

# MEDICARE COMPLIANCE

## Lack of Second-Level Admission Review May Hinder Compliance; Frequent Audits Needed

Inpatient admission criteria such as InterQual ironically might be causing compliance problems because some hospitals are not applying it correctly, according to a physician-consultant whose firm has reviewed 20,000 one-day stay inpatient and observation status cases.

InterQual is one of several medical-necessity screening tools for hospital admissions. The tools play an important role in compliance because unnecessary short stays are a top cause of Medicare inpatient payment errors, wasting \$1 billion a year (*RMC 2/19/07, p. 1*). Hospitals routinely apply the first step of the InterQual screening process, when case managers use “severity of illness” and “intensity of service” criteria to determine whether the patient qualifies for inpatient admission.

But hospitals often neglect the second step of the admission screening process — physician review — when patients don’t meet the severity-of-illness and intensity-of-service criteria, even though the physician review could change the admit decision, says Joe Zebrowitz, M.D., executive vice president and senior medical director of Executive Health Resources in Newtown Square, Pa. Instead, they just pack patients off to observation or outpatient services, he says. Using the first level of screening without physician input can lead to 35% to 50% overuse of observation, Zebrowitz says.

*The reason:* “Severity of illness and intensity of service don’t capture all that Medicare says comprises inpatient care,” he says. Medicare’s definition of inpatient care, according to the Medicare Benefit Policy Manual for hospital services covered under Part A (Chapter 1, paragraph 10), is broader than most criteria suggest, he says. It addresses factors like physician orders, patient history, types of facilities available, current medical needs and hospital bylaws. “It never specifically speaks to intensity of service. It talks about medical predictability and whether the patient will have an adverse outcome,” according to Zebrowitz.

And in the real world, that’s exactly how physicians make admission decisions, he says. “Physicians risk-assess a patient. They don’t look at whether the patient has three intensity of services and two severity of illnesses,” he says. “When push comes to shove, the physicians’ impression of risk is what differentiates between inpatient and outpatient,” and “this assessment is a

vital component that must be applied when the first level of InterQual screening does not say clearly ‘this patient is an inpatient,’” Zebrowitz says.

Here’s an example of how this plays out with two patients with chest pain (DRG 143), according to Zebrowitz. The first chest-pain patient, John, walks into the emergency department (ED) with chest pains that last for one minute at a time. It hurts when the physician presses on his sternum, which is atypical. There’s a low risk with that, but the doctor orders cardiac enzymes, an electrocardiogram and maybe a stress test. The second chest-pain patient, Arnold, walks into the ED saying he has the same kind of pain he had during his heart attack last year. It happens at rest and lasts an hour at a time. The physician orders the same workup as John but ultimately, at the point of admission, John will go to observation and Arnold will be admitted as an inpatient because of his unstable angina, his prior history of a heart attack and his higher risk of suffering another heart attack — “even if 24 hours later the workup is negative and the services were of the exact same intensity” as John’s, says Zebrowitz. On average, a chest-pain patient generates \$3,500 in DRG reimbursement if admitted as an inpatient and \$450 if treated in observation, he says.

Case managers may view these patients differently than doctors do, he notes. “Physicians look subjectively and nurses look objectively, so you need a process that combines both.” It takes both steps of InterQual to make the best admission decision, he says.

All this squares with the experience of Island Hospital in Anacortes, Wash. (which is not a client of Executive Health Resources), says Kirk Ruddell, compliance officer. Island Hospital used to rely mostly on the first level of InterQual review to guide admission decisions, and found many of its patients were placed in observation when they warranted an inpatient admission. A better approach: strengthen the second level physician review, as InterQual suggests. Island Hospital’s employed hospitalists perform this service, Ruddell says. “The hospitalists review everything,” he says. Solving the short-stay problem isn’t even the primary reason that 44-bed Island Hospital hired hospitalists, but it’s a sweet secondary gain. “Whatever we are paying them may even be offset by the increased revenue we are getting by admit-

ting more patients properly to inpatient rather than to observation," Ruddell says.

To improve admission decision-making, Zebrowitz says hospitals should have an "ironclad" process. "You need to audit, re-audit, and question yourself constantly.

Rules change, personnel changes, demographics change, the ED may set up an observation unit, [etc.]," he says.

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