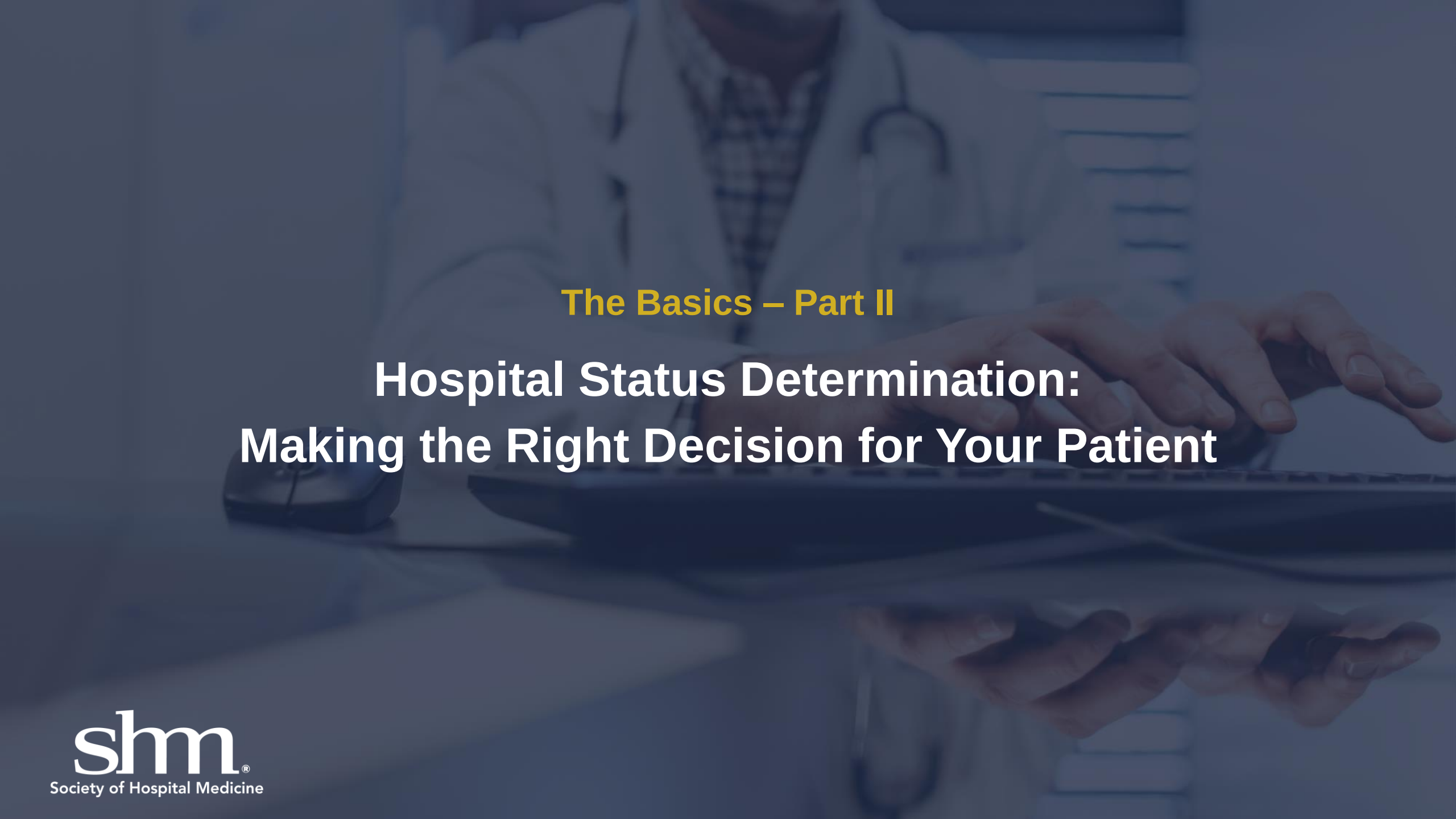

The Basics – Part II

Hospital Status Determination: Making the Right Decision for Your Patient

Society of Hospital Medicine

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Series Schedule

Target Audience

This series is for any pediatric hospitalist who manages patients in the hospital setting.

The Basics

- Part I – Foundations of Hospital Finance and Clinical Documentation
- **Part II – Hospital Status Determination: Making the Right Decision for Your Patient**

Case Studies

- Part I – Common Pediatric Diagnoses
- Part II – Complex Pediatric Diagnoses

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Learning Objectives

By the end of this session, participants will be able to:

- **Explain** the most common status assignments for hospitalized patients.
- **Demonstrate** how status assignments are made.
- **Describe** the impact of status assignments to the hospital, patient, physician, insurance company and researchers.
- **Review** tips to successfully complete a peer-to-peer discussion related to status assignment.

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History of Status

CMS created in 1965 by Lyndon B. Johnson.

- Former President Truman and his wife were the first people to receive their Medicare Cards.

Observation Status is created in the 1980s.

- Increasing rates of observation patients.

Recovery Audit Contractor (RAC) created in 2003.

- RAC Auditing began in 2005.

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Hospital Status Determination

Inpatient	Observation	Same Day Surgery / Extended Recovery	Outpatient in a Bed
• ICU or Acute Care • Highest level of medical/nursing care • Examples: sepsis, acute respiratory failure • Paid as DRG, Per Diem, Percent of Charges, etc.	• Unclear if patient will require inpatient care but warrants continued care beyond the ED/Ambulatory Care • Examples: Rule out sepsis in >28 day old, bronchiolitis without hypoxia, AGE with normal electrolytes • Paid by time/resource use	• Care following a planned ambulatory procedure with no complications • Post-anesthesia care unit or hospital bed placement following routine tonsillectomy • Bundled payment with procedure	• Planned care that usually is provided in an ambulatory setting but now provided in a hospital room • e.g., Planned PRBC infusion on a holiday Monday when clinics are closed • Paid as ambulatory care

Considered Outpatient Status

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Elective vs. Emergent Procedures

Elective

- **Initial status is determined by the authorization process.**
  - Based on the procedure and the patient's medical history.
  - Medicare Inpatient Only Surgical List
- **Status may be inpatient, observation, or same day care**
- **If the procedure is completed without complications, the hospital status is what was initially authorized by insurance.**
  - If the patient's recovery is not going as expected (for obs and same day surgery) then the patient's status can be changed based on symptoms.

Emergent

- **Depends on symptoms at presentation and the patient's medical history.**
- **Status may be inpatient or observation.**
  - Acute appendicitis with no complications: OBS
  - Acute appendicitis with complications (peritonitis, peritoneal abscess): INPT
- **For observation status, if recovery is complicated, patient may meet inpatient status.**

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Payer Guidelines for Status Determination

	Regulations	Criteria for Inpatient vs. Observation
Medicare	National	2-Midnight Rule and Clinical Judgement of estimated Length of Stay
Medicaid	State/Payer Level	**State/Payer Dependent Screening Criteria**
Commercial / Managed Medicare	Either of the Above	**Payer Dependent** but could be both of above

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Screening Tools

Screening Tools	Screening Tool Essentials	Adult vs. Pediatric
• No requirement for a specific tool or guideline. • Recommend using a consistent tool(s) to ensure no bias in assigning status based on payer (self pay vs. insurer).	• Milliman Care Guideline™ • InterQual™ • Institutional Clinical Pathways • Payer Clinical Guidelines	• Some guidelines were created specifically for pediatric populations.

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Steps in Determining Status

Look for reason for admission

- Review observation criteria to determine if patient needs hospital-based care.
- Review inpatient criteria to assign status.
- Diagnostic or therapeutic care can only be safely accomplished in a hospital setting due to the urgency of the situation or the intensity of the services provided.

Look for comorbidities

- Electrolyte derangements
- Level of fever
- Associated organ dysfunction (e.g., acute kidney injury)
- No appropriate care giver/follow-up available.

May use any applicable guideline

- There may be multiple appropriate guidelines.
- If multiple, you can use the one that provides the highest level of care.

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Timing of Status Assignment

Guidelines should be applied at the time the patient is being evaluated for hospital care.

If the patient's clinical course is improving, the status assigned at admission should not be changed to a lower status.

If the patient's clinical course is worsening, the patient's status should be reviewed to determine if higher status assignment is appropriate.

Status should be changed to a lower level ONLY if it was incorrectly assigned at admission. Use Code 44 for Medicare.

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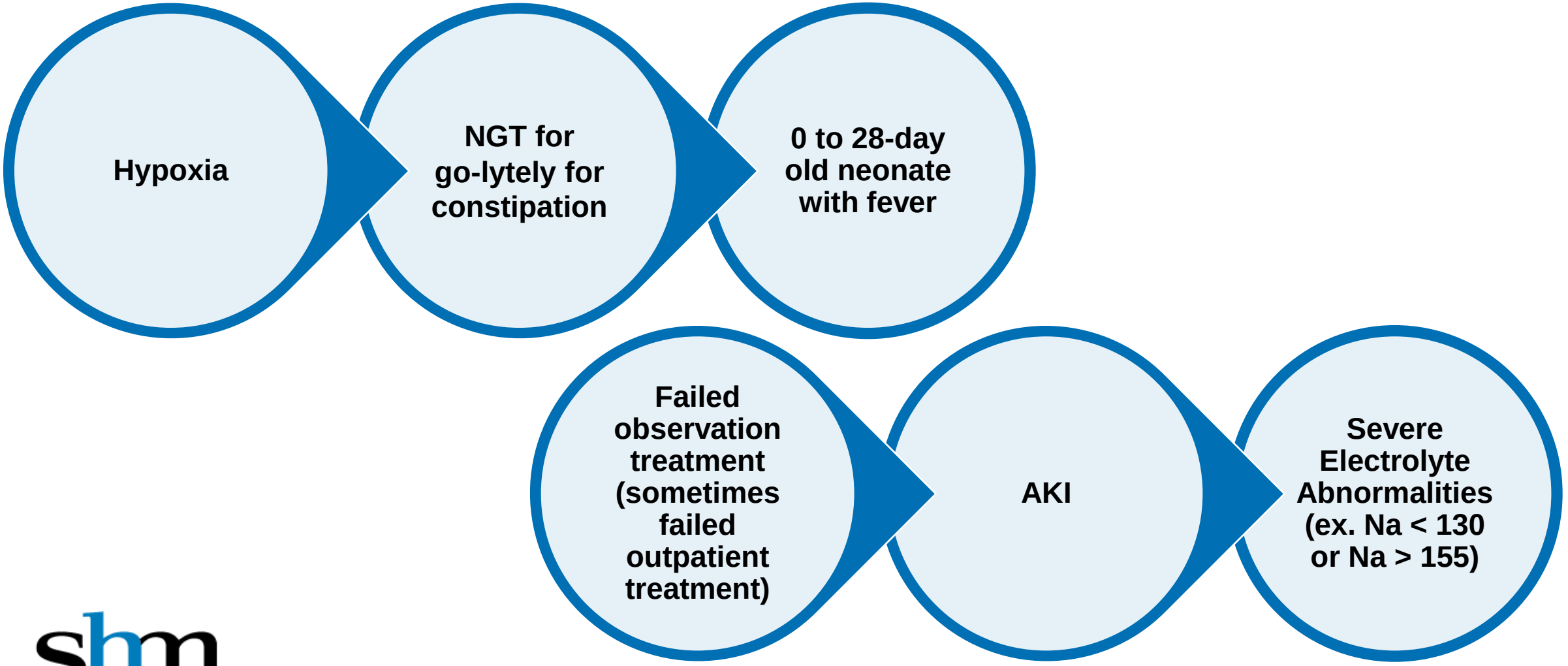
Examples of Inpatient Criteria



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Impact to Insurers, Patients, and Hospitals

Inpatient	Observation	Same Day Surgery / Extended Recovery	Outpatient in a Bed
• Highest cost of care • Highest reimbursement from payer • Usually zero or minimal cost to the patient	• Cost of care may be comparable to inpatient for pediatrics • Reimbursement is often much lower than inpatient • May include a financial obligation for the patient • May impact ability to transfer to SNF for Medicare patients	• Bundled payment with procedure • Includes post-operative recovery • If placed in a hospital bed, may include increased cost of care that is not reimbursed • Usually does not involve additional cost to patient unless moves to other status	• Paid as ambulatory care • If placed in a hospital bed, may include increased cost of care that is not reimbursed • Usually does not involve additional cost to patient

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Researchers must consider these different status types when obtaining data from large data sets.

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Peer-to-Peer Discussions

- **Requested by the payer to discuss the status assignment.**
  - Usually due to disagreement on status assignment on initial review by payer
- **Payer reviewer is usually a physician.**
- **Payer usually does not have access to the full medical record.**
  - UM RN notes
  - H&P note
  - Other select information
  - Usually does not have access to daily notes, vitals, labs (if not noted in documents), etc.

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Preparing for Peer-to-Peer Discussions

- **Talk with your Case Manager to know which screening tool is used to make the determination.**
- **Which specific guideline in the screening tool was used for this case?**
  - Request a copy of the guideline.
- **What criteria in that guideline did the patient meet?**
  - You can add to this list.
- **What additional information may be relevant to the payer in making the determination?**
  - Other complicating factors including complexity of health issues, etc.

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Intended Change

- Understand the importance of correct assignment of status for hospitalized patients.
- Appreciate how clinical care and documentation impact the status assignment and financial impact to payers, patients, and hospitals.
- Feel prepared to have discussions with payers on status assignment.
- Be a champion for both clinical care and financial stewardship in healthcare.

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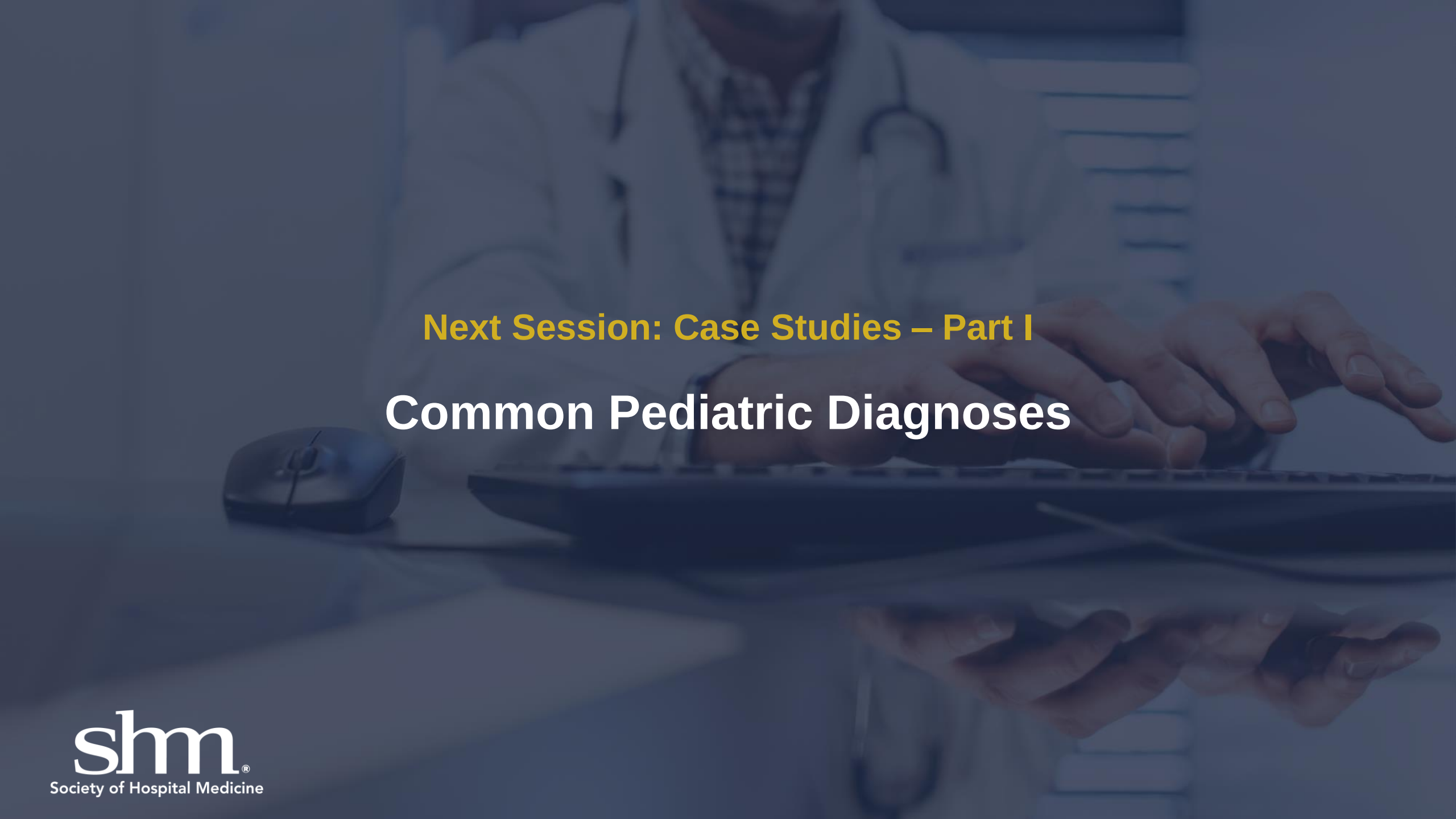

Next Session: Case Studies – Part I

Common Pediatric Diagnoses

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