The Dilemma of Short Stays: Observation vs Inpatient Documentation Requirements and Common Case Types
Your Presenter
Presentation Overview

• This webinar will explain what qualifies as a short stay inpatient admission versus an observation stay.
• It will discuss the documentation required to support the medical necessity of each using common case types as examples.
• It will define the two midnight rule and how it relates to medical necessity.
• The difference between condition codes 44 and W2, and how to apply them will also be explained.
By the End of this Webinar

• Participants will be able to:
  – Accurately differentiate between a short stay inpatient admission and an observation stay.
  – Identify documentation that will support the medical necessity of a short stay inpatient admission for common case types.
  – Define the two-midnight rule and explain how it relates to medical necessity.
  – Accurately apply condition codes 44 and W2.
Empowering Meaningful Care

Short Stays - Why a Dilemma?
Short Stays…Why a Dilemma?

- Payment
- RAC
- OIG
- Fraud
- Waste
- Abuse
Why A Dilemma?

• Payment
  – Part A vs. Part B
    ◆ MS-DRG case payment
    ◆ APC or fee schedule payment
  – Deductibles
    ◆ Patient responsibility
      ◆ Medicare deductible for each 60 day benefit period is $1,216.
      ◆ Part B deductible is $147 plus a monthly premium of $104.90 and a 20% co-payment.
## Why A Dilemma?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Inpatient or outpatient</th>
<th>Part A pays</th>
<th>Part B pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient goes to the ED and then is formally admitted to the hospital with a doctor’s order.</td>
<td>Inpatient</td>
<td>Your hospital stay minus your deductible</td>
<td>Doctor services</td>
</tr>
<tr>
<td>The patient visits the ED for a broken arm, gets x-rays and a splint, and goes home.</td>
<td>Outpatient</td>
<td>Nothing</td>
<td>Doctor’s services and hospital services</td>
</tr>
<tr>
<td>Patient comes to the ED with chest pain and the hospital keeps him for 2 nights for observation services.</td>
<td>Outpatient</td>
<td>Nothing</td>
<td>Doctor services and hospital outpatient services</td>
</tr>
<tr>
<td>The doctor writes an order for inpatient admission but UR tells the patient that they are changing him to outpatient. Condition code 44 is administered.</td>
<td>Outpatient</td>
<td>Nothing</td>
<td>Doctor services and hospital outpatient services</td>
</tr>
</tbody>
</table>
## Why A Dilemma?

<table>
<thead>
<tr>
<th>Top Reasons for Observation or Short Inpatient Stays**</th>
<th>Difference in Average Medicare Payments</th>
<th>Difference in Average Beneficiary Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red blood cell disorders</td>
<td>$2,801</td>
<td>$373</td>
</tr>
<tr>
<td>Irregular heartbeat (medium severity)</td>
<td>$2,444</td>
<td>$457</td>
</tr>
<tr>
<td>Circulatory disorders</td>
<td>$2,312</td>
<td>-$167</td>
</tr>
<tr>
<td>Coronary stent insertion</td>
<td>$2,267</td>
<td>-$817</td>
</tr>
<tr>
<td>Medical back problems</td>
<td>$2,085</td>
<td>$404</td>
</tr>
<tr>
<td>Digestive disorders</td>
<td>$2,047</td>
<td>$425</td>
</tr>
<tr>
<td>Nutritional disorders</td>
<td>$1,977</td>
<td>$474</td>
</tr>
<tr>
<td>Fainting</td>
<td>$1,890</td>
<td>$417</td>
</tr>
<tr>
<td>Signs and symptoms</td>
<td>$1,854</td>
<td>$359</td>
</tr>
<tr>
<td>Respiratory signs and symptoms</td>
<td>$1,792</td>
<td>$396</td>
</tr>
<tr>
<td>Loss of blood flow to the brain</td>
<td>$1,677</td>
<td>$415</td>
</tr>
<tr>
<td>Dizziness</td>
<td>$1,320</td>
<td>$466</td>
</tr>
<tr>
<td>Irregular heartbeat</td>
<td>$943</td>
<td>$572</td>
</tr>
<tr>
<td>Chest pain</td>
<td>$870</td>
<td>$419</td>
</tr>
</tbody>
</table>

*Average payments for observation stays are estimates because each reason is estimated based on information from the Part B hospital claim.

**This list includes the top 10 reasons both for observation and short inpatient stays.

Why A Dilemma?

- Hospitals are increasingly keeping patients in observation status for several days, increasing the beneficiaries costs. Six percent (6%) of observation stays were more costly than an inpatient admission, and over 3,000 cost more than twice the Medicare deductible.
- Observation claims greater than 48 hours have increased from 3% of all cases in 2006 to over 10% in 2011.
- Observation claims are billed at one third the rate of inpatient claims.
Why A Dilemma?

- RAC
  - One-day stays for inpatient admissions are a very easy target for RAC.
    - In a 2012 report the American Hospital Association summarized the findings of 2,266 hospitals that participated in a RAC survey. Of 86% of the survey participants, two thirds of their denials were for one day stays where the healthcare was provided in the wrong setting.
Why A Dilemma?

- **RAC**
  - Common case types denied:
    - Syncope
    - Chest Pain
    - Dehydration
    - Gastroenteritis
    - Cardiac Arrhythmias
    - Back pain
    - Percutaneous cardiovascular procedures
    - TIA
# Why A Dilemma?

<table>
<thead>
<tr>
<th>Top Reasons for Stays*</th>
<th>Rank</th>
<th>Observation Stays</th>
<th>Short Inpatient Stays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Digestive disorders</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Fainting</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Signs and symptoms</td>
<td>4</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Nutritional disorders</td>
<td>5</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Dizziness</td>
<td>6</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Irregular heartbeat</td>
<td>7</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Circulatory disorders</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Respiratory signs and symptoms</td>
<td>9</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Medical back problems</td>
<td>10</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Loss of blood flow to the brain</td>
<td>11</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Red blood cell disorders</td>
<td>13</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Coronary stent insertion</td>
<td>15</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Irregular heartbeat (medium severity)</td>
<td>21</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

*This list includes the top 10 reasons for observation stays and the top 10 reasons for short inpatient stays. Source: OIG analysis of CMS data, 2013.
Why A Dilemma?

• OIG
  – Audit in 2012 comparing Short Stays vs. Observation Stays
  – On average Medicare paid nearly 3 times more for a short inpatient stay than for a similar observation stay.
  • In 2012, Medicare beneficiaries had 1.2 million one day inpatient stays
Why A Dilemma?

- OIG
  - The OIG summarized findings from its audit of a non-profit health system in Delaware which included a 241 bed hospital in Wilmington, Delaware and a 913 bed hospital located in Newark, Delaware
    - Out of 281 inpatient and outpatient claims, 120, or 42% were billed incorrectly to the tune of $641,000.
Why A Dilemma?

• What went wrong?
  – Auditors found that Part A services were billed for inpatient hospital stays that should have been billed as an outpatient or observation stay.
  – The OIG states these stays were billed incorrectly due to inadequate controls and human error. There were obvious weaknesses in the admission screening process.
Why A Dilemma?

• Fraud, Waste, and Abuse
  – If you ignore an inpatient admission which doesn’t meet medically necessary criteria, and you know it will be denied if caught by auditors you’re committing fraud.
    ❖ You need to do the right thing by either delivering a condition code 44, or bill using a condition code W-2.
  – Inappropriate inpatient admissions lead to waste and abuse.
    ❖ (Three day inpatient stay for nursing home admission.)
Why A Dilemma?

• 3 Day Stays for SNF:

  Over 25,000 of the nearly 618,000 hospital stays, beneficiaries received ineligible SNF services following discharge from the hospital.

  *Of those, Medicare inappropriately paid for the SNF services to the tune of $255 million. Of 2,000 hospital stays Medicare didn’t pay for the SNF services the beneficiary was fully liable for the SNF charges to the tune of $10,000 each!
Medical Necessity Defined

- Stay abreast of CMS policy guidelines:
  - Know your Program Integrity Manual and utilize its guidance.
    - In addition to screening instruments, the CMS contractor should apply their own clinical judgment to make a determination of medical necessity.
    - For each case the review contractors will also utilize the following when making a decision on medical necessity:
      - Admission criteria
      - Invasive procedure criteria
      - CMS coverage guidelines
      - Published CMS criteria
      - Other screens, criteria and guidelines
Medical Necessity Defined

• Screening Criteria:
  – InterQual
  – MCG—formerly Millimin Care Guidelines
  – Other proprietary screening criteria
Medical Necessity Defined

• According to the Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A, Section 10, factors to be considered when making the decision to admit include such things as the following:
  
  – Patient's medical history and current medical needs
  
  – Severity of the signs and symptoms exhibited by the patient
    ❖ Acute, chronic, episodic, persistent .....  
  
  – Medical predictability of something adverse happening to the patient
    ❖ Respiratory status, fluid overload, dehydration....
  
  – Types of facilities and their capabilities that are available to inpatients and to outpatients
  
  – Hospital by-laws and admissions policies

The convenience (or inconvenience) to the patient or patient’s family in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, are not factored in when determining medical necessity. (Medicare Program Integrity Manual Chapter 6 - Intermediary MR Guidelines for Specific Services 6.5.2.A)
Inpatient Defined

• The Medicare Benefit Policy Manual contains information regarding what constitutes an appropriate inpatient admission.

• A patient is considered inpatient if formally admitted to a hospital bed for occupancy for purposes of receiving inpatient hospital services.
Short Stay Defined

• Any inpatient stay less than the average LOS for a certain diagnosis code.
  – Any inpatient stay less than two midnights.
  – Any inpatient stay greater than two midnights that doesn’t meet medical necessity.
  – A three day hospital stay for the sole purpose of qualifying for nursing home admission under Part A.
  – A one or two day inpatient stay for sepsis.
Observation Defined

- Observation stays are defined in CMS manuals as a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment that are being provided while a decision is being made as to whether or not admit the patient as an inpatient.
Empowering Meaningful Care

The Two-Midnight Rule
The Two-Midnight Rule

• If a patient has spent one day in observation and the physician feels the patient needs another night in the hospital, the patient can be appropriately admitted in spite of the fact it will be a one day hospital inpatient stay.

• Clear physician documentation must be present to support the short stay.

• Remember that the time spent in observation will not count towards a nursing home stay.
The Two-Midnight Rule

• Because of the increasing use of observation status, and the desire to reduce its financial burden to Medicare beneficiaries, CMS has instituted the “two-midnight” rule.
• 2014 Final Rule gave a definition of an appropriate inpatient admission—when a patient stays in the hospital at least two midnights.
The Two-Midnight Rule

• When does the two midnight rule start?
  – When hospital care begins, including:
    ❖ Observation care
    ❖ ED, OR, and other treatment services
    ❖ The start of care after resignation and initial triaging activities
    ❖ Excessive care time is excluded
• Although total time in the hospital is taken into consideration in the rule, the inpatient stay doesn’t start until the physician writes the inpatient order.
Empowering Meaningful Care

Case Studies
Case Study

- A 70 year old patient is admitted to the hospital from the ED on 12/01/2013 at 9:00 am with complaints of abdominal pain and feeling “feverish”.
  - Two hours later the patient complains of chest pain.
  - On 12/02/2013 at 10:00 am patient continues to feel “lousy” and has hypokalemia of 3.3. Physician decides to keep patient at least another day.
  - On 12/03/2013, at 8:00 am the patient is feeling much better and is discharged.
- The result?
A patient with a history of lung cancer with metastases to bone and brain is admitted for nausea and vomiting on 12/22/2013 at 2:00 pm.

The following morning, at 8:00 am the family and patient decide to go home with hospice and the physician discharges the patient later the same morning.

The result?
Case Study

• Patient admitted on 1/03/2014 at 8:00 pm with abdominal pain and elevated WBC. Later that evening he had an appendectomy.
  – 1/04/2014 patient continues to have nausea and vomiting and is given a dose of IV Zofran.
  – On 1/05/2014 the patient is feeling better and is discharged home.

• The result?
Case Study

- 80 year old male is brought to the ED via ambulance on 11/30/2013 at 8:00 pm after fall at home.
  - At 8:30 pm a clavicle fracture is confirmed. Patient lives alone and has no one to care for him. He is kept overnight.
  - On 12/01/2013 patient is doing well on oral pain medication but hospital still unable to locate any family member or friend to care for him.
  - On 12/02/2013 at 11:00 am the patient is discharged home with a family member.

- The result?
Case Study

- A 73 year old female patient presented on 11/28/2013 at 7:00 am for a scheduled outpatient elective angioplasty of the renal artery and was admitted and billed as an inpatient after the procedure. The patient had a history of HTN, CAD, COPD, diabetes, and non-ruptured cerebral aneurysm. The patient remained stable throughout her stay and was discharged the following day at 3:00 pm.

- The Result?
Empowering Meaningful Care

What Can We Do?
What Can We Do?

- Audit
- Educate Your emergency department
- Enlist your utilization committee and your clinical documentation team.
- Institute condition code 44 while the patient is still an inpatient.
- Institute condition code W 2 after patient discharged.
- Utilize observation status and the 2-midnight rule.
What Can We Do?

• Audit
  – Do your own based on your PEPPER report.
  – Start pre-bill documentation audits if you haven’t already done so.
  – Hire an outside firm to audit your short stays.
What Can We Do?

• Review your PEPPER Report?
• What is my PEPPER Report?

(Program for Evaluating Payment Patterns)

– My PEPPER report contains Medicare data on my hospital’s 13 specific target areas that often have payment errors for under or over coding, including:

  – Top ten one day stays for inpatient admissions.
  – Three day hospital admissions for nursing home stays
    • How many of these were medically necessary?
    – If the inpatient hospital stay is denied, the nursing home stay will also be denied.
What Can We Do?

• What’s In My Pepper Report:
  – Hospital stays less than 3 days for sepsis
  – Hospital stays less than 3 days for complex pneumonia
  – One day inpatient stays for chest pain
  – One day inpatient stays for syncope
  – Inpatient stays for percutaneous cardiovascular services
  – Inpatient short stay for back pain
What Can We Do?

• Educate your emergency department
  – Explain to the ED the use of observation services and the medical necessity criteria needed for an inpatient stay.
  – Instruct the ED physicians to document the full picture of the patient’s severity of illness and why it would not be safe to discharge the patient home.
  – Review short stay problematic ED admissions for a trend and share findings.
  – Hire a case manager for your ED, preferably for 24 hours a day.
What Can We Do?

• *Document, document, document!*  
• Your clinical documentation team can take an active role in reviewing for medically necessity on inpatient claims.  
• Capture as much specificity as possible with medical diagnoses and surgical procedures to support an inpatient short stay.
What Can We Do?

• Enlist your utilization committee and clinical documentation team
  – Use your utilization committee to overturn medically unnecessary inpatient admissions while the patient is still in-house by utilizing “condition code 44”
  – Have your clinical documentation team assist in capturing the highest severity of illness for your inpatient admissions; this will support your inpatient stay.
What Can We Do?

• Utilize condition code 44-
  – If a UR committee finds inpatient level of care doesn’t meet a hospital’s admission criteria they may change the status if all of the following condition’s are met:
    ◆ The change is made prior to the patient being discharged from the hospital.
    ◆ The hospital has not submitted a claim to Medicare
    ◆ The practitioner’s responsible for the patient’s care agrees with the UR committee’s decision; and
    ◆ The concurrence with the UR committee’s concurrence is documented in the medical record.

*The UR committee must give written notification no later than two days after the decision is made to the hospital, the patient, and the responsible physician.*
What Can We Do?

Condition Code 44 Flowchart

Four conditions that must be met in order to use Condition Code 44:

1. Is patient still in hospital?
   - Yes
   - No

2. Has the claim for the inpatient admission been billed?
   - Yes
   - No

3. Does the physician concur with the UR Committee decision?
   - Yes
   - No

4. Has the physician (responsible for the care of the patient) documented concurrence in the patient's medical record?
   - Yes
   - No

Bill as outpatient (Part B) using Condition Code 44. (Entire episode is treated as an outpatient encounter. Medical record must be retained in its original form. Patient will be responsible for outpatient coinsurance.)
What Can We Do?

• Institute condition code W2 after discharge:
  – When an inpatient claim is denied by Medicare and the hospital loses an appeal, or decides not to appeal, it may re-bill for Part B services which are medically necessary. The hospital can also bill for the services provided as an outpatient during the 3 day window.
  – Hospitals submitting Part B inpatient claims in these situations need to include condition code “W2” on the claim.
What Can We Do?

• Rebilling utilizing Condition Code W2:
  – A very complex process.
  – Inpatient Part B claim for services billable on an outpatient claim type.
  – Outpatient Part B claim for services rendered during the three day/one day payment window.
  – Part B rebilling claim must be submitted.
  – Part B rebilled claims without the W2 condition code will be rejected.
What Can We Do?

• Implement the two-midnight rule
  – Instruct physicians on how the rule works.
  – Engage your UR/CM and CDI teams to own the process of all patient stays starting from the ED and ending with discharge.
References

- http://www.wpsmedicare.com
- http://www.acep.org/content.aspx?id=36598
- http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf
Wrap Up and Questions

Thank you for attending our webinar!

Please complete the survey, your feedback helps us to design training to meet your needs.

You will receive an email within 10 days providing a link to the CE Certificate, the webinar recording and the presentation slides.