CASE STUDY 1 - Meyerson

A 74 year old man arrives at the ED at 8 AM after the nurses at the nursing home where he permanently resides noted that "he didn't look right." He has a history of advanced dementia, benign prostatic hypertrophy, TURP, hypertension, COPD and peripheral vascular disease. His vital signs in the ED are BP 92/50, HR 86 (occasional premature beat), Temp 97.8 and O2 sat 94%. The patient is somewhat lethargic and unable to respond appropriately to questions but can follow simple commands. Physical exam demonstrates clear lungs, a grade 2 coarse systolic murmur at the base and absent pedal pulses. There is no edema. The lower extremities are cool but color is good. There are no focal neurological deficits. Labs show Hct 46, Hgb 15, WBC 11K. BUN 64, creatinine 2.1, Na 144, K 3.6. Urinalysis shows sp gr of 1.020, trace positive protein, 1+ leukocyte esterase and 5-10 WBC per HPF. Chest X-ray shows normal sized heart, vascular calcifications and no infiltrates.

Scenario #1. **What is the correct placement decision for this case -- inpatient, outpatient, outpatient with observation services, or discharge?**

Observation. Patient appears to have a change in mental status from baseline due to moderate dehydration. Unclear whether patient has a urinary tract infection or asymptomatic bacteruria but the ED physician decides to give IV Rocephin pending the result of cultures. The attending physician does not expect that it will require more than two days (one night) in the hospital to correct dehydration.

Scenario #2. The next morning, patient's temperature spikes to 102.4. Starts to have a wet cough. O2 sat drops to 89% on room air. STAT chest X-ray shows new RLL infiltrate. What is the correct placement decision -- inpatient, outpatient, outpatient with observation services, or discharge?

Inpatient. Pneumonia has "blossomed" as the patient was hydrated. The physician expects the patient to meet the 2 midnight benchmark. This elderly patient has health care acquired pneumonia and will likely require another 2 or 3 days or more of hospital care.

Scenario #3. The patient's family arrives from out of town at 6 PM on the second day and informs the doctor that Grandpa was enrolled in hospice and they want comfort measures in accordance with his advance directive, which he wrote 10 years ago when fully competent. The hospice nurse recommends inpatient hospice for terminal care.

How does the hospital bill?

Inpatient Part A. At the time of admission, a two midnight or longer stay was expected. The admission did not reach 2 midnights because of unanticipated transfer to hospice, which CMS has said does not alter the ability to bill inpatient Part A.