CAH 1-2 day stay review

Can you afford to ignore this?

Background on 1-2 day IP CAH

- Brought about by CERT findings
- Poor trending by WA CAH's
- Of concern Aug 2010, Jan 2011, Feb 2012
- Targeted reviews shows high use (see "handout 1")
- See https://www.noridianmedicare.com/p-meda/coverage/service_specific_review.html#cah

Results – what happens to me?

- Pre-payment review can ensue (see “handout 2”)
- One time ADR notification

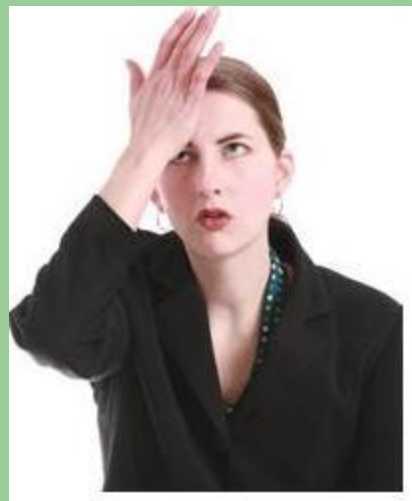
How do I respond to ADR?

- 30 days to respond to ADR
- With only 30 days, you need to respond correctly (see “handout 3”)

How do I appeal if denied?

- If denied, 120 days to appeal
- Severity of illness
- Intensity of service
- Patients status is appropriate for IS, SI and treatment plan
- Documentation is complete
- Appeals (see “handout 4”)

Observation vs Inpatient



Here we go – again

Handouts to review

- See “handout 5”
- See “handout 6”
- See “handout 7”
- See “handout 8”
- See “handout 9”

Ramifications of losing an IP stay and billing options

- Cannot recover the IP charges
- May be able to recover only the part B charges

Billing options for status changed while inhouse vs after discharge

- Meet status change requirements
- Use Cond code 44
- TOB 013X and 085X
- Move IP chgs to non-cov
- Part B chgs in covered
- No OBS chgs prior to status change
- Notify patient of OP status
- See “handout 10” and “handout 11”

- Bill “no pay” bill for IP
- TOB 0110
- All chgs for non covd, including days in non-cov
- Occ span code 77
- Bill part B separately
- TOB 012X
- Part B chgs ONLY, no IP chgs on claim
- See “handout 12”

Other ramifications of denied IP stays

- Red flagging Medicare
- Your error rate could prompt pre-bill audits
- Short time span to appeal
- You may not be popular with your local SNF
- See “handout 13”

Aggressive IP vs OP monitoring can discover issues

- Patients who did not meet IP criteria initially, then do meet criteria in same visit
- Patients who initially met IP criteria but no longer do
- Patients who have an entire admission not medically necessary

Case Studies

In depth analysis

Case Study #1- 2 day stay

85 year old female presents to ER via ambulance

- **Signs and Symptoms**
  - Short of breath (SOB)
  - O2 sats 87%
  - Resp Rate 24
  - Denies Fever and Chills
  - Temp 98.3 (afebrile)
  - Went to clinic a few days prior, given antibiotics and steroids
  - SS worsened over time increased cough, congestion
- **Assessment**
  - Admit for COPD Exacerbation
- **Plan**
  - Duoneb Q4
  - Xopenex PRN
  - Chest XRay (CXR)
  - Telemetry
  - IV Lasix, Rocephin and Lisinopril
  - BNP and cardiac enzyme

Case Study #1 Results

- **Day 1**
  - CXR showed mild CHF and bilateral pleural effusions
  - Elevated BNP, remainder labs within normal range
  - RR 24
  - O2 sats 94%
  - Afebrile
  - Note in Physicians dictation – “Patient doesn’t appear in acute distress”
- **Day 2**
  - Discharge

Case Study #1 Review and Comments

- **Case was DENIED** - ”Admission Criteria not Met (Documentation doesn’t support medical necessity for IP versus outpatient as acuity are not of such nature that they could only safely be provided in an Inpatient setting.)”
- **Lack of documentation** – mention but no real treatment of – CHF, renal insufficiency,
- **Meets Interqual Inpatient Respiratory/Chest criteria** - but due to the actual treatment, time length and lack of on going documentation, did not meet.

Case Study #2- 2 day stay

69 year old female presents to ER

- **Signs and Symptoms**
  - Nausea and Vomiting
  - Abdominal Pain
  - Possible Dehydration
  - Cannot keep down her medications
- **Assessment**
  - Nausea
  - Abdominal Pain
  - Dehydration
  - Possible Obstruction
- **Plan**
  - IV hydration
  - Will allow her current nausea meds – Etiology is unknown
  - Will get KUB and upright on her – the exam is fairly benign as far as obvious mass
  - If symptoms do not settle down, will get ABD/Pelvic CT scan.
  - It appears that some of this may be narcotic w/d due to vomiting

Case Study #2 Results

- **Day 1**
  - IV fluids, pain and nausea meds still running
  - Patient is much better today. ABD pain is settling down, vitals are stable. Pleasant woman in no acute distress.
  - ABD pain, etiology remains unclear.
- **Day 2**
  - Patient able to tolerate liquids
  - D/C to home

Case Study #2 Review and Comments

- **Case was DENIED** - ”Admission Criteria not Met (Documentation doesn’t support medical necessity for IP versus outpatient as acuity are not of such nature that they could only safely be provided in an Inpatient setting.)”
- **Lack of documentation** – Documentation supports Observation status. Etiology unclear – running tests to figure out.
- **Meets Interqual Inpatient GI criteria** - but due to the unclear etiology, and rule out procedures and verbiage, does not meet.

Case Study #3- 1 day stay

75 year old female I&D following total right hip

- **Signs and Symptoms**
  - Opening with high drainage output
  - Gram stain positive for staph
- **Assessment**
  - Possible deep joint infection
- **Plan**
  - IV Vancomycin pending deep cultures from surgery

Case Study #3 Results

- **Day 1** – OBS
- **Day 2 –** OBS
  - No acute distress
  - Labs within normal range for WBC, still awaiting cultures for deep joint infection
  - Plan to mobilize per PT protocol, as tolerated D/C in 2 days home
- **Day 3** – Switched to IP
  - No hip pain
  - Minimal drainage
  - Deep cultures have not returned – if return negative, D/C on Minocycline , otherwise will need to be on IV antibiotic therapy for 6 weeks
- **D/C –** Lab results negative to staff. Pt d/c on antibiotics for 6 -12 weeks

Case Study #3 Review and Comments

- **Case was DENIED -** ”Admission Criteria not Met (Documentation doesn’t support medical necessity for IP versus outpatient as acuity are not of such nature that they could only safely be provided in an Inpatient setting.)”
- **No reason for switching to Inpatient (other than over 48 hours)** – Issue was the deep culture results were too slow. Condition of patient did not change or become more acute, developing new signs or symptoms. If only reason to change status is due to number of hours approaching, a write off is in the future. NOT a good practice.

Case Study #4- 2 day stay

77year old male emergently presents to clinic

- **Signs and Symptoms**
  - Abd pain, cramps lower lt quadrant
  - Nausea
  - Denies fever, but has chills
  - Going on for past 7-10 days
  - Remarkable pulse of 99 sitting, 120 standing
  - Stent placement last week
  - Labs- KUB and upright showed multiple air-fluid levels through out colon and small bowel.

Case Study #4- 2 day stay (cont'd)

- **Assessment**
  1. ABD pain – by HX 1) diverticulitis, 2) colitis.
  2. HX of prostatitis.
  3. Coronary artery disease
  4. Dehydration
- **Plan**
  1. Keep NPO, start IV fluids and antibiotics and ABD/PELVIC CT scan, order stool studies, further workup pending results
  2. Check urine and get a PSA
  3. Serial cardiac enzymes and markers, just had a stent placed, keep on plavix and aspirin
  4. Not been eating or drinking well. Pulse is tachycardic when stands, goes up by over 20 points. IV fluids and see how he does.

Case Study #4 Results

- **Day 1** – Patient much better today.
  - Urine neg, WBC 8.7,Imaging shows stranding next to sig colon, multiple diverticula, suspicious for diverticulitis. CT also showed ileus.
  - **PLAN:**
  - Diverticulitis – he clinically has diverticulitis. He is better today, will continue on IV antibiotic, then if going well and able to eat and drink, will send home tomorrow on oral antibiotics
  - Coronary artery disease – enzyme marker are normal
- **D/C –**
  - Patient able to tolerate food and drink, much better. Will D/C to home on oral antibiotics

Case Study #4 Review and Comments

- **Case was ACCEPTED –**
- **Documentation –**
  - Clear plan on what was the suspected problem and how we were treating it and why when it was available. **What, How, Why. WHW**
  - Clearly stated the results every day
  - Clearly stated the continued problems or how the issues resolved
  - Clearly stated the current plan and back to WHW

Case Study #5- 2 day stay

89 year old female Presents to ED

- **Signs and Symptoms**
  - Severe dizziness
  - Tarry stool
  - Earlier in week at clinic with low hemoglobin of 7.8 started on Aciphex
  - Takes Aggrenox for HX of TIA
  - SOB

- **Because of dizziness, her severe anemia, her guaiac positive stool and her GI bleed, she is admitted for further workup and treatment**

Case Study #5- 2 day stay (cont'd)

- **Assessment**
  1. GI Bleed.Guessing upper bleed.
  2. Iron Deficiency. Fairly severe deficiency
  3. Near syncope. Suspect due to volume depletion from GI Bleed.
  4. Hypertension.

- **Plan**
  1. Will start her on Protonix IV and transfuse her. Will also try to clear up her iron deficiency. Hemoglobin came back 6.3
  2. After transfusion, will plan on IV iron as well she has not been able to absorb oral in the past
  3. Will watch and see how she does. Continue her usual blood pressure meds and watch closely
  4. Give her a little bit of Lasix after her 2nd unit if she is starting to sound wet at all.

Case Study #5 Results

- **Day 1** – Patient much better after transfusion
  - Still weak and having black tarry stools.
  - **PLAN:**
  - Continue IV Protonix. Give her IV iron today and if hematocrit stays stable will D/C home tomorrow.
- **D/C –**
  - Patient hematocrit stabilized and actually went up from the day before discharge to the day of discharge going from 32 to 33. It appeared that her bleeding had stopped. D/C to home and F/U as an outpatient

Case Study #5 Review and Comments

- **Case was ACCEPTED –**
- **Documentation –**
  - Clear plan on what was the suspected problem and how we were treating it and why when it was available. **What, How, Why. WHW**
  - Clearly stated the results every day
  - Clearly stated the continued problems or how the issues resolved
  - Clearly stated the current plan and back to WHW

Common Findings

- Diagnosis that appear to have a higher denial rate:
  - Pneumonia
  - COPD Exacerbation
  - Gastroenteritis
  - Abdominal Pain
  - Severe Anemia
  - Dehydration

Why are they being denied?

- Not enough Documentation of the medical thought process
  - Stating “meets Interqual Criteria” is not enough
  - Need the What, How, Why
  - Need Daily Notes from physician, hourly from nursing staff – especially for Observation patients

- Improper statements in the chart –
  - Patient wanted to stay for one more day/did not want to go home
  - Patient does not appear acutely ill
  - Patient does not have ride home

Why are they being denied? (cont'd)

- Initially not properly admitted in the correct patient status .
  - With little or no concurrent review
  - And/or no process to change the status BEFORE discharge. (Condition Code 44) see P&P "handout 14"
- Weak Treatment plan to "make" status requirements in Interqual
  - IV Solumedrol Q8 Does not constitute enough to pass for IP criteria. Even though it is stated in the Interqual Book- Remember Interqual is a "guideline"

  See "handout 15"

Practical Applications

Steps to decrease risk of denials

- Establish a 24/7 Utilization Review Program
- Engage Physicians and RN’s
- Develop a Seamless communication system

Develop a UR Program

- Make a organizational wide commitment to establish a seamless Utilization Review Function
- Develop a 24/7 UR functional process
- Develop an Internal UR Team
- Establish a UR Committee Reporting Function

The UR Team/Committee

- Why a UR Team?
- Who should be on it?
- How does it function?
- What are the goals?

Developing a UR Process

- Identify who will be responsible for 24/7 admission review. Assign responsible parties
- Develop a hand off process. – When, who, how
- Develop a seamless communication process/system.
- Establish an immediate follow up process
- See workflow examples (see “handout 16”)

Seamless Communication System

- Follow the patient through the system with the appropriate reviews. Ask?
  - Initially -Was the patient admitted in the proper status? Who? When? Document.
  - Daily/Concurrent – Is the patient still in the appropriate status? Who? When? Document
  - Is there a problem/question? WWD
  - How do we report/educate/follow up?

The UR Reporting Function

- Why have a UR Report?
- What is the purpose/goals?
- Who should be responsible?
- Example Report?
- See “handouts 17 & 18”

Engaging the Physicians & RN's

- Provide Education on: DATA,DATA,DATA
  - Denials Received
  - Problems Identified
  - Individual Physician Practice Patterns Compared
  - Patient Status Education
  - See "handout 19 & 20"
  - Documentation Examples

Things to Note

- There are reasons for over 48 hour OBS, and 1 and 2 day stays
- Reviewing initial status with Team within an hour is optimal.
- Communication, Follow up and Assigning clear responsibility is Essential - WWD
- Excellent, Clear Documentation is a must – What, How, Why
- Education, Reporting and Follow Up

Questions and follow up

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