CASE STUDY #3 - Hirsch

Beneficiary is an 85 year old male who presents at 4 pm to the ED with shortness of breath. He is a widower and lives with his daughter who helps him manage his medications and ADLs. The patient has a history of congestive heart failure and is on an ACE Inhibitor, a beta blocker and an aldosterone antagonist. His last ECHO was 3 months ago with systolic dysfunction and an ejection fraction of 38%. In the ED, his pulse ox reading on arrival is 86%, HR 120 and RR 22. He has rales on exam and peripheral edema. Labs with a BNP of 800, CBC normal, Na 127, BUN 32 and Cr 2.2 (last month 20/1.2). EKG with sinus tachycardia and Troponin normal. CXR demonstrates Kerly B lines and small bilateral pleural effusions.

The ED doctor administers IV Lasix and the patient diureses 500 cc but HR remains over 100 and pulse ox under 90%. The ED doctor documents "acute exacerbation of systolic heart failure with tachycardia, hypoxemia and possible acute kidney injury. What is the correct status if the ED doctor determines the patient requires hospitalization? The patient is admitted because he has multiple abnormal vital signs and labs and is unlikely to stabilize in under 2 midnights.

The patient sends two midnights in the hospital and responds well. He is up and walking the halls and feels great. The attending writes a discharge order. But his daughter calls and insists the patient be kept in the hospital for another few days until she returns to town. She is informed that a discharge order has been written and she would have to appeal the discharge with the QIO, which she does. She calls the QIO who requests the records from the hospital. A day later they rule in the hospital's favor, stating the patient was stable for discharge. The patient is entitled to stay until noon the next day. That morning the daughter calls and says that now that her father has spent over 3 days in the hospital she wants him sent to a SNF for therapy. Does he qualify for his part A SNF benefit?

There is no answer to this question, CMS has said it is up to the QIO to determine if the additional days were medically necessary (which they determined that they were not, based on their upholding of the discharge) or a substantial departure from normal medical practice (which must be determined on a case-by-case basis).

Scenario #2: The same patient presents but less severe. He is placed on outpatient observation. After the first midnight, the attending rounds late in the day and finds that the patient has not improved much and the doctor wants to continue the IV Lasix. The patient is kept another midnight. No admission order is written. The next morning the patient is ready to go home and the doctor realizes he never wrote an admission order. He calls you for advice. What do you tell him?

This patient has a benchmark stay; two medically necessary midnights in the hospital. CMS has indicated that the physician should write an admission order, authenticate it and then write the discharge order. The hospital can then bill for the full DRG even though the patient spent no midnights as inpatient. Since the patient is being admitted as inpatient, the rules concerning the Important Message from Medicare apply; the patient must be given the document and given time to consider if he wishes to appeal his discharge.