.com. ✧