The Patient Was Admitted… Now What?

Incorporating Care Management and Clinical Documentation Integrity in Hospitalist Workflows

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Disclosures

- None to report

Objectives

- Define and discuss the impact of inpatient providers on Utilization Management
- Define and discuss the impact of inpatient providers on CDI metrics, discharges, readmissions, and length of stay
- Define the partnership between Care Management and inpatient providers
- Define the next site of care decision process
- Post-acute follow up visits and the role of inpatient providers

A LITTLE ABOUT US

1

MAYO CLINIC ARIZONA

Mayo Clinic Arizona

Current and Future State

Mayo Brothers' Wisdom

"To keep a patient in the hospital longer than is necessary is an unwarranted expense to him or an unjustified tax on those who contribute to hospital expenses, besides keeping some other needy patient from being cared for."

- Dr. Charles H. Mayo, 1914

DOCUMENTATION

2

IMPACT OF IP PROVIDERS ON MEDICAL NECESSITY & CDI

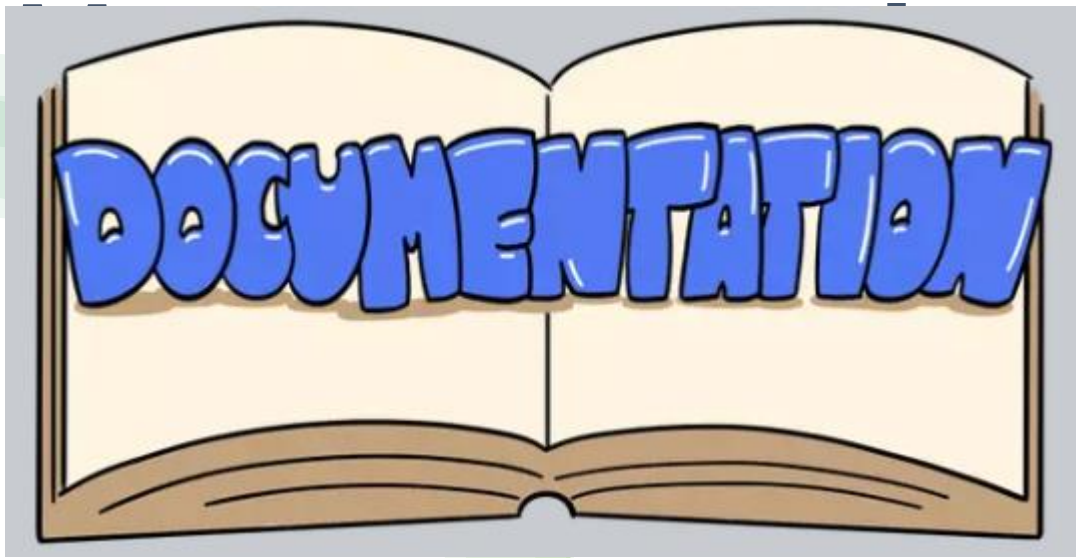
A Brief History of Utilization Management (UM)

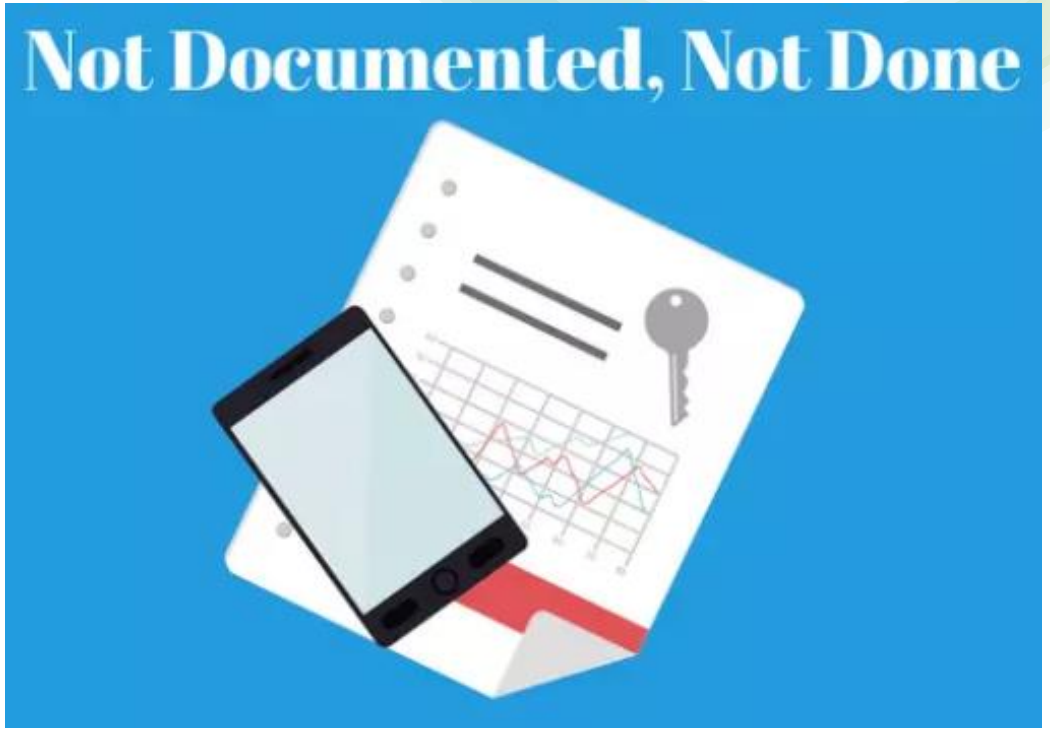
- Prior to 1965, UM was in its infancy
  - Patients with common ailments would spend weeks to months for illnesses that are now managed in days
  - Patients were managed by physician experience and local practice patterns
- CMS was created in 1965 – mandates that resulted:
  - Admissions committee to review:
    - Medical necessity for admission
    - Length of stay
    - Discharge practice
    - Necessity of services provided
  - Utilization review activities

The Purpose of Utilization Management

- Clinical care enhancement
- Appropriate resource use
- Reimbursement
- Financial implications
- Accurate record of patient acuity
- Improved communication
- Denial prevention

The Purpose of Utilization





“Medicare 101”

Part A

INPATIENT HOSPITAL CARE

SKILLED NURSING SERVICES

HOSPICE CARE

Part B

DOCTORS’ VISITS

OUTPATIENT HOSPITAL SERVICES

DURABLE MEDICAL EQUIPMENT

PHYSICIAN-ADMINISTERED DRUGS

Part C

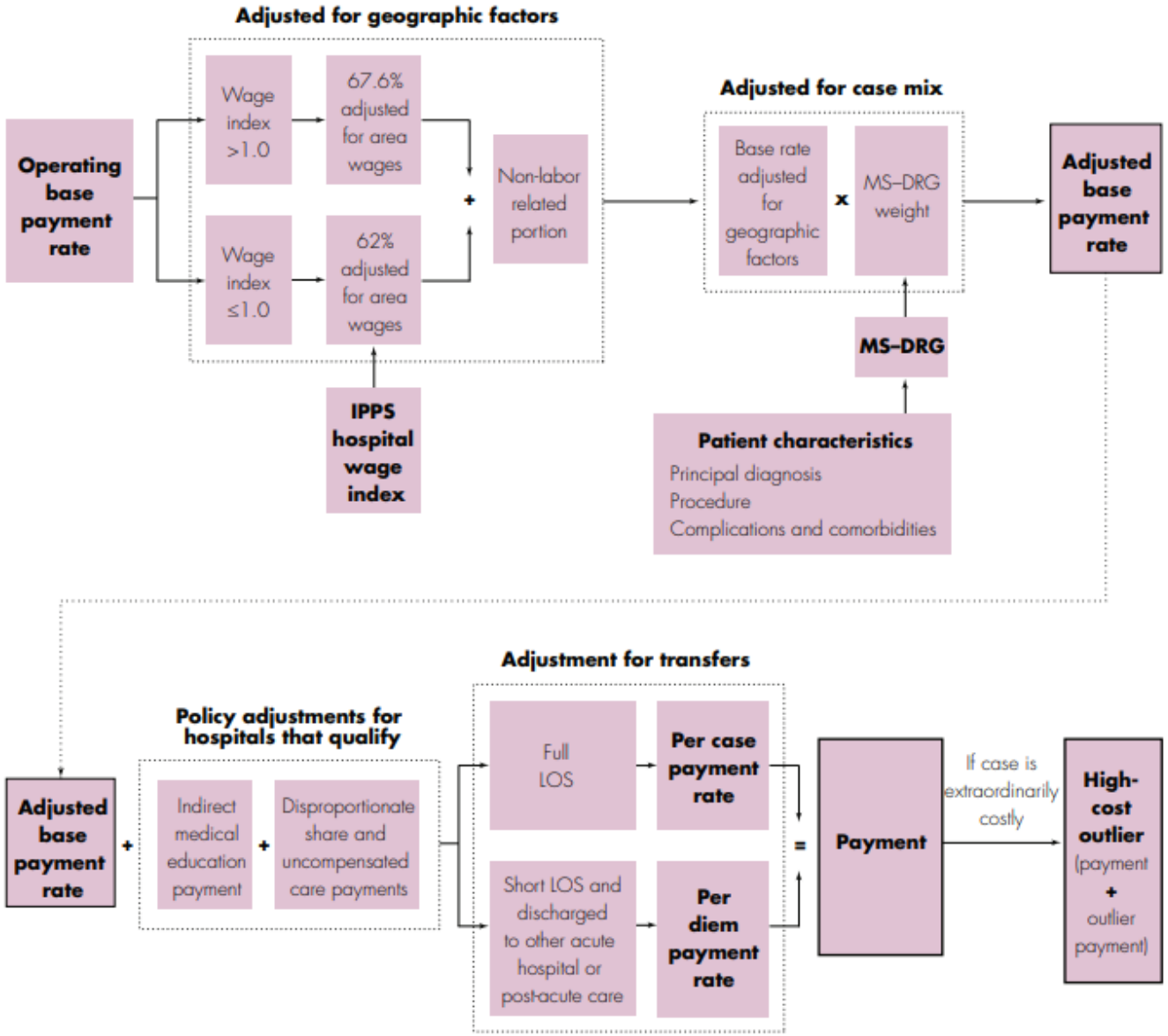
MEDICARE ADVANTAGE PLANS, WHICH COMBINE PARTS A & B

MAY COVER VISION, DENTAL, AND HEARING

Part D

PRESCRIPTION DRUG COVERAGE

Figure 1 Acute inpatient prospective payment system for fiscal year 2022

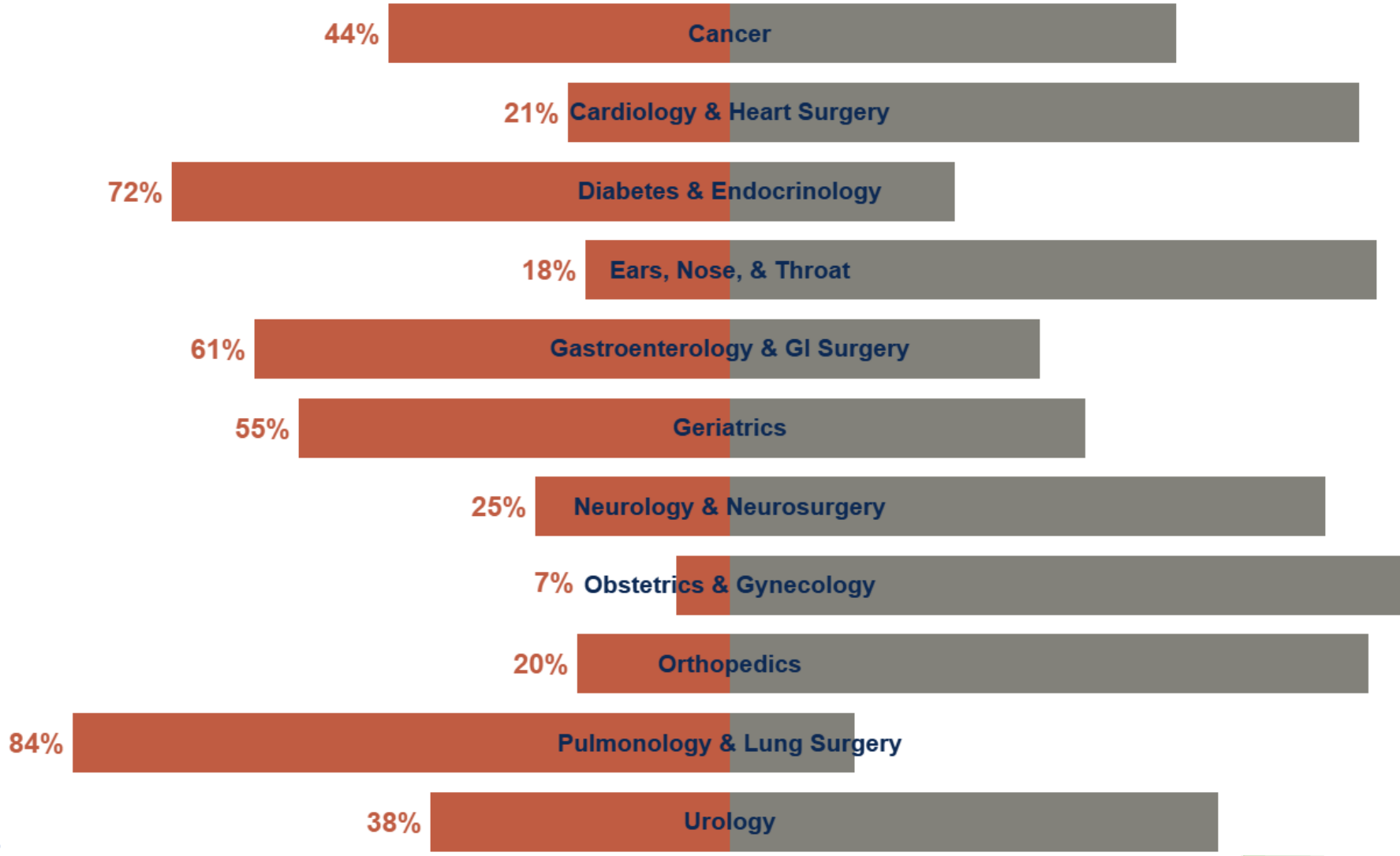


Note: MS–DRG (Medicare severity diagnosis related group), LOS (length of stay). Capital payments are determined by a similar system. Additional payments are also made for certain new technologies and rural or isolated hospitals. Hospitals may receive penalties or additional payments based on their performance on quality standards.

Impact of Provider Documentation: Utilization Management (UM)

- Why do inpatient providers matter?
- Importance of medical necessity documentation and admission status
- Some definitions to be familiar with
- Case examples

Percentage of patients seen by Hospital Internal Medicine vs. Other Service Lines



1/1/2021 – 8/8/2022

How Does Patient Status Impact CMI (and Reimbursement)?

- It remains of utmost importance to have the patient in the correct status at the correct time
  - Inpatient (IP)
  - Observation (OBS)
  - Outpatient in a Bed (OPIB)
- Example: Total Knee Arthroplasty (TKA) pre- and post-IPO list removal
  - Revenue per case decreases when moving from IP to OPIB/OBS
  - CMI also decreases

The Key Components of Medical Necessity

The **severity of the illness** which brought the patient to the hospital

The **intensity of the hospital services** provided

The **probability of an adverse outcome** if the patient receives care in a less acute setting

Review of Status Determinations

"The factors that lead a physician to admit a particular beneficiary based on the physician's clinical expectation are significant clinical considerations and must be **clearly and completely documented** in the medical record…"
IPPS Final Rule CMS-1599-F, Federal Register, p. 50944

- Inpatient
- Observation (outpatient)
- Outpatient in a bed / bedded outpatient

- Whether inpatient or observation status, all Medicare patients will have some out-of-pocket costs for their hospital stays

A Beginner's Guide to Status Determination

- "Two hats"
  - Medicare status
  - Non-Medicare status
- Commercial (and Medicaid / MAP's, which function similarly to commercial insurances)
  - Most hospitals/hospital systems use Milliman/MCG or InterQual
- Medicare
  - 2-Midnight Rule

Status Determination

- RN Case Managers start the decision-making process usually using either InterQual or Milliman (MCG) guidelines for their status recommendation
  - These are very objective principles that rely on arbitrary thresholds for severity of illness and intensity of service while only looking at a single illness or event
  - Does not take into account the risk from multiple illnesses and comorbid conditions
- If the patient's presentation does not fit into a very specific "box," a second level reviewer (physician) must make the decision
- The attending physician or Physician Advisor can use more comprehensive medical judgment to determine the patient's true severity of illness and anticipate length of stay
  - In many cases, this is how a Physician can "override" the criteria
- However, an appropriate status recommendation cannot be substantiated without adequate documentation and supporting information from the treating providers

Review of Status Determinations

Observation (Outpatient)

- Meant to be short term
- Appropriate when additional time is needed to determine if a patient needs inpatient care, or if the provider is unsure of the patient's course beyond the first midnight of care
- You are monitoring the patient to determine the next morning whether the patient can be discharged, needs continued observation, or meets the requirements for an inpatient admission
- For Medicare patients, the clock starts at the time care is initiated (ED time counts)
- For commercial and (most) MAP patients, the clock starts at the time of the "place in observation status" order
- There is no time limit for observation

Review of Status Determinations

Inpatient

History of the "Two Midnight Rule"

- CMS adopted the 2-midnight rule for admissions beginning on or after October 1, 2013:
  - Inpatient admissions will generally be determined to be valid if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and care is medically necessary
  - Inpatient admission is generally not appropriate for hospital stays not expected to span at least two midnights
  - RACs/MACs enforced the rule; MD review not required
- On July 1, 2015, CMS released the updates to the 2-midnight rule:
  - QIOs will review using InterQual as a screening tool
  - Physicians will review all claims that do not pass the initial screen
  - Physicians allowed to use best medical judgment to determine medical necessity of an admission
    - CMS emphasis on physician's medical judgment
    - Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation

The Key Components of Medical Necessity

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The **intensity of the hospital services** provided

The **probability of an adverse outcome** if the patient receives care in a less acute setting

Review of Status Determinations

Inpatient

- For Medicare: care that is considered reasonable and necessary for patients who require more than a 2-midnight stay in a hospital or who need treatment specified as inpatient only or "IPO" (i.e. specific surgical procedures)
- "Two Midnight Rule"
  - Applies to traditional Medicare only (and select MAP's in certain regions)
  - Remember the components of medical necessity
  - You expect the patient to stay for **at least 2 midnights of medically necessary care** that can only be delivered in a hospital setting
  - Exceptions: patient left AMA, death, transfer in/out of an outside facility and already crossed the midnights, patient is transitioning to NEW hospice care, **patient improved quicker than expected (*** this one requires extensive supporting documentation)**

The Key Components of Medical Necessity

The **severity of the illness** which brought the patient to the hospital

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Review of Status Determinations

Inpatient

- Inpatient status does NOT include:
  - Failure to thrive
  - Delays of care in waiting for consultants/test results
  - Delays of care due to weekend/holidays/staffing
  - Admission for expedited workup for a stable patient
  - Admission for patient's and/or provider's convenience
  - Management of chronic issues and/or chronic symptoms
  - Social issues / Placement after being medically cleared / Custodial care / Other barriers to discharge

Review of Status Determinations

Outpatient in a Bed / Bedded Outpatient

- Patients who meet for neither inpatient or observation, but are unsafe to discharge
- Typically post-operative patients
- This status should NOT be used if the patient comes through the ED
- These patients can be converted from OPIB to IP if necessary
  - In other words, they do not have to progress from OPIB → OBS → IP
  - For Medicare, just follow the 2-midnight rule

Why Not Just Admit Everyone to Inpatient?

Medicare: Recovery Auditor Contractors (RACs)

- Review claims for inpatient stays and determine if the admission to the hospital was medically reasonable and necessary
- If a RAC determines that the inpatient admission was not necessary and the care should have been provided on an outpatient basis, then the inpatient claim would be denied
- $ 3 billion / yr recovered for Medicare

Why Not Just Admit Everyone to Inpatient?

Commercial: Pre- and Post-Bill Denials

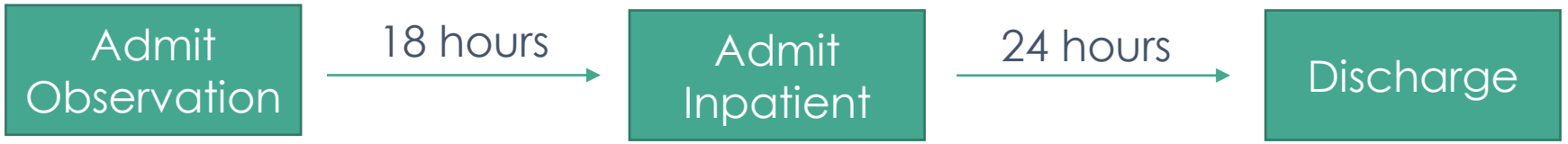
- Appeals process is expensive
  - Peer to peer for pre-bill denials
  - Written appeals are time consuming
- Insurance companies know that most hospitals have difficulty keeping up with denials
- Denial management has experienced a significant increase in efforts in recent years as a result

What Are Our Options If We Are Conservative at the Time of Admission?

(Why not just admit everyone to observation and convert to inpatient later?)

Initial admission order:

observation, then converted to inpatient



- Looks like a 1-day stay on the bill → therefore increased risk of audit
  - RN CM's enter an Occurrence Code 72
- Loss of revenue associated with observation care (reimbursed at lower rate) – specifically for commercial insurances

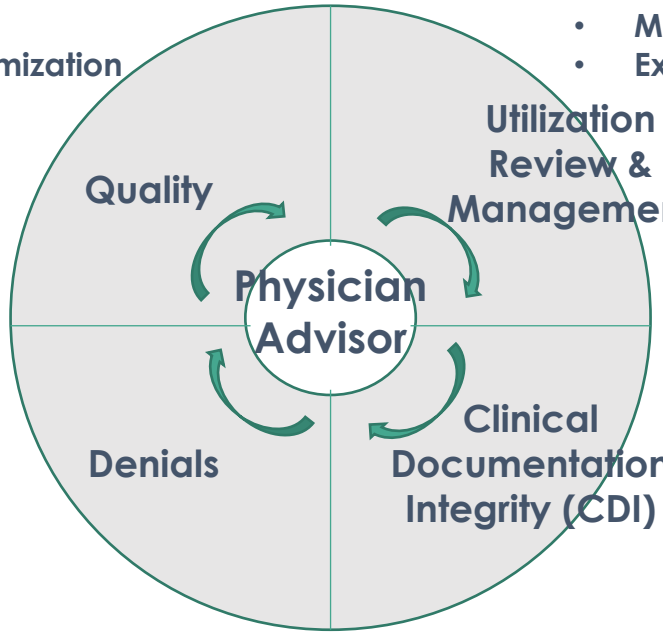
Condition Code 44 ("Code 44" or "CC44")

- A means of changing an inpatient status to observation status for Medicare patients
- Rule has been in place since September 2004
- Allows a status change without the need for the hospital to self-deny and bill limited items under Medicare Part B billing (an "M1")
- It must occur prior to the discharge order being written
- The hospital cannot have submitted a bill for inpatient services
- The attending physician/primary provider:
  - Must agree with the change in status
  - Must note their agreement and change the order in the medical record
  - The patient must be notified in writing of the change in status prior to discharge (Medicare Outpatient Observation Notice; MOON)
- If the attending does not agree:
  - Two members of the UM committee may overrule the attending, but the patient will remain an inpatient on record and the hospital will need to self-deny

Physician Advisors

- Patient safety indicators
- Hospital-acquired conditions
- Mortality risk adjustment optimization

- Status assignment
- Medical necessity/Transition Management
- Extended stay reviews

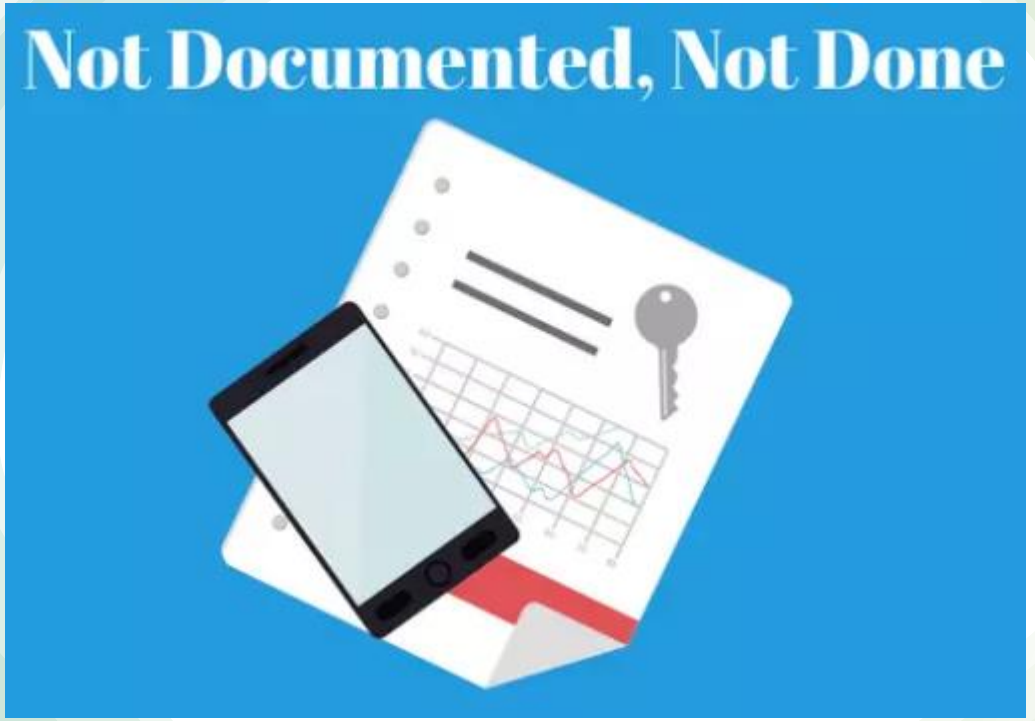


- Peer to peer support
- Appeals support
- Contract review

- Documentation education
- Case reviews
- Query support

Status Determination and Documentation:
Why Should You Care?

- An appropriate status recommendation cannot be substantiated without adequate documentation and supporting information from the treating providers
  - In other words, it can only be based on information that is actually in the patient's chart, so…
- **If you treated it, DOCUMENT IT**
  - **"If you think it, ink it"**
- If it isn't documented, IT DOESN'T EXIST



- On a DAILY basis, a patient's chart should contain documentation to:
  - Justify admission and continued hospitalization
  - Support the diagnosis
  - Describe the patient's progress and response to medications and services
  - Resolve those issues that are no longer active

- All patients should be billed fairly and appropriately
- Providers should follow current CMS guidelines and regulations when placing status orders
  - Not doing so deliberately is considered overbilling and Medicare fraud
- If a hospital is not following CMS guidelines, then it is at risk for not being compliant with Medicare's Conditions of Participation

Status Determination and Documentation – Case Example

Patient is OBS – flip to IP?

- "You can change to inpatient; the patient is staying another midnight. Home Health Care needs to be set up."

Patient is OBS – flip to IP?

- "The patient continues to require inpatient level of care due to inability to safely mobilize and for continued need for IV fluids. Additionally we are waiting to start full anticoagulation until tomorrow due to concern for bleeding. Tomorrow we plan to restart Eliquis and we will also take the Robert Jones dressing down and transition to a fiberglass cast. At that time, this will allow us to visualize the incisions to ensure that there is adequate hemostasis. We are concerned for continued bleeding upon resuming anticoagulation and thus need to keep the patient at an inpatient level of care to ensure he does not have an unexpected drop in hemoglobin."

Financial Impact on Patients: Why Does Admission Status Matter?

Observation

Patient pays Part B annual deductible + 20% of Medicare payment for observation services + 20% of physician billing + 20% of self-administered meds

- Medicare payment:
  - Payment for observation services to hospital (approx. $2300)
  - Physician billing (approx. $300)
  - Self-administered meds (approx. $100)
- What the patient owes:
  - Annual Part B deductible ($233)
  - 20% of Medicare payment ($460)
  - 20% of physician billing ($60)
  - 20% of self-administered meds ($20)
  - **Total = $773**

Inpatient

Patient pays Part A deductible + 20% of physician billing

(A benefit period BEGINS when the patient is admitted to the hospital and ENDS when they have not received any inpatient hospital or SNF services for 60 consecutive days) *** this is why it is important if a patient is running out of Medicare days

- Medicare payment:
  - DRG payment to hospital (payment varies…hint about the importance of CDI…)
  - Physician billing (approx. $500)
- What the patient owes:
  - Part A deductible ($1556)
  - 20% of physician billing ($100)
  - **Total = $1656**

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Inpatient

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(payment varies…hint
CDI…)
500)

20% of physician billing ($100)
- **Total = $1656**

Length of Stay:
Why Does Having a Longer Than Expected LOS Matter?

- Consumes hospital capacity otherwise used for additional patient care
- Increases variable-direct costs ($350-$550 per day on average)
    - E.G.: meals, medication, incremental staff time, laundry, facility services, etc.
- Increases patient risk of hospital-acquired issues
- What is an appropriate LOS benchmark for a hospital?
    - You cannot simply compare average LOS (ALOS) among similar facilities because every hospital has a different mix of patients and different acuity (remember CMI)
- The importance of Observed LOS to Expected LOS
    - How can your clinical documentation make an impact?

Let's Return To Medical Necessity:

It Impacts More Than Admission Status

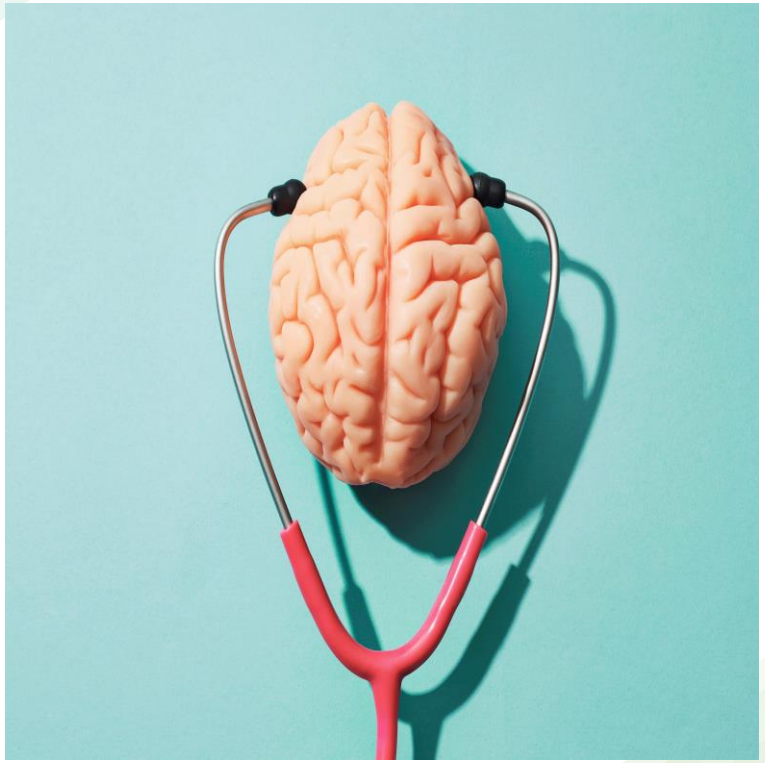
The **severity of the illness** which brought the patient to the hospital

The **intensity of the hospital services** provided

The **probability of an adverse outcome** if the patient receives care in a less acute setting

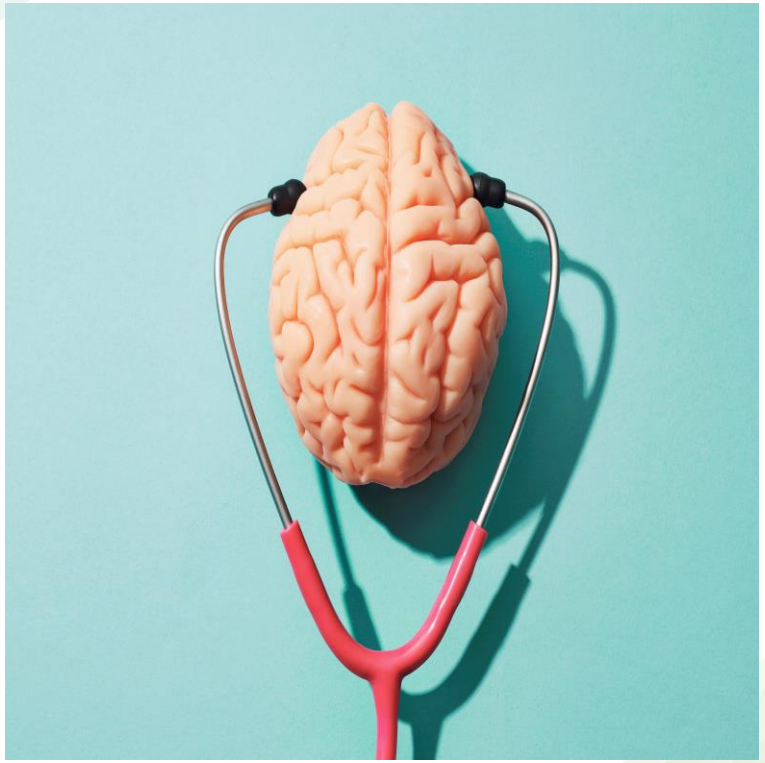
What Is Medical Necessity and Why Should You Care?

- CMS is required by the Social Security Act to ensure payment is made only for those medical services that are reasonable and medically necessary
- Health plans focus on appropriate utilization of resources by reimbursing only those services covered by the plan and are deemed to be medically necessary
- According to CMS, medical necessity are services that:
  - ✓ Are proper, needed, and provided for the diagnosis, direct care, or treatment of a patient's medical condition
  - ✓ Per CMS, the medical record must show "sufficient documentation...rooted in good medical practice."
  - ✓ Are not mainly for the convenience of the patient / provider / healthcare system



What Is Medical Necessity and Why Should You Care?

- For high quality medical necessity documentation, chart "SMART." Be **S**pecific, be **M**indful, be **A**ccurate, be **R**elevant, and be **T**imely
  - The issue is not the intervention; it is the need for the intervention in the hospital setting
  - **The ultimate question: why does your patient need to be admitted to the hospital, and then, why do they need to stay there?**
- Examples:
  - The patient is still having nausea/vomiting, and therefore cannot tolerate any PO meds. They require IV antiemetics, IV fluids, and we are continuing clear liquids only for now.
  - Blood cultures now positive for GPC. Will start IV antibiotics while we await further speciation.
  - Continue to wean high-flow oxygen; baseline O2 is 3L (continuous).
  - The patient became confused overnight and required Haldol. He remains confused this AM. Will pursue further workup with a Neuro consult and CT head. Consider EEG.



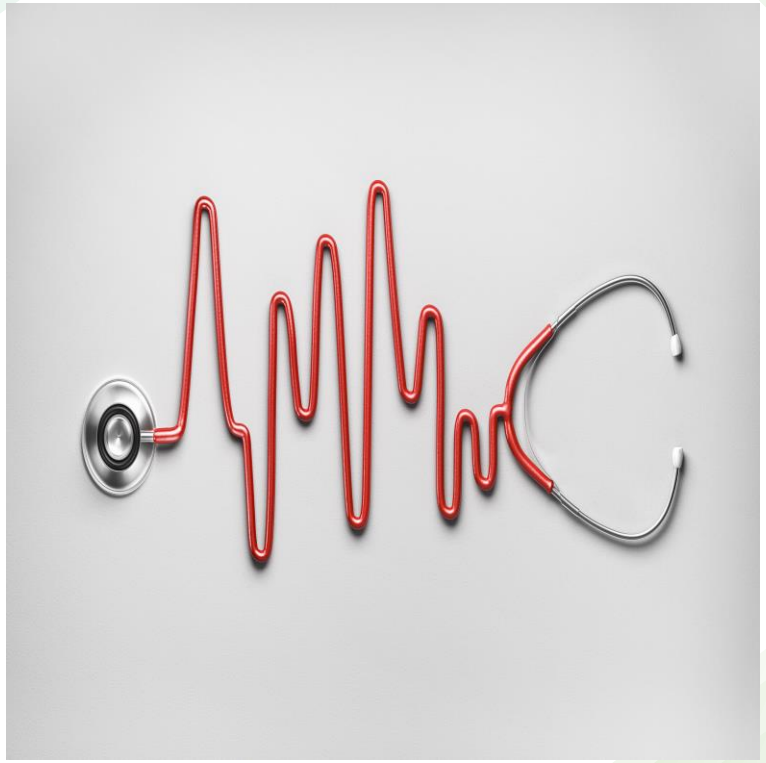
Example of Denial Due To Lack of Medical Necessity Documentation

- 50-year-old male with history of ADHD (on prescription amphetamines for many years) and narcolepsy presents with CHF. Patient reports flu-like symptoms 8 weeks ago; he improved initially but couple of weeks later notice fatigue and SOB. He was hospitalized at an OSH, where he was diagnosed with CHF with reduced EF of about 20% and was initiated on Lasix therapy. He left there AMA and presented to MCA.
- ED provider: "Given his significant heart failure, fairly recent diagnosis, and lack of medications, the plan to admit the patient for further evaluation and treatment."
- Physical exam and lab documentation included: "No apparent cardiopulmonary distress. No edema. Troponin unremarkable x2. "
- Plan included: "Cardiac MRI. Cath on Monday. Guideline-directed medical therapy initiation and titration as tolerated…may benefit from afterload reduction, considering hydralazine/isosorbide given AKI"
- Supplemental O2 given (ranged from 2 – 3.5L), but he discharged on room air
- Patient was already euvolemic on arrival to the ED. No IV diuretics given during entire admission.
- **Patient admitted as inpatient and DC'd 4 days later. Denial received from insurance for inpatient status.**

Example of Denial Due To Lack of Medical Necessity Documentation

- 75 y.o. female with a PHMx significant for a fall in January 2022 resulting in SDH. She was seen at an OSH and underwent burr hole craniotomy for SDH evacuation. Patient was DC'd to rehab and at F/U appointment she was noted to have an infected wound at surgical site. She underwent revision surgery of her wound and was started on IV Abx. She transitioned to PO Abx, but the wound started to dehisce again. She was scheduled for surgery twice at the OSH but they cancelled both procedures and now her wound is open to the cranial plate placed over the burr hole.
- On 8/25, ID documented: "Currently, she is not toxic and is hemodynamically stable. Her wound does not look infected, clean borders without redness or warmth. No purulence on gross examination. She would benefit of final closure of her wound with a short course of oral antibiotic therapy."
- On 8/25 and 8/26: Neurosurgery documented: "Daily dressing changes with betadine and wound lavage."
- On 8/27: Neurosurgery documented "Next dressing 8/29. Current plan is for surgery 8/31."
- Per UM/Denials RN: "Washout and revision surgery is a combination of both Plastic Surgery and Neurosurgery. Surgery not scheduled until 8/31. I'm not sure of the reason for the delay based upon the documentation from the Practice."
- **Denial received from insurance from 8/24 forward for delay in completing washout and revision.**

Medical Necessity:
How to Make Your (Patient's) Case Via Documentation

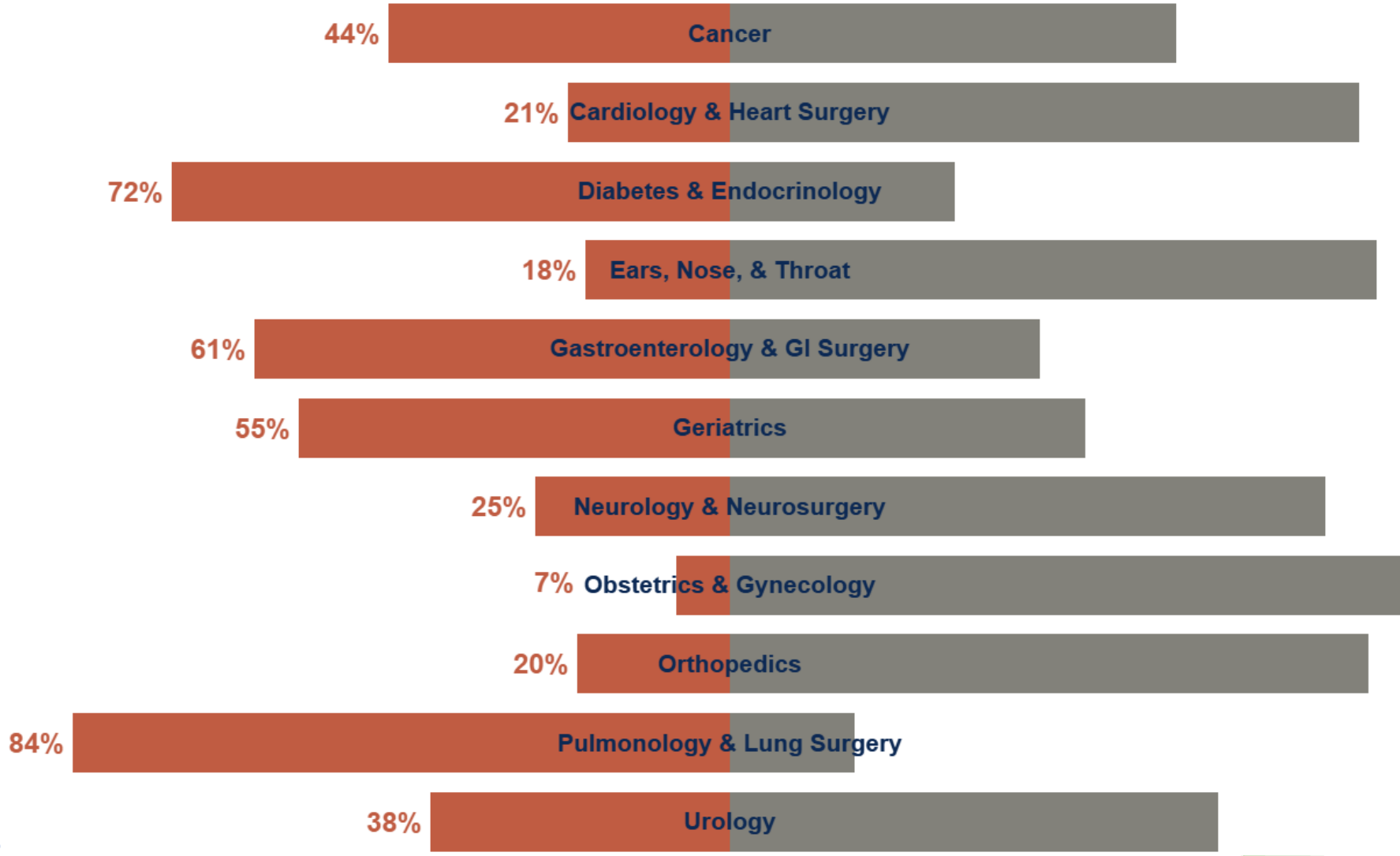


- All is well…but is it?
  - 82 y/o female with PMHx ischemic cardiomyopathy and Afib; presents with SOB 2/2 acute diastolic heart failure
  - Instead of…
    - "The patient has improved. She no longer feels SOB at rest. She denies CP or cough."
    - "Faint crackles in B/L lung bases. Legs with trace edema."
    - Plan: continue furosemide 80 mg IV BID
  - Document subjective symptoms precisely. Try this…
    - "Patient continues to feel SOB with exertion, although improved from yesterday and no longer SOB at rest. She notes that her breathing is still at 50% of her baseline."
- The stagnant note
  - 80 y/o male with PMHx HTN, CKD stage II; presents with weight loss, nausea, and dysphagia
  - Instead of…
    - The same A/P is there for 3 days…"Dysphagia, weight loss, nausea. Symptoms present over few months. Likely oropharyngeal, plan for swallow eval. Consider EGD if negative." This is hard to defend in the event of a denial.
  - Document the justification for the ongoing stay. Try this…
    - "The patient is not tolerating adequate PO intake due to ongoing nausea. He remains dehydrated; we will continue IV antiemetics and bolus with IVF. Consult GI due to continued poor PO intake. Consult nutrition.
- The buried plan
  - "Note bloat" and repeating the patient's initial presentation and workup thus far - continuing to add to the list rather than updating it
  - Summarize your findings and highlight the action plan. Try this…
    - "Severe protein-calorie malnutrition; patient is at risk for refeeding syndrome. Closely monitor electrolytes.

Impact of Provider Documentation: Clinical Documentation Integrity (CDI)

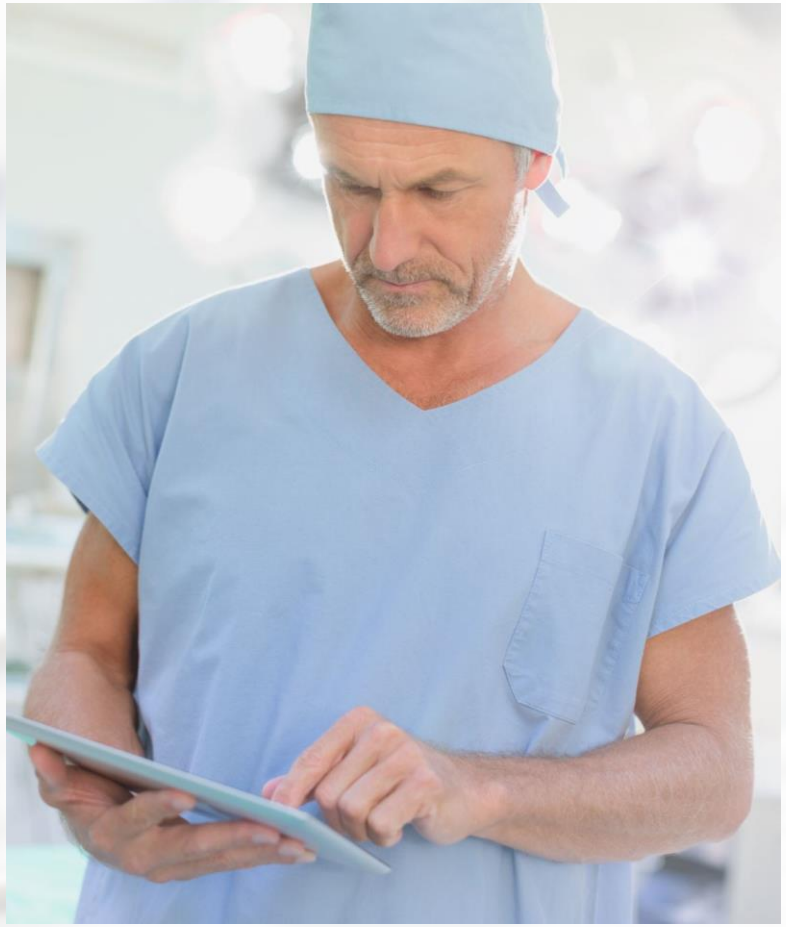
- Why do inpatient providers matter?
- Importance of CDI on DRG capture and its impact on other metrics
- Some definitions to be familiar with
- Case examples

Percentage of patients seen by Hospital Internal Medicine vs. Other Service Lines



1/1/2021 – 8/8/2022

Purpose of Clinical Documentation Integrity



- To ensure that health records accurately reflect the clinical scenarios ***to support continuity of care***
- To completely and accurately represent the hospitalization which will lead to ***appropriate coding and billing***
- To ensure ***quality scores***, which are based on billing data, accurately reflect the care provided
- To validate medical records documentation to better ***defend those that are audited*** by external agencies

DOCUMENTATION IMPACTS

Quality Scores:
Readmissions
Mortality
PSIs

Medical Necessity
Length of Stay

Regulatory
Compliance

Communication

Professional Billing
& Coding

Research

Insurance Denials
& Medical Necessity

Hospital &
Provider Profiles

Severity of Illness
(SOI)
Risk of Mortality
(ROM)

Legal Record

Reimbursement

Value-Based
Purchasing

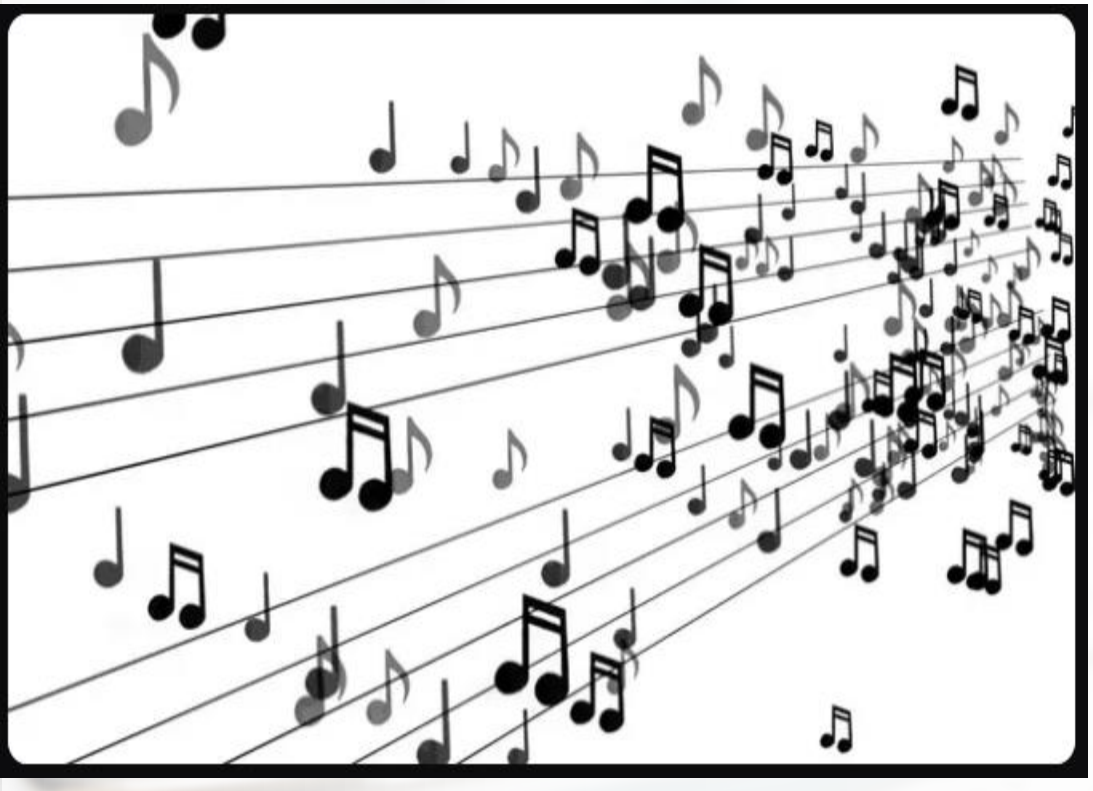
Glossary of terms

- **APR-DRG:** All Patient Refined Diagnosis Related Group is a payment groups designed for the *Medicaid* population. Payment is calculated based on severity of illness
- **CC:** Complication/Comorbidity. A classification of diagnosis codes with a high acuity assignment but less than an MCC code.
- **CDIS**: Clinical Documentation Improvement Specialist. Achieves complete and accurate documentation through documentation reviews and education of patient care team members.
- **HAC:** A condition or complication that develops during a hospital stay than can negatively impact reimbursement and quality metrics
- **HCC**: Hierarchical Condition Category. Risk-adjusted reimbursement model based on chronic and cumulative conditions called "hierarchical condition categories."
- **ICD-10 ICD:** (International Classification of Diseases) is the global health information standard for mortality and morbidity statistics and is used in clinical care and research to define diseases and study disease patterns, as well as manage health care, monitor outcomes and allocate resources.
- **LOS:** Length of Stay. Can be calculated statistically as ALOS (average length of stay) or GMLOS (geometric mean length of stay, removing outliers).
- **MCC:** Major Complication/Comorbidity. A classification of diagnosis codes with highest acuity assignment.
- **MS-DRG**: The most widely used reimbursement payment system in healthcare using a three-tiered system which can be impacted by comorbid conditions/ complications or major comorbid conditions/ complications.
- **PSI**: Patient Safety Indicators provide information on potentially avoidable safety events that represent opportunities for improvement in the delivery of care.
- **ROM**: Risk of Mortality. Likelihood of dying. Calculated with 1-4 scoring system.
- **SOI**: Severity of Illness. The extent of physiologic decompensation or organ system loss of function. Calculated with 1-4 scoring system.

Purpose of CDI and Building a DRG

- Why does hospital provider documentation matter?
- https://www.youtube.com/watch?v=kOHAOXmuyyE

M.U.S.I.C. in Differential Diagnosis Generation



- **M**anifestation
  - E.G.: sepsis, heart failure, chest pain, angina
- **U**nderlying cause or pathology
  - E.G.: UTI, alcoholic cardiomyopathy, GERD, coronary atherosclerosis
- **S**everity or **S**pecificity
  - E.G.: severe sepsis, uncontrolled diabetes, systolic or diastolic heart failure
- **I**nstigating or precipitating cause
  - Indwelling Foley cath, NSAID use, carbon monoxide poisoning
- **C**omplications or **C**onsequences
  - Septic shock, diabetic neuropathy

When documenting a diagnosis, place it in one of these categories and then look for the other four, linking them with terms such as "due to," "resulting in," and the like

Courtesy of CDIMD Physician Champions

Case Example

- Mr. Jackson is a 67-year-old man with COPD and CHF (EF 38%), who presented to the ED with 2 days of shortness of breath, confusion and a low-grade fever.
- SNF staff reported that he was in his usual health until two days ago when he had a coughing spell while eating. The next morning, he was confused and lethargic. His prescribed oxygen was increased from 2 L to 4 L. He continued to feel poorly and had a low-grade fever of 100° F with increasing confusion, prompting transport to the ED.

Physical Exam:

- General: Awake and confused, oriented to self only. Thin and frail, appears older than stated age.
- Lungs: Diffuse wheezes. Crackles in the right base. Tripoding and unable to speak in full sentences.
- Heart: Regular. No murmurs.
- Extremities: No edema in the legs.

Labs:

Na: 130
K: 4.5
BUN: 28
Cr: 1.2
WBC: 12.1
HGB: 10.1
PLT: 217

Vital Signs:

Temp: 102° F
HR: 102
RR: 24
BP: 125/75
SpO_2: 89% on 4L
BMI: 18

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Non-specific Documentation

Principle Diagnosis	ICD-10 Code	MCC/CC/ HCC	Mortality Risk Score
Exacerbation of COPD	J441		
Secondary Diagnoses			
Disoriented	R410		2
Lethargy	R5383		
Heart failure, unspecified	I509	HCC	6
Frailty	R54		
Fever, unspecified	R509		

DRG 192: COPD w/o CC/MCC
Length of Stay: 2.4 days
Severity of Illness/Risk of Mortality: 1/1
30-day Expected Mortality Risk Score: 8 (possible points 100)
Relative weight: 0.69
Reimbursement: X
HCC: 0.66

Optimal Documentation

Principle Diagnosis	ICD-10 Code	MCC/CC/ HCC	Mortality Risk Score
Aspiration Pneumonia	J690		
Secondary Diagnoses			
Metabolic Encephalopathy	G9341	MCC	10
Acute hypoxic resp failure	J9601	MCC, HCC	
Severe malnutrition	E43	MCC, HCC	11
COPD w/ exacerbation	J441	CC, HCC	3
Hyponatremia	E871	CC	4
Chronic systolic heart failure	I5022	CC, HCC	6
Chronic iron deficiency anemia	D50.9		1

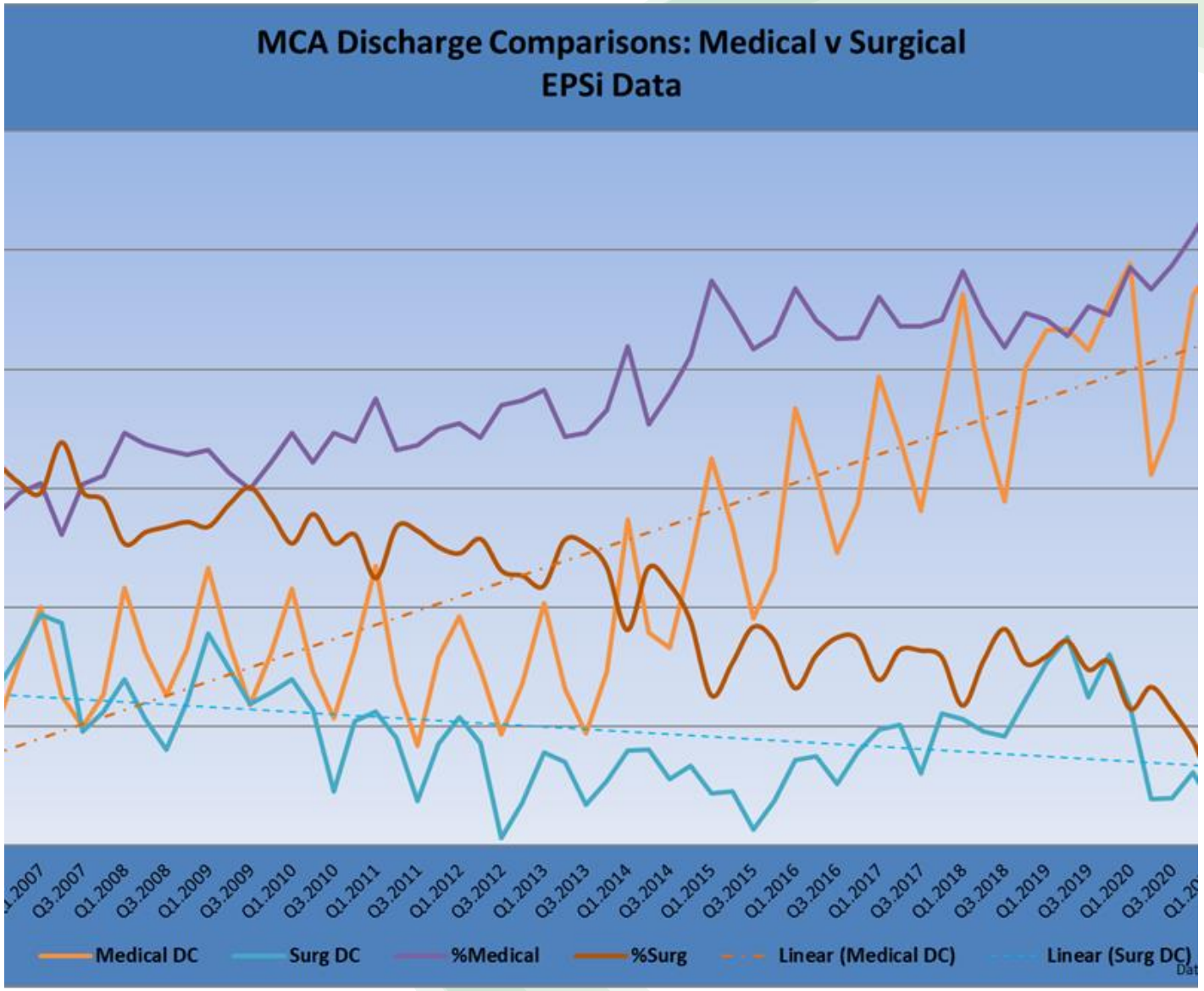
DRG 177: Resp Infection & Inflammation w/MCC
Length of Stay: 5.4 days
Severity of Illness/Risk of Mortality: 4/4
30-day Expected Mortality Risk Score: 31 (possible points 100)
Relative weight: 1.85
Reimbursement: 2.5X
HCC: 1.92

THE IMPACT OF INPATIENT PROVIDERS

3

DISCHARGES, READMISSIONS, AND LENGTH OF STAY

Discharge Comparisons



Readmission Reduction, Length of Stay, and Healthcare Costs

What measures are included in the Hospital Readmissions Reduction Program (HRRP)?

- Acute MI
- COPD
- Heart Failure
- Pneumonia
- CABG
- THA / TKA

READMISSIONS

Per CMS.gov and the Hospital Readmissions Reduction Program (HRRP), a 30-day risk standardized unplanned readmission includes any unplanned readmissions that happen within 30 days of discharge from the index (i.e. initial) admission, AND, patients who are readmitted to the same hospital or other applicable acute care hospital for any reason.

LENGTH OF STAY

The length of an inpatient episode of care, calculated from the day of admission to the day of discharge, and based on the number of nights spent in the hospital.

HEALTHCARE COSTS

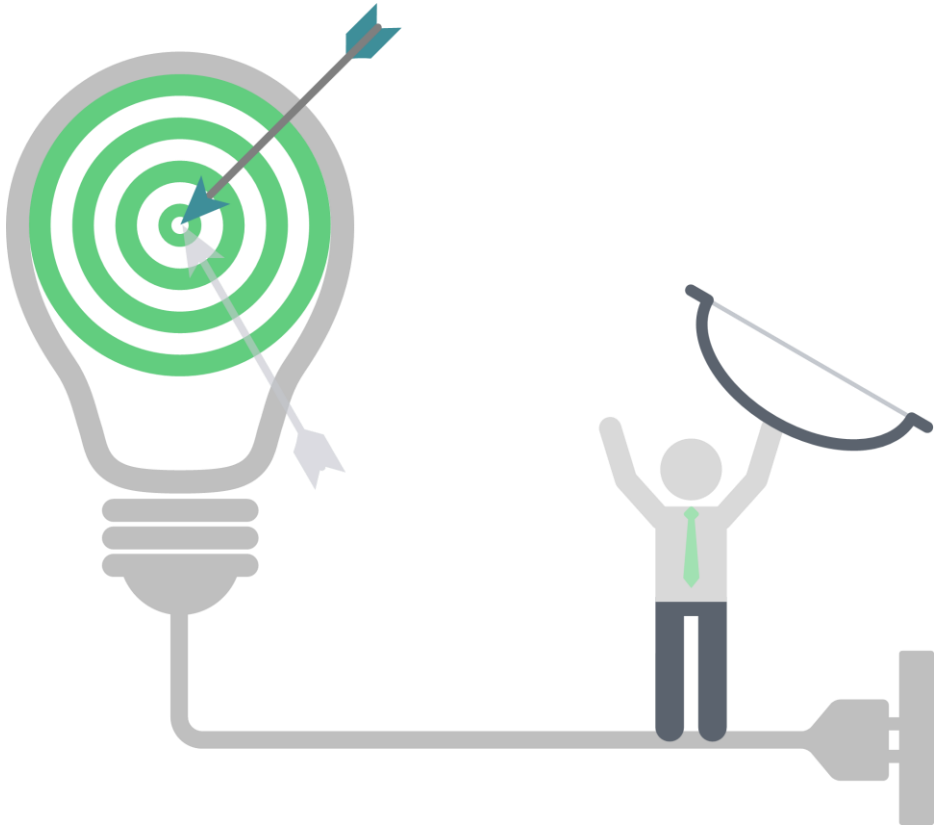
Such as: hospital care, physician and clinical services, prescription drugs, other health / residential / personal care services, skilled nursing facilities, retirement communities, home health care

The ALOS is generally very familiar. It is simple arithmetic mean or what most people refer to as the average. The length of stay for the patients in question are added together and divided by the number of patients.

The GMLOS is a little more complicated. Geometric mean is a statistical/mathematical term that is applied in many other areas outside of health care. This is calculated by multiplying all of the lengths of stay and then taking the nth root of that number (where n=number of patients).

So why does Medicare use the GMLOS? The advantage of the GMLOS is that it will minimize the impact of outliers. If the number of patients is relatively low, one patient with an uncharacteristically long or short LOS will significantly increase or decrease the ALOS respectively, but the effect on the GMLOS will be less. Medicare has to determine "appropriate" LOS based on a large amount of data that includes outliers on both extremes. The goal is to get to a number that can be utilized in the DRG payment formula. GMLOS is the best method for that purpose.

CARE MANAGEMENT



4

CARE MANAGEMENT & HOSPITALIST COLLABORATION

Case Example

76 YEAR OLD FEMALE

Patient has a past medical history significant for CAD S/P stenting, HTN, HLD, COPD, GERD, and oral carcinoma S/P resection. She presented to the ED with a one-week history of falling and bilateral lower extremity weakness. She had fallen 3-4 times at home. She also notes an unintentional weight loss of 15-20 pounds over the past month and therefore had increased her calorie intake (including eating banana splits) to try to gain weight. She was in contact with her PCP, who initially thought she may have had a TIA. She started to use a walker at home because of fear of falling. She specifically noted that she would fall to the right during these episodes. She had developed headaches over the past week as well. Her PCP therefore directed her to go to the ED.

WORKUP

Upon arrival to the ED, CT of the head revealed a right frontal mass with vasogenic edema, concerning for either a primary brain neoplasm versus metastatic disease. CT of the abdomen/pelvis noted small bilateral adrenal lesions suggestive of adenomas. CT of the chest showed an anterior segment left upper lobe lung mass highly suggestive of primary lung malignancy in the setting of emphysema with nodal metastatic disease and likely pulmonary metastasis within the left lower lobe. Also visualized were additional subcentimeter upper lobe groundglass opacities, likely preinvasive adenocarcinoma spectrum lesions.

What are the concerns about this patient?

What discharge needs might she have?

Case Example

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What discharge needs might she have?

CASE MANAGEMENT "OFFICIAL" DEFINITION

"Case Management in health care delivery systems is a collaborative practice including patients, caregivers, nurses, social workers, physicians, payers, support staff, other practitioners and the community. The Case Management process facilitates communication and care coordination along a continuum through effective transitional care management. Recognizing the patient's right to self-determination, the significance of the social determinants of health and the complexities of care, the goals of Case Management include the achievement of optimal health, access to services, and appropriate utilization of resources."

The ACMA's official definition of Case Management

CARE MANAGEMENT SCOPE OF SERVICES

- Utilization Management (UM)
- Resource Management
- Addressing psycho-social-financial-spiritual needs
- Tracking/reporting regulatory compliance and quality indicators
- Denial Management / Prevention
- Facilitation of transition care / discharge process
- Readmission reviews / prevention
- Spiritual care / chaplain services
- Community provider relationships (you may have preferred providers)
- Participation in charity care approval process

CARE MANAGEMENT IS THE LINK FOR OPTIMAL CARE

HOSPITAL

Care Coordination Team

Medical Director

Quality

Ethics

Revenue Cycle

Hospital Administrator

Nursing

Medical Practice

Chief Nursing Officer

Office of Patient Experience

…And the Hospitalist is their hospital partner

Care Management Team

COMMUNITY

Community Medical Providers

Payer Case Management

Skilled Nursing Facilities

Palliative Care/Hospice

Long-Term Acute Care

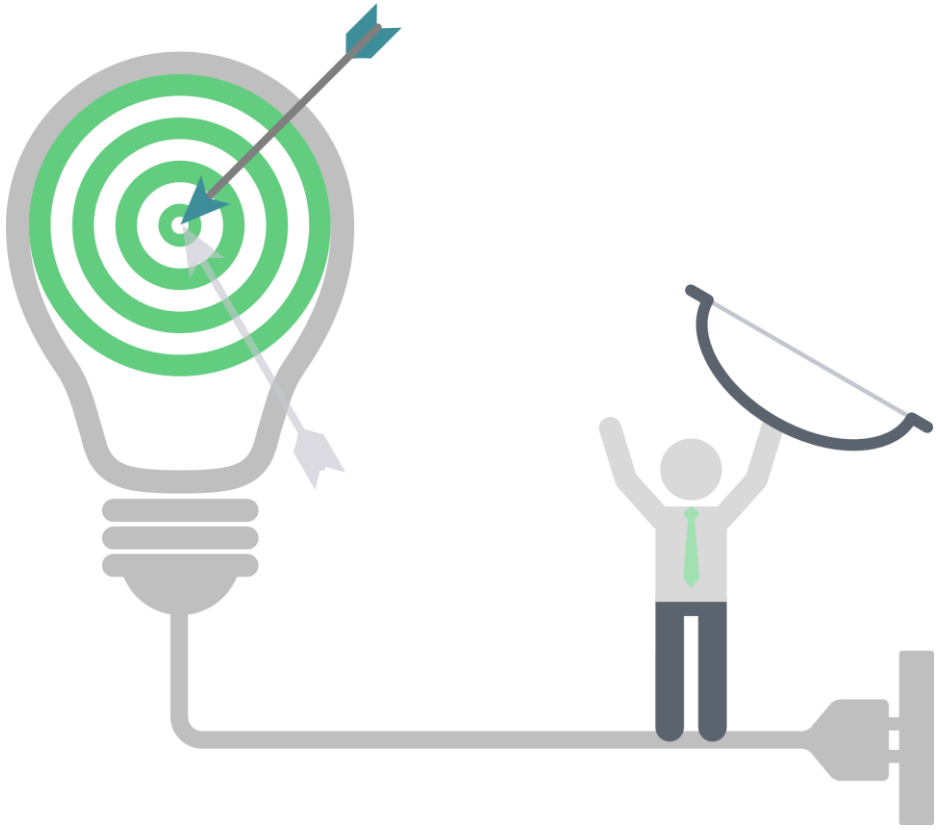
Home Health Agencies

Infusion Companies

Durable Medical Equipment

Community Agencies

DISPOSITION PLANNING



5

NEXT SITE OF CARE DECISION PROCESS

Post-Acute Care

- **Rehabilitation or palliative services that beneficiaries receive after, or in some cases instead of, a stay in an acute care hospital**
- **Things to consider first:**
  - Does the patient meet criteria for these services?
  - Does the patient need DME? Home oxygen? Wound VAC? Life vest?
  - Prior auth(s) needed?
- **Settings**
  - Home health services (HHC)
  - Group home (can also add HHC)
  - Skilled nursing facility (SNF)
    - Can be long-term care
  - Acute rehabilitation (IRF)
  - Long-term acute care hospital (LTACH)
  - Hospice care
    - Inpatient
    - Home with hospice (includes group home)
    - SNF with hospice
  - Hospital at Home
  - Outpatient IV infusions (ambulatory infusion center)

Skilled Nursing Facility (SNF) Placement

- Medicare
  - To qualify for SNF placement, Medicare beneficiaries must meet the "3-day rule' before SNF admission
  - The 3 days do NOT include ED time, observation time, or the day of discharge
  - This equates to 3 consecutive midnights as an inpatient
- Commercial / MAP plans
  - The facility obtains the auth from the insurance company (not the hospital)
  - Care Management needs to send the SNF referral prior to Friday morning, or the patient very likely will remain in the hospital until after the weekend
- We are still under the current PHE CMS waiver for the 3-day prior inpatient hospitalization (currently extended through October 13, 2022)

Skilled Nursing Facility (SNF) Placement

Returning to a SNF after leaving

Bookmark

If you leave a skilled nursing facility (SNF) and return to that SNF or another one within 30 days, you do not need another three-day qualifying hospital stay. If you return after 30 days have passed, Medicare will not pay unless you have been in the hospital for another three-day qualifying stay in the 30 days before you enter the SNF.

Medicare will only cover your care in a SNF while you are there. If you need to leave the SNF for any reason, including going to the hospital, Medicare will not pay to hold your bed at the SNF. Also, though you may qualify for Medicare-covered SNF care after you leave the hospital, you may not be able to return to the same SNF, for instance if the SNF no longer has space for you.

In some cases, you may be able to save a bed at a SNF if you need to leave the SNF for a short period. The SNF can charge for this service, and you will be responsible for paying the full cost of the charge out of pocket. In some states, Medicaid may pay for the bed-hold. If you have Medicaid, contact your local Medicaid office for more information.

SPECIFIC TRANSFER SITUATIONS

SKILLED NURSING FACILITY (SNF)

- Start the process early
- 3-Midnight inpatient stay required
- Reasons:
  - IV Abx
  - PT / OT / ST
- What will Medicare pay for / insurance authorization

ACUTE REHABILITATION FACILITY (IRF)

- Does not require a 3-midnight inpatient stay
- Must tolerate 3 hours of daily rehabilitation
- What will Medicare pay for / insurance authorization

LONG-TERM ACUTE CARE HOSPITAL (LTACH)

- Requirements:
  - ≥3-night ICU stay
  - Multiple complex needs
  - Must stay at LTACH for least 30 days
- Complex need examples:
  - Trach
  - Vent weaning
  - Tube feeds
  - IV Abx
  - Therapies
  - Complex wound care

INPATIENT HOSPICE

- Patient need
  - Pain mgmt
  - Drains / Lines
  - Oxygen
  - Complex wounds
- Hospice agency assessment
- Family choice

HOSPITAL AT HOME

- A work in progress, but made great strides given the events of the past two years
- In its infancy at MCA; current patient requirements
  - Only certain insurance
  - Inpatient status
  - No plans for immediate discharge

OUTPATIENT CARE

6

POST-ACUTE FOLLOW UP VISITS

EXECUTIVE SUMMARY AND ANNUAL FINANCIAL VALUE

From May 1, 2020 to September 30, 2021, we have accomplished the following with this partnership:

13,059
Outreach Calls Made

82% (10,706)
Patients Reached Opening Question

78% (10,217)
Patients Reached First Clinical Question

71% (9,620)
Patients Completed the Call

1 Hours
Median Time to Intervene

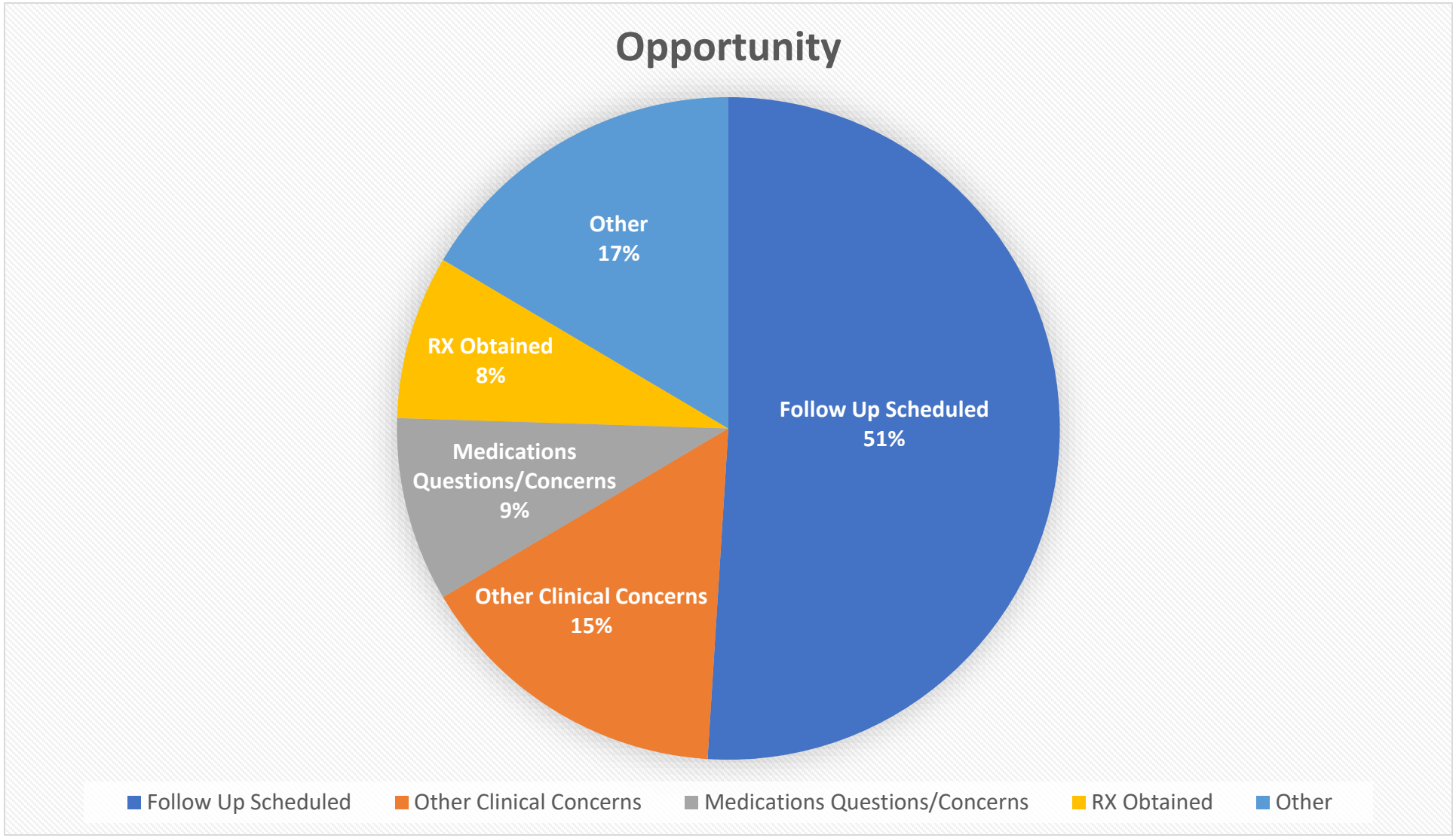
30%
Patients Requiring Intervention

READMISSIONS ANALYSIS KEY FINDINGS

- There is a demonstrable need to follow up with patients' post-discharge
- Patients who engage with the post-discharge outreach program are **28% less likely to readmit within thirty days.**
- **Callback staff engaged with 86%** of patients that reported issues on the outreach call.
- Patients with issues who are called back within 2 hours have **20% less readmissions than patients called after 2 hours.**

Readmissions	Annual Readmissions Savings (Estimated - $10,000)	Annual Labor Cost for Callbacks		Return on Investment
~532 Readmissions Prevented Annually	$5,320,000	$300,000	$50,000	$4,970,000
~266 Prevented in 6 months annualized	Avg. cost of All Cause readmissions from hyperlinked study.	Assumes 3 employees making $100k annually	Manually calling just those patients who report issues takes approximately 17% of the time it would take to call all patients manually.	

AREAS OF OPPORTUNITY



Data from May 1, 2020 to September 30, 2021

Post-Acute Follow Up Visits

- Internal versus external systems
  - Does your system have internal or external post-acute facilities?
    - Often external facilities will want to do their own discharge planning
    - This is why inpatient providers' discharge instructions are even more important; this is where the necessary follow-up instructions are (i.e. the After-Visit Summary and/or the discharge summary)
  - For external patients, often the PCP's offices will want to hear directly from the patient before scheduling follow up appointments because patients tend to cancel the ones arranged by Care Management
  - Do you have agreements with outside agencies (e.g. DME, home oxygen, HHC)?
    - If not, you may want to consider this
    - If yes, this can be of great benefit for complex discharges

Post-Acute Follow Up Visits

Does your system include outpatient care?	E.G.: The Mayo patient versus the non-Mayo patient – this impacts who places post-acute visit orders • If yes, good communication with scheduling leadership could be of benefit • If no, who is the point of contact for outpatient scheduling? • Who writes those orders? The on-call provider? The discharging provider?
Crucial conversations with ED and ED leadership	What is the ED holding capacity? Are they willing to keep patients a bit longer to allow time for outpatient scheduling rather than admitting the patient? An issue for MCA was carving out space in outpatient provider calendars for acute visits Identify your most common specialties where ED providers are placing outpatient follow up orders •Focus attention on creating calendar space for those specialties •For MCA: GI, Cardiology, PM&R/Pain Mgmt, Neuro, Ortho Be descriptive and intentional with what "next available" means

Post-Acute Follow Up Visits

Medication Reconciliation

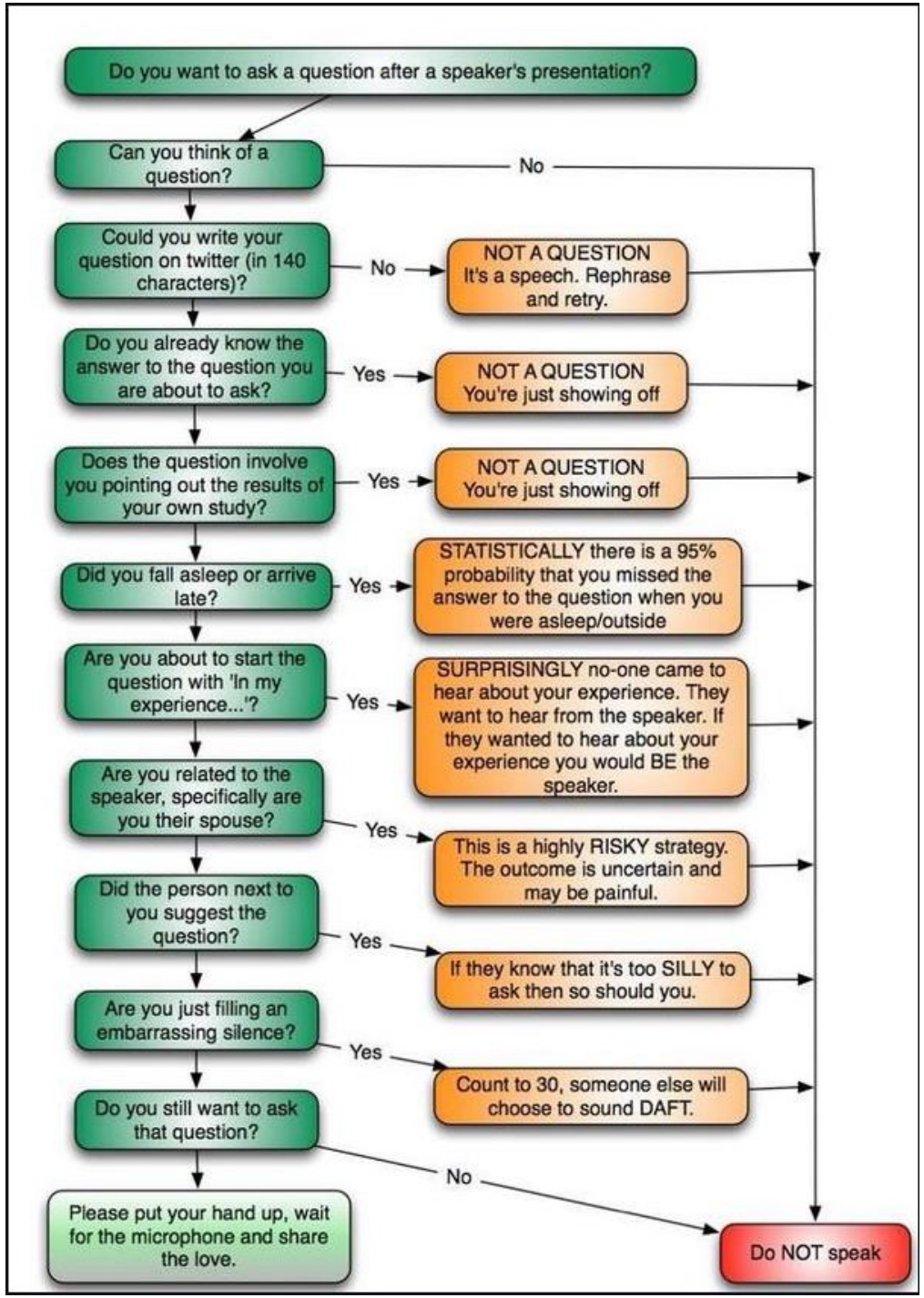
- Ensuring the discharge summary matches the After-Visit Summary (paperwork the patient and/or facility receive)
  - 1. Potassium has been low, and was only at 3.5 today. That is with Potassium chloride 40mEq given daily per the MAR. I see it isn't continued on Orders. Please clarify if it should be?
  - 2. Patient w/ A1c of 6.3%, was on sliding scale insulin per the MAR, no meds to address blood glucose on discharge Orders. Should sliding scale insulin or another med be on the Orders?
  - 3. Heparin 5,000 units q8hr per the MAR, omitted on Orders. Clarify if no longer needed?
  - 4. Duloxetine 60mg QHS given per the MAR, but Orders say 60mg QHS + 30mg daily? Please clarify are we increasing today?
  - 5. Gabapentin 100mg BID given per the MAR, discharge orders state to given 300mg BID. Are we increasing today?
  - 6. "Continue Folic acid & thiamine" per Mayo provider notes 4/18. Not listed on Orders. Clarify if these should be added?

Transportation

- Does your facility have its own transportation to post-acute facilities?
- Do the post-acute facilities rely on outside transportation agencies?
- Does the patient need transportation from their home to any of their post-acute appointments?

SPECIAL THANKS

- Cathleen Zehring, MM, BSN, ACM-RN, Care Management, CM Nurse Administrator
- The entire Mayo Clinic Arizona Care Management team
- Mayo Clinic Arizona Physician Advisors:
  - Rashi Arora, MD
  - Kenneth Mishark, MD
  - Collins Obioha, MD
  - Brittäne Valles, MD
- Mayo Clinic Enterprise Inpatient CDI Education Team



QUESTIONS & ANSWERS

Contact Information

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References

- https://sharing.mayoclinic.org/mayo-brothers-wisdom/
- Kwok, C. S., Abramov, D., & Parwani, P. (2020, December 17). Physician's Weekly. *Https://Www.physiciansweekly.com*. https://www.physiciansweekly.com/cost-of-inpatient-heart-failure-care-and-30-day-readmissions-in-the-united-states.
- Littlewood, D. (2018, November 27). Care Management – What Value Does It Bring to Your Practice and to Your Patients? *Https://Www.pamedsoc.org*. https://www.pamedsoc.org/list/articles/what-is-care-management.
- Loomer, B. (2019, January 24). Fifteen Ways to Show Your Value at Work [web log]. https://www.amanet.org/articles/fifteen-ways-to-show-your-value-at-work/.
- Spat, P. (2000). How to measure the value of case management. *Hospital Case Management*. https://www.reliasmedia.com/articles/61556-how-to-measure-the-value-of-case-management.
- https://mhg-university.blogspot.com/2020/03/ncov-19-and-medicare-2020.html
- https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf
- https://cpahalltalk.com/audit-documentation/
- https://www.freecodecamp.org/news/how-to-write-good-documentation/
- https://depositphotos.com/102771818/stock-illustration-its-complicated-red-stamp-text.html
- https://www.medicareinteractive.org/get-answers/medicare-covered-services/skilled-nursing-facility-snf-services/returning-to-a-snf-after-leaving