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GOAL: Reduce risk for denial; Decrease denied days, Decrease LOS; Assign appropriate Status. Assure that the patient gets the right care, for the right reason, for the right duration, in the right status and in the right setting.

TOP DENIED ADMISSIONS 2015:

1. Esophagitis, Gastroenteritis, digestive disorders
2. Syncope and collapse
3. Cellulitis
4. Laparoscopic Cholecystectomy
5. GI Hemorrhage
6. COPD
7. Anemia
8. Seizures
9. CP/Circulatory Disorders
10. Simple pneumonia
11. TIA
12. Dehydration/Electrolyte abnormalities
13. Diabetes
14. Kidney and UTI
15. Appendectomy
16. Bronchitis/Asthma
17. Back pain

THINK ABOUT OBSERVATION FOR THESE ABOVE PATIENTS FROM THE ED (EVEN IF ED PHYSICIAN DOES NOT SUGGEST IT, OR EVEN IF THEY HAVE PLACED AND INPATIENT ORDER.)

<u>*** IT IS THE PROVIDER'S RESPONSIBILITY TO INFORM THE PATIENT THEY ARE IN OBSERVATION STATUS***</u>.
(If the patient or family has payer or financial questions, Refer to/ Consult Case Management.)

From the <u>patient perspective</u>: What is Observation Status? Here are suggestions for you to share with the patient:

- When you're put in the hospital, you're assigned either inpatient status or observation status. If you have severe problems and require highly technical skilled care, you are assigned inpatient status.
- If you are not sick enough to require inpatient admission but you are too sick to get care at your doctor's office, you are assigned observation status....
- You might be assigned to observation status when doctors aren't sure exactly how sick you are. They can observe and treat you in the hospital and if you become sicker or require more extensive treatment, you will become inpatient status. If you get better you will go home.

From the <u>MD perspective</u>:

- The purpose of observation status is to determine the need for further treatment or inpatient admission. Thus a patient in observation status may improve and be released, or be admitted as an inpatient. 24 hour cap is the goal.
- Observation status is that of an outpatient (copays/pre-approval for procedures, etc.)
- We do not need insurance carrier approval for OBS
- Observation status requires signed physician status orders
- No stay is valid without appropriate documentation
- "After 24-48hrs" --does not mean patient automatically becomes IP if he/she is still here and not ready to go home yet. Review this on a case by case basis for possible discharge vs. upgrade to IP. The patient must meet medical necessity for IP admission (adding IV abx and fluids and consultations do not generate approval for inpatient).
- OBS and IP rates of MD reimbursement for H&P, follow-ups and discharges are within $1 of each other. Professional services are reimbursed by insurance companies for OBS just like inpatient admission
- If a case seems soft, you expect the patient will get better quickly.
- When there are social issues, and patient is requesting to be admitted, it is not medically necessary reason to admit

Consider OBS:

- younger, healthy patient with few comorbities
- IVF, IV antibiotics, afebrile, taking po, no outpt Rx
- labs are normal or have improved within 1-2days
- has a diet order (even cl lq)-radiologic testing is essentially normal
- RA sats are normal, cxr normal on IV steroids
- chest pain with no ekg changes-new mass
- acute diverticulitis , pyelonephritis, acute copd/asthma exacerbations, chest
- pain, syncope, abd pain, cellulitis, dvt
- when you are not sure ... can these things be done at Subacute level or TCU?

Consider Inpatient:

- Two midnight stay is medically likely
- Patient requires high 02/bipap/ vent--- need grossly abnl ABG
- ekg changes with symptoms treated as ACS with ACT, bblocker, plavix, statin
- etc.
- at least 3 units for transfusion
- radiologic study shows perforation, abcess, obstruction, OM, complication of
- some kind
- laproscopic procedure converted to open
- not tolerating po, still npo after 48hrs
- any type of ICU care (not sure because patient is in the ICU)
- after 1-2 days patient is getting worse, no improvement

<u>Documentation is key</u>—it not only dictates the plan of care and treatment, but is used by Utilization and the Physician Advisor to clarify when a payer is considering a denial.

- **Key words and phrases:**
  - Failed outpt Rx (be specific in meds taken and length- antibiotics, steroids, etc)-
  - unable to tolerate PO, n/v
  - INTRACTABLE pain (requiring multiple dosage of IV narcotics (6 doses/ 24hrs
  - for IP and failed PO meds)
  - Worsening, persistent, not improving, not progressing, uncontrolled
  - Document abnl VS of the day or comment of abnormal LABS (BS dropped to 56, P115)

- **Do not copy and paste!**

- **Document outline clear plan of care.... Examples that all payers need to validate payment:**
  - If patient is afeb taking PO, *document <u>why</u>* patient cannot be switched to po antibiotics/meds)
  - Patient is not stable for dc today *because.......*
  - *Upgrading to IP status because......*
  - Discharge "if cleared by"..... this is not a valid order.
  - Please discuss with your consultants yourself for appropriate discharge order. If your consultant does not respond, <u>please call him/her.</u>