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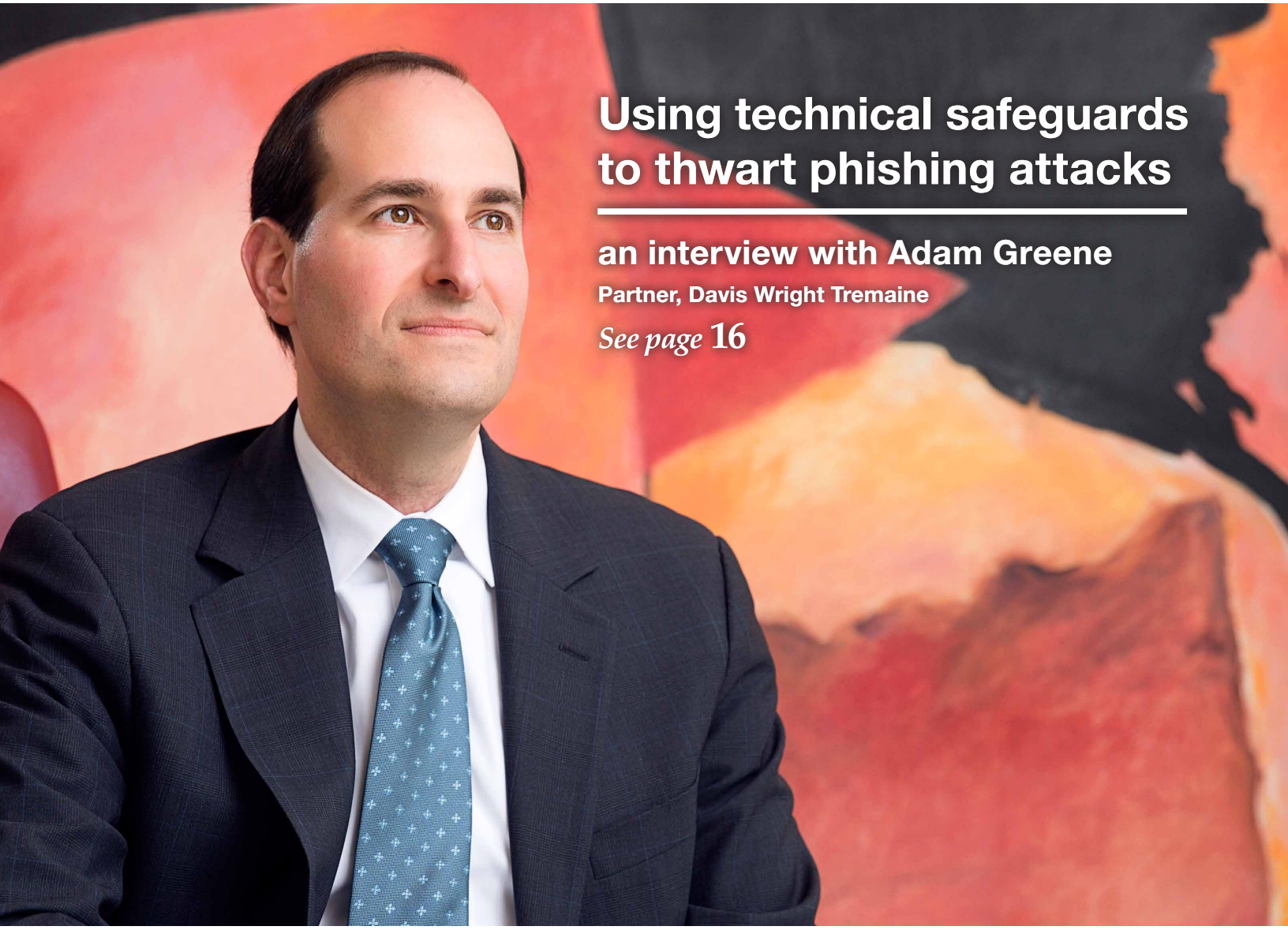

Using technical safeguards to thwart phishing attacks

an interview with Adam Greene

Partner, Davis Wright Tremaine

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by Ronald L. Hirsch, MD, FACP, CHCQM

What is the "right" observation rate?

» There is no standard for measuring observation rates; avoid comparing your rate to other hospitals.
» Medicare's observation payment in 2016 increased 85% from 2015.
» Medical observation is fundamentally different from surgical observation.
» If your follow Hirsch's Law, your observation rate is at the benchmark for your institution.
» Measure hours in observation and work to improve that.

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Hardly a week goes by when I am asked either what a hospital's observation rate should be, or what a hospital can do to lower their observation rate because it is felt to be "too high." So what is the right rate, and is your rate too high?


Hirsch

First, you have to be sure you are comparing apples to apples. How is the observation rate determined in each institution? Observation is often a catch-all for all patients who are staying in the hospital but are not admitted as inpatients. In reality, observation is a specific service ordered for outpatients who require a period of monitoring in the hospital beyond the Emergency Department (ED) evaluation or after routine recovery from an outpatient surgery. Observation is not to be used for the routine recovery patient who spends the night in the hospital, for the patient who cannot get a ride home, or for the patient who is dropped off by the family because they cannot take care of their loved one any longer.

The observation rate also depends on how it is calculated. Are patients who receive observation services, but are subsequently admitted as inpatients counted in the rate? Is the rate the number of observation patients compared to all patients who spend a night in the hospital (inpatient and outpatient) or compared to all inpatients? Does the rate look solely at fee-for-service Medicare, where the observation rules are clear, or does it include Medicare Advantage and commercial patients, where the differentiation between observation and inpatient is often determined by contractual terms or at the whim of a reviewer who may be incentivized to deny as many inpatient admissions as possible?

Observation is also not always a bad thing. The current ambulatory payment classification (APC) for observation services provided to patients where the billing requirements are met increased by 85% from 2015 and now pays $2,275 (APC 8011).[1] If observation services are provided efficiently with a minimum of incidental services, the reimbursement can exceed the actual costs of providing that care. Reimbursement for many of the lower weighed diagnosis-related groups (DRGs) barely exceeds that amount, so it is possible to make money on observation and lose money on inpatient admissions.

Two-Midnight Rule

The Two-Midnight Rule draws a bright line at two midnights. "…The decision to admit

becomes easier as the time approaches the second midnight, and beneficiaries in necessary hospitalizations should not pass a second midnight prior to the admission order being written."[2] Patients in medically necessary hospitalizations should not pass two midnights without being admitted to inpatient status. Many hospitals have not embraced this and keep patients in observation past the second midnight, despite the presence of medical necessity for hospital care. These hospitals are losing the opportunity to convert an outpatient APC payment into a DRG payment.

Likewise, patients who are expected to require treatment for less than two midnights should not be admitted as inpatient, except for situations outlined in the "rare and unusual exception" policy provided by the Centers for Medicare & Medicaid Services (CMS) in their guidance.[3] Some hospitals have adopted the philosophy that the payment for observation services is inadequate, and they therefore feel justified in admitting them as inpatient patients who are not expected to pass two midnights but are at "high risk of an adverse outcome,"[4] such as patients with chest pain with a high Thrombolysis in Myocardial Infarction (TIMI) score.[5] Furthermore, these hospitals are emboldened by the recent changes the Recovery Audit program with the record request limit lowered to 0.5% of all Medicare claims, lowering the risk of actually having any of these one-day inpatient admissions ever audited.[6] This is anathema to the concepts of compliance and should be avoided unless and until CMS gives guidance that such admissions are appropriate.

Observation best practices: Hirsch's Law

Because of the many variables in defining and measuring observation rates, it is better to set a best practice policy and aim to meet or exceed that policy in order to achieve your hospital's benchmark observation rate. The best practice for observation services is the modestly named "Hirsch's Law," which states that if every patient requiring the use of a hospital bed is reviewed by case management for proper admission status, with the use of a secondary physician review as appropriate, and every patient is placed in the right status, and observation services are only ordered for the patients where observation services are appropriate per regulations, and every patient goes home as soon as their need for hospital care has finished, and every patient who requires a second midnight stay is admitted as an inpatient, then your observation rate is at your benchmark.

How does one meet the requirements of Hirsch's Law? Adequate resources dedicated to Utilization Review (UR) are critical. The UR staff needs to be available to assist physicians in making these decisions when patients are presenting to the hospital for further care. Many hospitals provide full staffing on weekdays, but have only limited staff available on evenings and weekends. Unless the ED closes on Friday at 5 p.m. and reopens on Monday at 7 a.m., there needs to be UR staff available off hours. It should also be conveyed to physicians that these are purely payment issues, so they do not get defensive and resist asking for help; they are not being told what antibiotic to choose or what specialist to consult.

Because it is felt that "processes that cannot be measured cannot be managed," rather than comparing observation rates between hospitals and subjecting yourself to incorrect assumptions, there are several measures that can be used. First, as noted, keep your data clean by looking only at Medicare fee-for-service patients. Including other payers will taint your data, depending on your payer mix and the rules used by the other payers, or lack thereof. Hospitals should also look at the length of stay for medical patients receiving observation services and work to optimize that. If you want to look at observation services

after outpatient surgery, keep that data separate from medical observation; the two cannot be compared because of the fundamental difference in their care.

Compare apples to apples

If you are going to compare your observation length of stay to other hospitals, be sure that they are not including observation provided routinely to patients after an outpatient procedure (often incorrectly used to enable the bed control system to assign the patient a bed for overnight use) or observation care provided as a courtesy. Likewise, your medically necessary observation hour counting and billing should end when medically necessary hospital care has ended. Observation care that is provided after that point should be reported on a separate line on the claim and used solely to determine how much "free" care you give away, which can then be improved with focused efforts.

Ensure that tests needed to determine an observation patient's stability for discharge, such as cardiac stress tests and magnetic resonance imaging (MRI), are prioritized over routine tests; that the physicians responsible for interpreting those tests, such as radiologists and cardiologists, are available when the tests are completed; and that the results are expeditiously relayed to the treating physician for a disposition decision. It would be relatively easy to break this down by diagnosis, service, day of the week, and physician to target quality improvement efforts.

Next, look at the number of patients receiving observation services who are hospitalized more than two midnights to determine if any of these had medical necessity for hospital care beyond the second midnight and, therefore, should have been admitted as inpatients. And finally, take a close look at all inpatients who spend only one midnight to ensure that they truly met one of the specified exceptions and that the documentation supports that exception.

Conclusion

This deep dive into your data will provide you with accurate, measurable, and actionable information to ensure you are placing patients in the right status, optimally providing their care, receiving the reimbursement you deserve, and avoiding a surprise visit by an auditor or the Inspector General.

1. Federal Register, Volume 80, page 70333-70336. November 13, 2015. Available at http://bit.ly/1V6XypI
2. Federal Register, Volume 78, page 50946. August 19, 2013. Available at http://bit.ly/1SfDJsL
3. CMS: Fact Sheet: Two-Midnight Rule. October 30, 2015. Available at http://go.cms.gov/1W4eADW
4. Idem.
5. Buck Christensen: Thrombolysis in Myocardial Infarction (TIMI) Score. June 19, 2014. Available at http://bit.ly/1Sk1NxY
6. CMS: Medicare Fee-For-Service Recovery Audit Program. January 1, 2016. Available at http://go.cms.gov/1W4eIDA