AR Systems, Inc
Training Library Presents

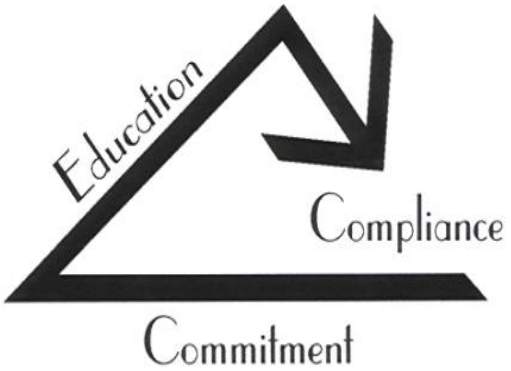
Utilization Review:

ER 1st Point of contact;

Direct admit challenges;

Surgery PLUS

Instructor:



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Where do inpts/observation patients come from?

- **ER & direct admits**/hot spot & **Inpt surgery**/more time to complete
- Attack these two hot spots with a pro-pt status focus, not placing and chasing. No patient is assigned a bed without pt status "blessed."
- Develop internal flows to attack:
  - **ER** – how much UR coverage ? 24/7? or utilize ER lead RNs or house supervisors.
  - **Direct** – patients are referred to the hospital directly from the physician's office or clinic –bypassing the ER and any onsite physician intervention.
  - **Inpt surgery** – all daily inpt surgery schedules are reviewed by UR to review outpt being scheduled as outpt & Inpt Only confirmation of CPT code assignment.

Let's get started–

– It is the 'why..because"

- Lots of 'chatter' but evaluate this process flow.
- ER 1st question: Can the pt go home safely from the ER? Assess the reasons the provider (ER doc consults with the provider directing care) and document same. (Risk factors, history of like condition with outcome, presenting factors, plan)
- OR 1st question: if not on the inpt only list, does the surgeon 'attest' that the pt will need 2 MN to resolve/recover from the surgery?
- Direct 1st question: Who made the pt status decision?
- 2nd question: If no, move to OBS and evaluate closely/ER. If no, start surgery as outpt, watch for the unplanned event and then assess- 2 MN? If yes, move to inpt with other elements of the inpt certification. If no, move to obs and watch closely for the rapid discharge or if unable to , move to inpt if a 2nd MN is required

UR role in the ED

- Can be a wide scope-imperative to define the role.
- Can be pulled in different directions – discharge planning and all difficult discharges
- If SW presence in ED – ensure differentiation of duties/responsibilities
- Vital that UR have a 'physical space' in the ED – interact with providers, nursing, EMT , other ancillary disciplines.
- Must be able to keep 'pulse' on all activity in ED.

UR Workflow in the ED

- Monitor patient activity occurring in the ED
- Identify potential 'in-hospital' patients – create communication system with the ER team.
- Review clinical presentation and findings/treatments of identified patients.
- If Traditional Medicare – apply the 2 MN rule. Watch closely for the 1st MN in the ER – as dialogue with the ordering/admitting provider will address 'need for 2nd MN.' (Benchmark)

More UR work flow in ER

- If the provider can estimate the care is for 2 MN/presumption, UR ensures the order clearly outlines the need/plan and helps facilitate the handoff from ER to hospitalists.
- For commercial payers – UR identifies the payer's rules for inpt and begins the conversation.
- If observation is the most appropriate status – no 2 MN need/Medicare or –does not meet the payer's definition of inpt/Clinical Guidelines – UR facilitates the order of same.

Better Practices in ER

- Establish a collaborative practice with SW.
- Set up triggers for readmission – both 30 day and rapid readmissions –establish processes for evaluating patients.
- Develop 'hand off' mechanism for ED UR and floor UR.
- Document all UR –physician conversation in the medical record. A dedicated area for UR to document patient status work – to support the ordering/admitting physician's documentation.

Challenges of Direct Admits

- If the hospital allows for direct admits from a clinic or office, what is the hospital's internal policy to protect from incorrect patient status assignment?
- Does the clinic call the house supervisor/clinical coordinator for bed placement? Is UR called prior to confirmation of inpt vs obs?
- Who does the direct contact with the office to receive the rationale behind the 'admit to inpt' or 'place in observation?"
- High risk for a) error in pt status determination especially based on individual payer rules, b) no documentation to support pt status determination.

Surgery scheduling joins the UR team- hot spots

- Inpt only – scheduling gets CPT code, researches, notifies UR if problems. (Or who does this ?)
- Outpt surgeries being scheduled as inpt – scheduling notifies UR of a potential problem.
- Inpt ordered but NOT on the inpt only list: Will it take 2 medically appropriate midnights for this surgery/post surgery? Must be determined prior to surgery.
- "Stay the night" being done routinely for outpt procedures with no medical reason. Accidently billed as a) observation, b) inpt or c) extended recovery.
- PATTERNS – UR tracks and trends concerns/non-compliant surgeons.
- PS Avoid "Frickin Free' but track by provider and type of procedure.

Observation challenges

- Medicare – Can the provider declare the pt will need 2 MNs at the onset of care? No, but not safe to go home? Then place in obs with an action plan. Monitor closely. As the 2nd MN approaches, safe to go home? If not, does the pt need a 2nd MN? If yes, CONVERT to inpt. 1st outpt MN does NOT count toward 3 MN SNF.
- Non-Medicare – whatever the payer determines –with some 'help."

Dedicated Outpt Ambulatory Beds = focus is outpt

- Change the focus of 'mini-inpt' to an outpt who is aggressively/rapidly being assessed/reassessed to determine to discharge safely or be admitted.
- Medicare – triggers in dedicated bed to 'actively involve the hospitalists/primary care provider' as each order is completed, move to an updated order: new order, d/c or admit. Watch closely as **the 2nd MN approaches.**
- Surgical cases – going home! Place routine recovery/after PACU rather than on the floor. Perception: not an inpt.
- Dedicated staff (Hospitalists, UR, Clinical) and focus on outpt and rapid discharge or timely conversion.
- Recovery beyond 'routine (usually 4-6 hrs) = extended recovery. Planned recovery beyond routine with a medical reason to be a bed. Ordered with an action plan – never just "**stay the night.**" UG

Ideas for UR Coverage

- No one has enough UR coverage. Now that we have tackled that elephant in the room, let's talk.
- Evaluate UR resources only. Explore incorporating into an Integrated CDI program- more cross trained, more eyes in the record.
- ER – assess volume per hr. Determine hrs of coverage if 24/7 is not financially supported. Share the FTE with D/C planning/SW for down times.
- Housewide – weekends MUST have onsite coverage. Determine activity times – 12 hrs usual.

UR Better Practice Ideas

- Conduct time study to determine full scope of current work.
- GOAL= reallocate work to maximize on the RN's clinical skills, more interaction, more coverage
- More clerical work to clerical staff – fax/send to payers, daily reconciliation with payers, follow up , etc.
- LPN does payer clinicals/if required.
- Work with providers to tell the story better – from the beginning.
- Identify a dedicated Outpt Ambulatory Treatment unit/ATU – recovery, extended recovery/planned beyond routine, Obs, outpt scheduled treatment/blood.
- Assign Hospitalist and UR to dedicated obs /ambulatory unit.
- UR – high focus daily.
- Aggressively watch every outpt after the 1st midnight. Convert or safely discharge prior to the 2nd MN/CMS.
- Join the Denial Prevention Team!

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