Report on
MEDICARE COMPLIANCE
Volume 24, Number 18 • May 18, 2015

Inpatient Reviews Are Expected to Shift to Whether Hospital Care Was Needed at All

When the dust settles and auditors are unleashed again on inpatient admissions, they probably will have a different bent. Rather than tunnel vision about hospitals billing Medicare for inpatient admissions that should have been billed for outpatient or observation services, auditors will likely turn their attention to the broader concept of whether patients needed to be in the hospital at all or for as long as they were, one expert said. There is overlap with classic patient-status reviews, but there will be a different way to think about audits, reinforcing the importance of the documentation required to support the medical necessity of hospital care — including the risk of adverse outcomes.

"I expect the primary focus of auditors will be whether the patient needed to be in the hospital," said Ralph Wuebker, M.D., chief medical officer of Executive Health Resources in Newtown Square, Pa., at the Health Care Compliance Association's Compliance Institute in Orlando, Fla., on April 20. The three areas he believes they will focus on are whether care was custodial, whether it was provided for the convenience of the patient and whether the discharge was delayed to ensure the hospital could generate Part A payment under the two-midnight rule.

Audits May Have New Focus

Although they are auditing MS-DRG coding and the medical necessity of inpatient procedures, some auditors' hands are partly or completely tied in terms of patient-status reviews. They are off the table for recovery audit contractors this year; Congress blocked them through Sept. 30, 2015, and CMS told *RMC* in January the incumbent RACs would not perform patient-status reviews through Dec. 31, 2015 *(RMC 1/12/15, p. 1)*. Medicare administrative contractors are limited to probe and educate reviews, which evaluate hospital compliance with the two-midnight rule for inpatient admissions and will continue through Sept. 30. Hospitals report they are starting to face the third round of probe and educate reviews.

The two-midnight rule changed the calculus of inpatient vs. outpatient decisionmaking. The way CMS framed it, patients either require hospital care, or they don't. If they require hospital care, for how long is the next question. And, of course, the hours patients spend in observation or outpatient services, including the emergency room (after medical care is initiated), count toward the two midnights because what matters is their total time spent in the hospital *(RMC 12/23/13, p. 1)*. What auditors will question is whether hospitals are delaying care to get patients across two midnights. "Medicare contractors will probably start to scrutinize the way commercial payers do," Wuebker said. "Being in the hospital can be unsafe, so reviewers will ask whether the patients need to be there." CMS has explicitly warned against admitting for convenience; classic examples are a Friday admission for a Monday diagnostic test because the hospital isn't staffed to perform it on the weekend and admitting patients the night before a procedure to perform pre-procedure testing. And social admissions/custodial care *(RMC 2/16/15, p. 1)* are not covered by Medicare, although CMS says the risk of an adverse outcome is a piece of the medical-necessity puzzle, and hospitals often have social admissions to prevent adverse outcomes.

Also, he said, "I think auditors will target when there is a contradiction in the order and length-of-stay expectation." Physicians sometimes write conflicting information, such as "I anticipate one midnight in the hospital, and hence she will be admitted under observation." There's no way to defend admissions pursuant to that kind of order, he said. "These are things that case management should watch like a hawk," Wuebker said. "They are layup denials."

'Midnights' Are Alien to Physicians

While the audit focus is shifting, the fundamentals of establishing medical necessity in physician documentation are the same, he said. The one exception is physicians expressing their expectation of patients' staying two midnights. But that doesn't mean hospitals should hammer away at it with physicians. While "two midnights" is evocative terminology to regulatory experts, such as compliance officers and attorneys, it doesn't necessarily resonate with physicians. Because patients can receive the same medications, treatments and diagnostic tests in inpatient, observation and outpatient beds, acknowledging to physicians this is purely a reimbursement concept helps defuse tension and establish rapport.

"Don't speak to physicians in terms of midnights," he advised hospitals. "They think in terms of days in the hospital." If physicians believe patients will be discharged the same day or the day after they come into the hospital, most of the time physicians should order observation or outpatient services. "That's really straightforward and will help doctors get it right most of the time." Patients having an endoscopy who are expected to go home later that afternoon are outpatients, while patients undergoing a coronary artery bypass graft typically are inpatients for three days because that's the standard of care, Wuebker said. Similarly, patients given IV fluids for gastroenteritis belong in observation, and it could be a red flag if they're admitted. The same goes for cardiac catheterizations because the patients typically are sent home the same or following day. "That's where case management is critical," he said. "Those cases should be on the top of the list and ensure documentation is supportive."

Here are the seven key pieces of documentation for medical necessity under the two-midnight rule, said Wuebker, summarizing CMS's "inpatient" definition:

(1) Physician order

(2) Past medical history (e.g., comorbidities)

(3) Severity of signs and symptoms (e.g., pertinent positives on physical exam)

(4) Current medical needs (e.g., plan of care and accompanying orders)

(5) Facilities available for adequate care

(6) Predictability of an adverse outcome (e.g., suspected diagnosis and need for hospital services)

(7) Expectation of length of stay

Physicians generally do a pretty good job documenting the patient's history, current medical needs, severity of signs/symptoms and facilities available to provide adequate care, but they may drop the ball when it comes to documenting the risk of an adverse outcome, Wuebker said. They tend to write down symptoms rather than diagnoses or tentative diagnoses, which explain the potential for adverse outcomes. "What is your concern, and why are you concerned?" he said. It's straightforward; physicians can fill in the blanks of "I suspect that…" or "I am worried about this, and here's why" or "Given the patient's history of X and current presentation of Y, adverse outcomes are likely," with details.

It's not that enlightening to put down "nausea and vomiting." They could be a sign of the stomach flu or a bowel obstruction, with door No. 1 vs. door No. 2 meaning a big difference in acuity, Wuebker said. "Acknowledge to physicians that 'we don't need you to be perfect. We are not keeping a batting average on you,'" he said. Rather, "'we need you to document your primary concern or two.'"

Driving this point home will have a tremendous impact on chest pain, the catch-all diagnosis and compliance black hole. Chest pain is a symptom, not a diagnosis, and could explain a multitude of conditions, including unstable angina, pneumonia, gastroesophageal reflux disease (GERD) and heart attack.

Suppose a 76-year-old man comes to the hospital after having 20-minute episodes of chest pain for a couple of days. He has a history —— a previous heart attack, stent placement and diabetes — and now his left arm is tingling, and he feels the same way he did during his last heart attack. The physician documents "chest pain, EKG, enzymes, maybe stress test in the morning." With that documentation, said Wuebker, "that case is at high risk of denial." The auditor would contend the doctor wasn't concerned about anything and just cited the symptoms and plans for tests. Proper documentation would connect the dots, he said, such as "due to pain similar to a prior MI [myocardial infarction] and cardiac history, I am concerned about unstable angina. Based on concern for unstable angina, we will do a stress test." Even if everything turns out fine, the physician gave a clear rationale for the hospital care, Wuebker said. "If you can wipe out symptoms from documentation, it will go a huge way toward reducing exposure," he said.

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