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Short-Stay Inpatient Rate is Zero? Time for Documentation Improvement

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The revised exceptions policy found in the 2016 Outpatient Prospective Payment System (OPPS) Final Rule (CMS-1633-F), which became effective Jan. 1, 2016, may change how providers determine patient status. The policy acknowledges specific situations in which inpatient status is appropriate even when the stay is less than two midnights, if supported by proper documentation. As a result, hospitals may need to reevaluate their documentation improvement programs.

The 2014 Inpatient Prospective Payment System (IPPS) Final Rule (CMS-1599-F) stated that hospital claims with lengths of stay less than two midnights were not generally considered appropriate for inpatient payment. But the landscape shifted a bit with CMS-1633-F, which included a change in policy to allow that admissions not meeting the two-midnight benchmark could still be considered inpatient if the medical record supports the admitting physician's determination that the patient requires inpatient care.

Under the policy change, for stays when the physician expects the patient to need less than two midnights of hospital care and the procedure is not on the inpatient-only list or on the national exception list, an inpatient admission would be "payable on a case-by-case basis under Medicare Part A in those circumstances under which the physician determines that an inpatient stay is warranted and the documentation in the medical record supports that an inpatient admission is necessary."

As a result, hospitals that have applied a strict time-clock approach to inpatient versus observation designations may want to reevaluate this approach. In October, the quality improvement organizations (QIOs) began patient status reviews for adjudicated claims from acute-care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities for dates of admission within the previous six months. We have already learned of QIOs issuing review results letters and approving claims for inpatient coverage when the length of stay was less than one midnight.

Can't Go By the Clock

On Dec. 31, 2015, the Centers for Medicare & Medicaid Services (CMS) issued sub-regulatory guidance titled, Reviewing Short Stay Hospital Claims for Patient Status: Admissions on or After Jan. 1, 2016. The guidance discussed the appropriateness of an inpatient admission in cases in which the medical record could support the need for inpatient care despite the expectation that the patient stay will span less than two midnights.

CMS specifically stated, under the revised exceptions policy, that Part A payment is appropriate on a case-by-case basis when the medical record supports the admitting physician's determination that the patient requires inpatient care, despite the lack of a two-midnight expectation. The QIOs will consider complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event to determine whether the medical record supports the need for inpatient hospital care.

Documentation, Not Duration

The key in all of this: Documentation. The QIOs will expect all supportive factors to be documented in the physician assessment and plan of care. Moving forward, it is critical that hospitals keep this in mind as they evaluate short-stay cases. If your hospital's one-midnight inpatient rate is zero, for example, you likely have a documentation improvement opportunity.

QIOs will be reviewing the entire medical record – not just the length of stay – to evaluate the reasonableness of the physician's expectations, but "entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission." In other words, it is essential that physicians' plans of care, treatment orders, and notes are documented completely and accurately early in the patient stay so that their determinations will hold up under auditor scrutiny.

Time for Documentation Improvement

While the QIOs have only been reviewing cases for a short time, early indications suggest they will look at more than just the clock. The QIOs have stated that the review process will include InterQual screening criteria and if any are unmet, a medical necessity review by a physician. Now is a good time to look for patterns in how your cases are determined and for potential gaps in your documentation process. A physician advisor review can help improve gaps in your utilization management (UM) process.

One straightforward way to test your UM process is to conduct a manual review of a broad selection of records. Select 30 or so cases. If you are placing all less-than-two-midnight cases in outpatient status, a second-level review by a physician advisor will probably be beneficial.

Not all less-than-two-midnight cases are the same, but hospitals can use documentation improvement and second-level physician review to make sure each patient status is accurate and appropriate.

About the Author

Dr. Ralph Wuebker serves as Chief Medical Officer of Executive Health Resources. In this role, Dr. Wuebker provides clinical leadership within the company and works closely with hospital leaders to ensure strong utilization review and compliance programs. Additionally, Dr. Wuebker oversees Executive Health Resources' Client Services teams, who provide onsite education for physicians, case managers, and hospital administrative personnel and help hospitals identify potential compliance vulnerabilities through ongoing internal audit.

An expert in CMS regulations, medical necessity compliance, utilization review, denials management, and program integrity efforts, Dr. Wuebker also serves as an industry thought leader and editorial advisor to the media, as well as a highly respected and distinguished industry speaker.