3 Days
2 Midnights
1 Confusing Status

The Challenging Policy Landscape for Observation Services

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Special Thanks

Harold Pollack PhD
Jeanne Marsh PhD
Keith Brown
Conflicts of Interest

Emergency Physicians Monthly

The Heart Course: Emergency
Benjamin Rush Society
Medical Society of Virginia
Special Thanks

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Director, Quality and Safety Research and Strategy
Center for Outcomes Research and Evaluation
Emergency Medicine
Yale School of Medicine
Special Thanks

Michael Ross MD
Emory

Pawan Suri MD
Medical College of Virginia
Hill aides can quietly stay off health exchanges

By BURGESS EVERETT and JAKE SHERMAN | 10/29/13 7:06 PM EDT Updated: 10/30/13 5:42 PM EDT

Obamacare is, once again, turning Capitol Hill upside down.
What is Obs?

Schema: Clinical vs Administrative

RAC Audits

3 Day Rule

2 Midnight Rule

Future: U of C & nationally
Jargon
Peter Hill MD
not ready for discharge

not sick enough to be admitted
not ready for discharge

not sick enough to be admitted... yet?
not ready for discharge  ED LOS longer >6h

not sick enough to be admitted... yet?

admission decision
not ready for discharge

not sick enough to be admitted... yet?

period of monitoring

specific test

more treatment

ED LOS longer >6h

admission decision
not ready for discharge → ED LOS longer >6h

not sick enough to be admitted... yet? → admission decision

period of monitoring → abdominal pain

specific test → stress, echo, MRI...

more treatment → pain control, fluids, asthma

asthma
CMS Manual System, Pub. 100-02 Medicare Benefit Policy:

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

*(up to 48 hours for Medicare FFS beneficiaries)*

***Note that managed Medicare and private insurance companies’ admission status rules may vary from those of FFS Medicare (often 23 hours or 24 hours).*
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(up to 48 hours for Medicare FFS beneficiaries)

***Note that managed Medicare and private insurance companies’ admission status rules may vary from those of FFS Medicare (often 23 hours or 24 hours).
Medicare vs private payers
similar but unclear
Medicare paid for:

- chest pain
- asthma
- CHF exacerbation

(unti 2007, now any Obs)

Medicare vs private payers
similar but unclear
Medicare paid for:

- chest pain
- asthma
- CHF exacerbation

(Current until 2007, now any Obs)

Current most common:

- chest pain
- GI symptoms
- syncope

Medicare vs private payers

- similar but unclear
<table>
<thead>
<tr>
<th>Confused??</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Unit</td>
</tr>
<tr>
<td>Clinical Decision Unit</td>
</tr>
<tr>
<td>Rapid Diagnostic and Treatment Unit</td>
</tr>
<tr>
<td>Chest Pain Unit</td>
</tr>
<tr>
<td>Clinical Decision and Treatment Unit</td>
</tr>
<tr>
<td>Extended Evaluation Unit</td>
</tr>
<tr>
<td>Emergency-Acute Care Unit</td>
</tr>
<tr>
<td>Short Stay Unit</td>
</tr>
<tr>
<td>(not a Holding Unit)</td>
</tr>
</tbody>
</table>
Where: dedicated unit?
Who: emergency vs inpatient?
How: protocol?
Where: dedicated unit?

Who: emergency vs inpatient?

How: protocol?

What matters: Observation services
E/M services

Clinic Visits
Emergency
Critical Care
Inpatient Services
Observation Services
E/M services

- Clinic Visits
- Emergency
- Critical Care
- Inpatient Services
- Observation Services

- Clinics
- EDs
- Critical Care Units (+EDs)
- Inpatient Beds (+EDs)
<table>
<thead>
<tr>
<th>E/M services</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Clinic Visits</td>
<td>Clinics</td>
</tr>
<tr>
<td>Emergency</td>
<td>EDs</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Critical Care Units (+EDs)</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>Inpatient Beds (+EDs)</td>
</tr>
<tr>
<td>Observation Services</td>
<td>...Anywhere!</td>
</tr>
<tr>
<td>Setting</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Type 1</td>
<td>Protocol driven, observation unit</td>
</tr>
<tr>
<td>Type 2</td>
<td>Discretionary care, observation unit</td>
</tr>
<tr>
<td>Type 3</td>
<td>Protocol driven, bed in any location</td>
</tr>
<tr>
<td>Type 4</td>
<td>Discretionary care, bed in any location</td>
</tr>
</tbody>
</table>

## Hospital Settings In Which Observation Services Are Provided

<table>
<thead>
<tr>
<th>Setting</th>
<th>Description</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Protocol driven, observation unit</td>
<td>Highest level of evidence for favorable outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care typically directed by ED</td>
</tr>
<tr>
<td>Type 2</td>
<td>Discretionary care, observation unit</td>
<td>Care directed by a variety of specialists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit typically based in ED</td>
</tr>
<tr>
<td>Type 3</td>
<td>Protocol driven, bed in any location</td>
<td>Often called a “virtual observation unit”</td>
</tr>
<tr>
<td>Type 4</td>
<td>Discretionary care, bed in any location</td>
<td>Most common practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unstructured care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor alignment of resources with patients’ needs</td>
</tr>
</tbody>
</table>

Evidence

clinically effective

more efficient vs inpatient

particularly protocol-driven

<table>
<thead>
<tr>
<th></th>
<th>Unit</th>
<th>Any location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol</td>
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<td>2</td>
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<tr>
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<td>3</td>
<td>4</td>
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<tr>
<td></td>
<td>Unit</td>
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<td>Protocol</td>
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<td>Clinical</td>
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<tr>
<td>Protocol</td>
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Clinical

Administrative
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<tbody>
<tr>
<td>Protocol</td>
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</tr>
<tr>
<td>Discretionary</td>
<td>3A</td>
<td>4A</td>
</tr>
<tr>
<td></td>
<td>3B</td>
<td>4B</td>
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</table>

Clinical: 2

Administrative: 4B
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<thead>
<tr>
<th>Protocol</th>
<th>Unit</th>
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<tbody>
<tr>
<td>1: Best evidence of best outcomes</td>
<td>&gt;1/2 run by ED</td>
<td>2: “virtual observation unit”</td>
</tr>
<tr>
<td>2:</td>
<td></td>
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<tr>
<td>Clinical</td>
<td></td>
<td></td>
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<tr>
<td>3A: Care directed by a variety of specialists</td>
<td>&gt;1/2 based in ED</td>
<td>4A: Most common Unstructured Poor alignment of resources with patients’ needs</td>
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<td>3B: Directed to OU by clinical staff</td>
<td></td>
<td>4B: Billed as Obs by admin</td>
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<tr>
<td>Admin</td>
<td></td>
<td>Used to avoid RAC audits &amp; readmission penalties</td>
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<td>2:</td>
<td>“virtual obs unit”</td>
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<td>Clinical</td>
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<td>3B: Directed to OU by clinical staff</td>
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<tr>
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<td>Used to avoid RAC audits &amp; readmission penalties</td>
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1960s  Obs & EM begin

1984  Medicare starts paying

2007  1/3 hospitals have dedicated OU Type 1 or 3, >1/2 ED

2007  change in payment CP/asthma/CHF

2014  89% of hospitals bill for Obs
2007-2009
26% increase

2006-2011
65% increase
78% from ED
9% from Cath/OR

Similar case mix
Why so much Obs?

Effective

Efficient

Minimize boarding

Decrease expenditures
Why so much Obs?

Effective
Efficient
Minimize boarding
Decrease expenditures
...avoid payment denials
RAC Audits

Medicare overpayments
$20 billion/year

2003    Medicare Modernization Act
2005-8  demonstration
2006    permanent
2010    ACA expanded
         MA, Part D, Medicaid
**RAC Phase-In Schedule**

- **March 1, 2009**: Region D (HDI), Region B (CGI), Region C (Connolly)
- **March 1, 2009**: Region A (DCS)
- **August 1, 2009 or later**: Remaining states

*VT, NH, ME, MA, RI, CT (J14) Part A claims (including Part B of A) will not be available for RAC review until August 2009 due to the MAC transition. Part B claims in RI will not be available for RAC review until August 2009 due to the MAC transition. All other Part B claims are available for RAC review beginning March 1, 2009.*
Obamacare site developer CGI Federal also won bid to help with federal Sandy funds

Published October 28, 2013 • FoxNews.com
RAC Audits

Returned $2.5 billion in overpayments
RAC Audits

Returned $2.5 billion in overpayments

50-75% (up to 90%?):

“medical necessity” of “care delivered in inappropriate facilities” for short stay admissions
RAC Audits

Returned $2.5 billion in overpayments

50-75% (up to 90%?):

“medical necessity” of “care delivered in inappropriate facilities” for short stay admissions

i.e. overuse of short-stay inpatient admissions
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<td>Inpatient</td>
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<tr>
<td>Part B</td>
<td>Part A</td>
</tr>
<tr>
<td>1.5 million</td>
<td>1.1 million</td>
</tr>
<tr>
<td>$2.6B</td>
<td>$5.9B</td>
</tr>
<tr>
<td>$1,741</td>
<td>$5,142</td>
</tr>
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</table>
Obs vs Admit?

How are we supposed to know:

should we Obs?

should we admit?
Obs vs Admit?

How are we supposed to know:

should we Obs?

should we admit?
Obs vs Admit?

Admitting all = inappropriate

Discharging = “extremely hazardous”

Primary Criterion: more accurate disposition

RAC audits
Interqual & Milliman
Readmission penalties
RAC Audits

$2.5 billion in overpayments
RAC Audits

$2.5 billion in overpayments vs $300 million in underpayments
RAC Audits

$2.5$ billion in overpayments

vs $300$ million in underpayments

mostly incorrect DRGs
Why both?

Contingency payments

9-17% to RAC

perverse incentive to over-audit
Mortimer: Tell him the good part.

Randolph: The good part, William, is that, no matter whether our clients make money or lose money, Duke & Duke get the commissions.
Why both?

Contingency payments

9-17% to RAC

pervasive incentive to over-audit

Appeals

orig. 6%  44% overturned

now >40%  70% overturned
Appeals

administratively burdensome

drawn-out

inconsistent

overwhelmed: volume & delays
Appeals

contesting audits = expensive
return initial payment until concluded
Appeals

contesting audits = expensive

return initial payment until concluded

but!
Appeals

contesting audits = expensive

return initial payment until concluded

but!

RACs have 3 year look-back window

can only bill Part B within 1 year
Administrative push to substitute Obs

some = clinically appropriate

some underuse of Obs

particularly if it can fit in a protocol

Type 1 & 2
Some administrative pressure for 3B Obs

clinically appropriate for admission
4B Hospital admin reclassify

admissions → Obs

just prior to DC
4B Hospital admin reclassify admissions just prior to DC

bill less less chance of audit
17,000 claims

$120 million in Medicare payments
17,000 claims

$120 million in Medicare payments

RAC identified about 3% of these as improper:
17,000 claims

$120 million in Medicare payments

RAC identified about 3% of these as improper:

$1,903,620 in overpayments

$1,887,176 in underpayments
after a big headache for the hospital...
$1,903,620 in overpayments

$1,887,176 in underpayments

CMS saved: $16,444

Contractor payment: ~$400,000
[video 2]
To amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.

Rep. Sam Graves +232 cosponsors
+27 Senate

Penalize RAC for successful appeals
Require CMS to make criteria
Bill Part B during challenge

Decrease perverse incentives for 3B & 4B
<table>
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- Clinical
- Administrative
Obs vs Readmissions?
Obs vs Readmissions?
Obs vs Readmissions?

30-Day, All-Condition Medicare Redmission Rates

- Congestive heart failure
- Acute myocardial infarction
- Pneumonia

Risk-Adjusted 30-Day Readmission Rate (%)
Obs vs Readmissions?

Obs vs Readmissions?

Obs vs Readmissions?

30-Day, All-Condition Medicare Redmission Rates

- 2007: 19.0%
- 2008: 18.5%
- 2009: 18.0%
- 2010: 17.5%
- 2011: 17.0%
- 2012: 16.5%
- 2013 YTD: 16.0%
Obs vs Readmissions?
Confusing for Doctors
Confusing for Patients

Where: dedicated unit?

Who: emergency vs inpatient?
3 identical appearing patients in adjacent beds: ED patient, Obs patient, & boarding inpatient
Fighting ‘Observation’ Status

By SUSAN JAFFE     JANUARY 10, 2014 2:41 PM   •  53 Comments

Every year, thousands of Medicare patients who spend time in the hospital for observation but are not officially admitted find they are not eligible for nursing home coverage after discharge.
Fighting ‘Observation’ Status
By SUSAN JAFFE  JANUARY 10, 2014 2:41 PM  53 Comments

Every year, thousands of Medicare patients who spend time in the hospital for observation but are not officially admitted find they are not eligible for nursing home coverage after discharge.

$10,000 patient bills!
Emerging state laws to require notification
Emerging state laws to require notification

No recourse to alter

No teeth
Emerging state laws to require notification

No recourse to alter

No teeth

Can’t appeal CMS payment for a paid bill

Bagnall v. Sebelius (2d Cir)
Cost Sharing

OIG report 2012
Cost Sharing

OIG report 2012

94% substantially lower
Cost Sharing

OIG report 2012

94% substantially lower

exceptions: SNF
very long Obs
Cost Sharing

OIG report 2012

94% substantially lower

exceptions: SNF very long Obs

Type 1 Obs = lowest cost sharing
Cost Sharing

6% (n=84K) paid more than IP deductible
Cost Sharing

6% (n=84K) paid more than IP deductible

0.2% (n=3K) paid more than 2x IP deductible
Cost Sharing

6% paid more than IP deductible  \( (n=84K) \)

0.2% paid more than 2x IP deductible \( (n=3K) \)

Admit more for 12 of 14 conditions

$359-$572 more
Cost Sharing

6% (n=84K) paid more than IP deductible
0.2% (n=3K) paid more than 2x IP deductible

Admit more for 12 of 14 conditions
$359-$572 more

Outliers:
Stent ($817) & circulatory disorder ($359)
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<td>Setting</td>
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</tr>
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<td>Medicare</td>
<td>Part B</td>
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<tr>
<td>Total Charge</td>
<td>$1,741</td>
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<tr>
<td>OOP</td>
<td>20%</td>
</tr>
<tr>
<td>Average OOP</td>
<td>$401</td>
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Every year, thousands of Medicare patients who spend time in the hospital for observation but are not officially admitted find they are not eligible for nursing home coverage after discharge.

$10,000 patient bills
3 Day Rule

Medicare:

3 inpatient midnights for SNF
3 Day Rule

Medicare:

3 inpatient midnights for SNF

Obs doesn’t count!
3 Day Rule

**Medicare:**

3 inpatient midnights for SNF

**Obs doesn’t count!**

**SNF:**

2.9% of all Obs

4% of >72h Obs
3 Day Rule

SNF: 2.9% of all Obs
4% of >72h Obs

Under 30k patients
Medicare paid for 92%!
3 Day Rule

SNF: 2.9% of all Obs
4% of >72h Obs

Under 30k patients
Medicare paid for 92%!

2,000-7,500 patients at risk for SNF services
Realign Cost-Sharing

Arbitrary division of Medicare Parts

Protect patients

Might even save Medicare money!
Realign Cost-Sharing

Arbitrary division of Medicare Parts

Protect patients

Might even save Medicare money!

Incentivize protocols (Type 1 & 2)

Require % care protocols?
H. R. 1179

To amend title XVIII of the Social Security Act to count a period of receipt of outpatient observation services in a hospital toward satisfying the 3-day inpatient hospital requirement for coverage of skilled nursing facility services under Medicare.

Rep. Joe Courtney +161 cosponsors
+27 Senate

Count Obs toward 3 Day Rule

No CBO score
To amend title XVIII of the Social Security Act to provide Medicare coverage of extended care services without regard to a requirement for a 3-day prior hospitalization, and for other purposes.

Rep. Jim McDermott

Eliminate 3 Day Rule
To amend title XVIII of the Social Security Act to provide Medicare coverage of extended care services without regard to a requirement for a 3-day prior hospitalization, and for other purposes.
113TH CONGRESS 1ST SESSION

H. R. 3144

To amend title XVIII of the Social Security Act to provide Medicare coverage of extended care services without regard to a requirement for a 3-day prior hospitalization, and for other purposes.

Rep. Jim McDermott

+0

no S companion

Eliminate 3 Day Rule

1988 Catastrophic Coverage Act
waived 3 Day Rule

243% increase in SNF payments
3 Day Rule dropped for pilots

Pioneer ACOs

Bundled Payment

Medicare Advantage
3 Day Rule dropped for pilots

Pioneer ACOs

Bundled Payment

Medicare Advantage

95% = 12 million beneficiaries!
3 Day Rule

No easy answers – need some control
otherwise: increase SNF spending
quick DC & maximize DRG
3 Day Rule

No easy answers – need some control
otherwise: increase SNF spending
quick DC & maximize DRG

Count Obs increase 4B Obs (SNF)
3 Day Rule

No easy answers – need some control
otherwise: increase SNF spending
quick DC & maximize DRG

Count Obs → increase 4B Obs (SNF)

Only count Obs if admitted?
Who to Obs vs Admit?
Who to Obs vs Admit?

2 Midnight Rule
Who to Obs vs Admit?

2 Midnight Rule

78 Fed. Reg. § 160, 50965
Cross 2 midnights = appropriate for admission
Cross 2 midnights = appropriate for admission
1. Benchmark
2. Presumption
3. Order
4. Certification
1. Benchmark: MD expects 2 MN
2. Presumption: RAC can’t audit
3. Order: in chart, with support
4. Certification: order, reason, statement
| Actual LOS | MD expectation |  |  |
|------------|----------------|-----------------------------|
| >2MN       | Admit          | Admit if med necessary      |
| >2MN       |                | Obs if not                  |
| <2MN       | Admit if med necessary |                |
| <2MN       | Obs            | Obs if not                  |
Issues

Time based criterion = arbitrary
Issues

Time based criterion = arbitrary

$\leq 24 \neq$ less sick
Issues

Time based criterion = arbitrary

<24 ≠ less sick

longer admits ≠ more services
Issues

Time based criterion = arbitrary

$\leq 24 \neq$ less sick

longer admits $\neq$ more services

But it’s not totally unreasonable

Essentially a shorter DRG
Issues

“2 midnights” vs hours

October 15
Issues

“2 midnights” vs hours
Issues

“2 midnights” vs hours
Issues

“2 midnights” vs hours
Issues

“2 midnights” vs hours

24’01” vs 43’59”
Issues

Will all admits <2MN be challenged?
Issues

Will all admits <2MN be challenged?
administrative burden
backlogged appeals
contingency / incentives
2MN effects

1. more short stay admits
2MN effects

1. more short stay admits

2MN effects

1. more short stay admits

2MN effects

1. more short stay admits

2MN effects

1. more short stay admits
decreased DRG 0.2%
2MN effects

1. more short stay admits
2. decrease procedural admits
2MN effects

1. more short stay admits

2. decrease procedural admits
   increase cost sharing
   decrease hospital revenue
2MN effects

1. more short stay admits

2. decrease procedural admits
   - increase cost sharing
   - decrease hospital revenue
   - silver lining?
2MN effects

1. more short stay admits
2. decrease procedural admits
3. help SNF & RAC issues
2MN effects

1. more short stay admits
2. decrease procedural admits
3. help SNF & RAC issues only for longer admits
How are hospitals handling 2 MN?
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intense Utilization Review
How are hospitals handling 2 MN?

intense Utilization Review

simple education & check boxes
<table>
<thead>
<tr>
<th>Prompt</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admission Type:</td>
<td>Ambulatory, Observation, Inpatient</td>
</tr>
<tr>
<td>2. Requested Admission Date:</td>
<td></td>
</tr>
<tr>
<td>3. Estimated Length of Stay (days):</td>
<td></td>
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**Deficiency**

**Cosign Order**

**ADMIT TO INPATIENT ACROSS 2 MIDNIGHTS**

**Process Instructions**

Please document in the clinical justification question the specific rationale of WHY the patient needs a hospitalization that will span a minimum of 2 midnights.

If your patient will not stay longer than 2 midnights or does not need the medical necessity criteria for inpatient admission based on your current clinical judgment, please consider the "Place in Observation" or "Place in Ambulatory" orders as appropriate.
Who’s correct?
Who’s correct?
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>October 1, 2013</td>
<td>initial start date</td>
</tr>
<tr>
<td>April 1, 2014</td>
<td>CMS delay</td>
</tr>
<tr>
<td>October 1, 2014</td>
<td>HR 3698, CMS delay</td>
</tr>
<tr>
<td>April 1, 2015</td>
<td>SGR Patch (probe &amp; educate)</td>
</tr>
</tbody>
</table>
No idea.

RACs
CMS
Courts
To delay the enforcement of the Medicare two-midnight rule for short inpatient hospital stays until the implementation of a new Medicare payment methodology for short inpatient hospital stays, and for other purposes.

Rep. Jim Gerlach +158 cosponsors
+17 Senate

Delay
Short DRG
Short DRG

Modifier?

List?

Reimbursement vs Obs?

Another distinction?
Peter Hill MD
Peter Hill MD
Site of service

Report “site of service”

Get better data on Type vs Efficiency
CMS settlement

2 year backlog
CMS settlement

2 year backlog

68% of payment
CMS settlement

2 year backlog

68% of payment

mostly short stay inpatient reviews
<table>
<thead>
<tr>
<th>Obs</th>
<th>Short Inpatient (&lt;2 MN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,741</td>
<td>$5,142</td>
</tr>
</tbody>
</table>

68% = $3,500
Summary

Obs care: wonderful

Challenges

RAC → 3 Day Rule → patient finances

Obs vs Admits

improve 2MN
Summary

RAC

Part B during appeals

Penalize overturned appeals
Summary

3 Day Rule

count Obs (at least for admits)

rationalize cost sharing
2MN

Need some guidance

MN vs hours = vague

Outpatient procedures
Summary

Incentivize Type 1 & 2

% protocol

Report site
Madhu Yarlagadda MD
Brian Callandar MD
Tipu Puri MD PhD
Tom Spiegel MD MBA MS
Advanced Practice Service

24 beds

“inpatient”

immediate transfer upstairs

protocols in & out

3A → 1
LOS longer than typical ED visit (e.g. >6h)

Typically <24-48 hours total stay
Straightforward diagnosis with clear management plan

or

single diagnostic test not available off-hours

or

will take an extended time (e.g. V/Q)
EXCLUSIONS

Expected stay >48 hours

Unstable

Placement issues (May need SNF, homeless without acute medical needs, or with longer care requirements (e.g. LMWH)

Injection drug users who need home therapy (potential home nursing issues)

Cystic Fibrosis

Sickle cell crises (General Medicine)

Acute medical complexity
Infectious
(e.g. requiring IV antibiotics, failed outpatient therapy; use guideline antibiotics)

- Cellulitis
- Pneumonia
- UTI

Antibiotic protocols

PICC

Case management for home care & prescriptions

**EXCLUSION**: SEVERE SEPSIS OR SEPTIC SHOCK
Respiratory
(serial nebulizers & monitoring)

COPD
Asthma

EXCLUSION: NIV, <Q2H NEBULIZERS, IMPENDING RESPIRATORY FAILURE
IV Therapy

Acute kidney injury
Diarrhea
Simple blood transfusion
Acute pain control
Electrolyte abnormalities
  - Hyponatremia
  - Hyperkalemia
  - Hypokalemia

Diabetic complications
  - Hypoglycemia
  - Hyperglycemia
  - New diabetes
  - Mild DKA

EXCLUSION:
  - SICKLE, COMPLEX, FREQUENT ADMISSIONS, CANCER, PAIN
Hemodialysis

Fluid overload (single session)
Hyperkalemia
IR/permacath placement

EXCLUSION: QRS WIDENING
Diagnostic Testing

MRI
Echocardiogram
Pretreatment for CT with IV contrast
V/Q scan
After hours ultrasound (e.g. low risk threatened abortion, high risk DVT)
CHEST PAIN & SYNCOPE

Patients getting any management more intense than a q4h troponin should be admitted to Cardiology

Note both APN Cardiology Clinic & same-week stress tests are available
Future directions:

Neurology: TIA

Surgical patients

Simple appy, chole, IUFD, ortho

Diagnostics

All ED MRIs (who will be discharged)

Off-hours low risk threatened abortions
Admit when between services?

Obs rolled into DRG
Summary

Obs:

Good for patients
Good for hospital finances
Good for CMS