Case Studies Working Lunch

7th National Boot camp

July 29-31,2019

It is all about the Medicare Advantage Plan - they are not Traditional Medicare.

Goal of great working lunch

- Review 2 cases/present 1 and discuss the case and all the 'other stuff' that could be occurring that impacts the decision:
  - Identify the pt status and defend your decision.
  - What issues are pertinent to the P2P call- Medicare Advantage Plans?
  - What additional 'points of clarity' could be added to or enhanced in the documentation to support inpt?
  - Is this case a) great inpatient, b) marginal inpt or c) give it up, dude! CRAP!
  - Share your strategy to 'find the inpt' and if not, why not.
  - HAVE FUN!

APPOINT a representative from your table to present 1 case to the group. Allow 2 mins.

Faculty to host tables & Assigned Case Studies

(Done by 1:35) Medicare Adv/MA

Grab lunch and join your table

- Table 1: Phillip Baker & Michele Marcum 1&2
- Table 2: Jennifer Bartlett 3&4
- Table 3: Ernie de los Santos 2&17
- Table 4: Ronald Hirsch 5&7
- Table 5: Maria Johar 6&9
- Table 6: Mike Adleburg/David Ault & Marlene Allen 10&15

Enjoy learning with the case studies & other fun ‘stuff”

- Table 7: Diana Cokingtin 8&14
- Table 8: DeVonne Grizzle & the Health Lawyer team 11&12
- Table 9: Ed Norwood 13&19
- Table 10: Tim Brundage 16&18
- Table 11 and 12 – No case studies

Case #1 – P2P call- Only approved OBS

- 79 YO female presents to cardiologist complaining of dyspnea at rest. Symptoms have progressed over the last 2 weeks and has gained weight but not sure how much.
- Patient with known complete heart block with permanent pacemaker, multi-vessel coronary artery disease considered not a surgical candidate, ejection fration of 20-25%, NY Heart Association Functional Class IV.
- Patient is being sent to the hospital directly from the cardiology office.

- What does the PA and UR team need to know to request an inpt from this MA plan?
- What strategies would you use in the P2P call to fight for an inpt? Or give up inpt and accept obs?
- MA plan. What do you need to know? Contracted? Non contracted? Strategy.
- What is this payer's definition of an 'inpt?"

Case #2: Denial from Humana. P2P too

- 79 yr old pt recently transferred from a CAH with sepsis (AKI,Tachypnea, hypotension, respiratory failure, hemoptysis)with ongoing treatment for MAC.
- The pt arrived at 3 am and was started on vancomycin and Zosyn. The patient was minimally improved the next day and contact was made with the quaternary center. They recommended sending back which was done.
- The pt ended up intubated, ARDS, MSOF, etc at the next facility but survived.
- Humana denied our 1 day stay. Initiated a P2P –'felt it would be a slam dunk"
- SURPRISE! Humana's Med Director – initially focused on 'pt doesn't meet MCG. Then moved to 'no fever." PA reminded – MCG is 1st level screening and that it is our job to determine if the pt was complex enough to support inpt. We agree 'pt is really sick" –YAHOO
- But then the Med Dir states –'the pt only stayed 1 night and all you did was stabilize him."
- What now? Did the hospital know that Humana is using MCG? What is the hospital only has IQ to use? Strategy for appealing? Or give it up to obs.

Case #3: Inpt at risk (Wellmark Medicare/MA)

- DOA: 3-15 Inpt order at 1717 on day 1.
- Summary: 48 yr old f who is seen with flank pain, found to have acute pyelonephritis, is placed on IV Rocephin, IV pain control, and IVF – awaiting final cultures.
- Inpt order: This patient has a UTI with acute pyelonephritis and is receiving (IT Abx, pain control). She remains at immediate risk for advancing infection leading to sepsis and renal failure, thus significantly increasing her morbidity and mortality. Therefore, recommend maintaining Inpt, even though payer wants to convert to obs.
- Initiate a P2P call. Points to include? (failed outpt therapy is present) Frequent UTI's led to this visit.
- What is the MA's definition of an inpt?

Case #4: 5 day stay   BCBS

- 80 yo M who is seen with back pain following a ground level fall, found to have acute changes on imaging. Placed on IV Morphine, cleared by neurosurgery, and is awaiting approval for Rehab placement.
- Day 1: Obs at 1457   on day 3 – reviewed by PA
- PMH: HTN, hyperlipidemia, GERD, CAD, OA, BPH, DM. A/P: Mechanical fall with back pai and radiculopathy; IV morphine.
- Obs per payer: This pt has already been cleared for discharge by speciality team and is awaiting placement.   (Pt and physician are upset due to delays)
- Options for the internal team:

  1) Agree with obs if d/c today

  2) Payor slow to approve Rehab; denies rehab day 4

  3) Day 4, SNF referral set. No reply on day 4 or 5.

  - DAY 5: Discussion with payer – PA…   WHAT IS THE PLAN?   Was inpt approved?
  - What is this plan's Definition of inpt?

Case #5: Payer denied inpt

- 72 yr old m presents to ED with weakness and vomiting. History of fall 2-3 days prior with difficulty ambulating after but then able to ambulate next day. Prior 24 hrs, little oral intake and slept most of the time.
- Dx includes intractable vomiting, weakness, acute kidney injury, and hypokalemia. Physical exam in ED notes tachycardia but the heart ratae in the note is 80. Admitted inpt 4-14; d/c 4-16.
- Initial labs: WBC 11.1, K3.1, creatine 1.82 (baseline stated to be 1.4) anion gap 21, lactic acid 2.1, CRP high sensitivity 5.7, troponin 0.06 Comorbid conditions: arrythmia, asthma, CAD, COPD, CHF, obesity, MI, diabetes, hypertension, hypokalemia, renal failure, stroke.
- Course: H&P worsening weakness associated with 20lbs loss but good appetite. Skin lesions on the hands and chest are noted and states some nausea and emesis. Plan notes progressive weakness with hx of lung lesions on CT (no mention of when this study was performed as it was not in the record) and will start with peripheral smear for work up. H&P also notes that lactic acid is resolved and mild AKI will hold ACEI.
- 4-15 pt is feeling better and able to ambulate better. He ate breakfast and feels much better. Waiting on OT & PT as may need SNF.
- OBS OR INPT? What are the determining factors? What is this payer's definition of an inpt?

Case #6: 1 day inpt/denied

- 71 yr F presented to the ED with palpitations and shortness of breath. This was similar to previous episodes of atrial fib which required cardioversion. Treated for headache and nausea in the ED with resolution of those complaints. Hemodynamically stable with irregular tachycardia. Labs unremarkable.   Princ Dx: Paroxysmal Atrial Fib
- H&P notes admitted as inpt with atrial fib with rapid ventricular response with plan to cardiovert that morning. Plan further states that will monitor in ICU overnight and discharge the following morning. Does note mild pulmonary edema but plan for Lasix and no respiratory compromise. The discharge summary discusses the dilitiazem drip but the history clearly only discusses the plan for cardioversion with no mention of the drip.
- Inpt or obs? What would be the strategy to find an inpt?
- What is the payer's definition of an inpt?

Case #7: 2 day stay/denied

- 72 yo M presents to the ED with recent dx of asthma or other obstructive airway disease followed by pulmonologist with persistent dyspnea and cough. States 02 sats on home device were in the 80's. Physical exam in ED notes no respiratory distress with mild rhonchi but no wheezing and respiratory rate of 18.
- Admitted as inpt with acute on chronic respiratory failure,COPD, left lower lobe pneumonia. Labs ph 7.43, pC02 38, pO2 59 with sats of 89 on room air. No WBC rest of labs normal except elevated glucose of 15 and PSA of 8.16
- Plan to admit with IV Rocephin along with azithromycin and solumedrol. No description of any respiratory distress or increased work of breathing and Rate of 19. Progress note on day 2 notes significant improvement with persistent dyspneal with exertion. Exam with only mild wheezing but no rhonchi. No mention of lab results to support continued stay.
- D/C notes significant improvement in breathing with no residual wheezing or rhonchi but persistent need for 02. Repeat chest x-ray reports no visualization of the previous LL infiltrate but new small pleural effusion. ? documentation to support acute respiratory vs chronic respiratory failure..
- Inpt or obs? What additional documentation would help to support inpt? What is the MA's definition of Inpt?

Case #8: P2P call. Defend Patient Status Decision

- 76 YO female recently treated for bronchitis by her primary care physician with antibiotics and bronchodilators initiated by two days prior who was involved in motor vehicle accident with deployment of air bags and loss of consciousness at the scene.
- Initial saturations by EMS mid 80s. Emergency department evaluations demonstrated a minimally displaced fractured sternum with sats 96-98% on 2 liters 02. Also noted swelling in the sternocleidomastoid muscle felt to be related to the seat belt.
- Patient complaining of lot of chest pain and difficulty taking other than a very shallow breath. Also unable to raise arms above 30 degrees due to pain.

- During the P2P call, what key elements would be necessary /present to find the inpt?
- MA plan. Strategies to have. Contracted? Non –contracted?
- What is this payer's definition of an inpt?

Case #9: P2P call. Defend the patient status: Obs or inpt

- 73 YO female brought to the ED by family with increased weakness and confusion with history that she may have been running a fever.
- Work up demonstrated new onset atrial fibrillation with rapid ventricular response, troponin 0.47, WBC 16,400 creatinine 1.2, BUN 61, chest x-ray possible LLC infiltrate and new pericardial effusion.
- Initial impression was a concern for possible pericarditis and LLL pneumonia.
- Diltiazem bolus with conversion to sinus rhythm, blood cultures and IV fluids and antibiotics, trend troponins and consult cardiology.

- MA plan. Contracted? Non- contracted? Strategy. Questions to know.
- What is the MA's definition of an inpt?

Case #10: 3 day stay

- 76 yoM admitted for elective right knee. Post operative course complicated by blistering of skin with edema of the leg and slow ambulation eventually discharged to home. Discharge note indicated pt responded to ice and elevation.
- Dx: Bilateral primary osteoarthritis of knee.
- Post operative complications. Note on face sheet – ‘not approved for 4 days – untimely peer to peer” Payer wanted site to ‘adjust off 2 days of the 4 day inpt stay.”
- What is the strategy for this one? What is the payer’s definition of inpt for surgeries? Are they using Medicare’s Inpt only list? What are they using?

Case #11
Do we have a lost inpt below?

84 year old male presented to the MD office for increasing dyspnea and edema that did not respond to outpt. Diuretic therapy. Treatment included echo, IV diuretics, abx, bronchodilators for wheezing, routine labs, CXR, IV lasix x1

Co-morbid conditions: TIA, stroke, CAD, HTN, COPD, Chemo 9-1-15.

10-12 Direct admit to OBS status.

No obs order found.

Care Mgt documented beginning of care/obs – 4:00 pm

Dx in order: CHF

Course of tx: Tele documentation x10 times in the note with no tele order. Strips mounted x3 times with RN signature and note. Increasing dyspnea and SOB that did not respond to outpt therapy.

10-13

Inpt order written at 1003 am.

At the time of inpt conversion – nursing wrote: 10-13 0930 – "Previous documentation from obs admission – refer to ambulatory assessment."

No physician documentation at time of conversion.

Standing Heart Failure Core Measure Orders are signed illegibly without a date, time, or any boxes checked to the order.

10-14- Discharged 1855

- Any risk factors?
- Is this an inpt? Why or why not? What is the MA's definition of an inpt?

Case #12- Readmission

- Coventry MA – two accounts within 11 days of each other.
- Initial: DRG 617 - amputation of lower limb for endocrine, nutrition, metabo/approved. 2nd admit – DRG 176 pulmonary embolism w/o MCC. /denied.
- Clearly these two cases are not linked based on DRG and Dx. They deny regardless of dx. In fact, the rationale for the inpt denial even states:
- *"Index case for osteomyelitis and amputation of left great toe and first metatarsal. No need to consider linking since IP denied. But also, anticoag management during IP appeared to have been appropriate so this complication appears unavoidable. Current case technically meets MCG criteria based on hypoxemia but minimal 02 supplementation needed and member asymptomatic so severity and intensity fit better with obs level of care."*
- Inpt stategy to win 2nd admit as unrelated? (FYI – P2P payer's MD – you get 1 of the 2 – pick which one you want paid for? How do you fight that?0

Case #13: 6 day stay

- 79 yo F presents with 'vague complaints chiefly involving new onset left chest and shoulder pain." Multiple contusions were noted of unknown duration with concerns about possible assault. Work up otherwise negative and placed in observation for dementia with behavioral disturbance and other chronic disease diagnoses all of which were at baseline.
- Dx – chest pain unspecified
- H&P with neuro checks and IV fluids. Note a blood gas in the documentation with patient on 2 liters of 02 not addressed in the documentation Progress note on day 2, given Zyprexa for agitation but essentially at baseline for cognition with note to encourage family to appropriate disposition and if they or patient refuses placement, then discharge home the next day with change to inpt status at that time w/no worsening or acute issues notes.
- Is there a potential for inpt ? What is the MA plan using to define an inpt.

Case #14: 1 day stay

- 26 yo F presented to the ED complaining of sudden onset temperature to 101.5 associated with nonproductive cough, chills, nausea and feeling weak and lightheaded. Onset of symptoms just prior to presentation.
- Vital signs were heart rate of 101, BP of 158/75, respirations 19, temp 100.0. Nursing also noted she had allergy testing two days prior to presentation. Examination was unremarkable. Impression was sepsis, fever, leukocytosis.
- Comorbid: morbid obesity, bipolar, GERD, hypothyroid and tobacco abuse.
- H&P- impression was sepsis "3/4 SIRS" although nowhere in the record was recorded temp >100.5 and the highest recorded heart rate was 101. Lists admit as obs- did the admitting provider truly suspect sepsis? To that point, the record states to hold antibiotics. Inpt order was done by ER provider.
- 13 hrs after admit, all symptoms are resolved.
- What is the case for inpt? What additional focus areas needed addressed?
- What is the inpt criteria this MA plan is using?

Case #15: 2 day stay

- 55 yo F presented to ED with 3 –day history of nausea, vomiting an diarrhea. Took regular medications through the night before but unable to keep anything down. Vital signs 222/107, HR 101, Temp 99.1, Respirations 21 and BMI 36.48.
- Initial lab: WBC 20.83, hemoglobin 18.5, CRP 22.3, urinalysis with ketones>160 and protein >300, UDS positive for cannabinoids, beta hydroxybutyrate 2.78, glucose 307, lactic acid 2.73, potassium 3.2 and procalcitonin 0.05. Initial blood gas resulted in PH 7.52, pC02 16, pO2 100 and HCO3 13.4. CT abd and pelvis are negative for acute findings.
- Comorbid – diabetes type 2, COPD, CAD,HTN and previous CVA. Dx: Type II diabetes with ketoacidosis without coma. Admitted as inpt.
- 1st night – intractable nausea requiring IV medications to control her BP along with clonidine patches. N/G tube recommended/rejected. Family concerned over significant cognitive decline and OT consult showed moderate impairment.
- What would be the strategy for an inpt? What criteria is this MA plan using to determine inpt?   (Note the pt is on Medicare due to earlier CVA/disabled)

Case #16 – Denial after d/c

- 85 yo demented female admitted under IP status for elevated troponins (0.12 to 0.17) after a syncopal episode. After consultation with cardio and neuro (for NSTEMI and AMS/syncope) decision was made to opt for palliative care.
- PA on call was asked to downgrade her to obs but declined and wanted to wait for Humana's decision. He did not want to self-deny a borderline case. Denial letter came after discharge.
- In hindsight, should the PA have recommended a self denial rather than fight the 'no order for obs' issue after d/c?
- Or with a failed P2P call, the MA's MD will say they will allow OBS but we don't have an OBS order?
- What is the plan's definition of an inpt? Start there 1st!
- Strategies

Case #17
How about this inpt?

73 year old male with an accidental environmental toxic exposure presents to the ED.

- 12-1
- 9:00 am Pt arrives by ambulance to the ED. Pt is awake and alert.

  9:03 am Poison control consulted which advises that pt requires telemetry monitoring; plan to intubate if necessary. Small hospital facility, tele monitoring is only available in the ICU.

  9:07 am Therapeutic and Dx modalities have all been ordered and initiated. Pt airway intact.

  10:00 am MD requests transfer to ICU for Tele. Determination will be dependent on clinical presentation and results of diagnostic and therapeutic modalities.
- 12-2

  10:30 am Medical concerns/sequelae resolving; airway remained intact absent mechanical intervention.

  12:00 noon Physician writes orders to discharged

- Was there an opportunity to make this an inpt? How about rare and unusual?
- ICU = Inpt? Discuss
- What is the MA's definition of an inpt?

Case #18
A goodie!

72 year old F presented to ED via EMS c/o worsening productive cough, wheezing, and shortness of breath. Received IV solumedrol during transport to ED. EKG without changes, normal sinus rhythm, 02 sat 95-96% RA.

Per ED report, acute exacerbation of COPD, IV antibiotics, and RT treatments administered.

WBC count monitored.

ED 9-30 0253

No inpt order found.

H&P plan: Will monitor WBC count, start her on broad spectrum IV antibiotics and IV steroids, and continue RT treatments.

Progress notes: Less dyspnea, occasional cough, no wheezing. Change to po Prednisone, possible discharge 10-2-15.

Discharge summary: Seems to be improving…insisted on going home due to family issues.

Actual D/C : 10-1

Is this an inpt? Why or why not?

How could this have supported an unplanned short stay inpt?

What risk factors are present? What is the MA's definition of inpt?

Case #19
See a lost inpt?

72 yr old M to ED with 5 days of increasing cough, SOB, chills and fever. Can take 2-3 steps at a time and needs to rest. Pulse ox 86-87% RA.

Inpt order: 4-17 0143

Placed on 3 Liters of 02, lung bases diminished bilaterally. Duoneb treatments initiated. CXR to rule out pneumonia. Blood cultures, lovenox.

H&P: I anticipate the pt will be in the hospital 3 to 4 days ..will use steriods to control COPD. Acute exacerbation of COPD. We will get on IV antibiotics, IV steriods, mucolytics and pulmonary toilet in the form of Duoneb and albuterol.

Progress note 4-17: breathing better, afebrile, pulse ox 96-98%.

D/C 4-18 Got off 02 very quickly and responded to therapy extremely well. His lungs opened up nearly 100% with fairly preserved air exchange. He was discharged much quicker than anticipated. He was feeling well and wanted to go home.

Was this a presumption inpt? Why or why not?

What is at risk with this case? What is the MA’s definition of an inpt?

Case #20
This is a good one!

72 year old F presented to the ED 4 days ago for a T7 compression fracture and presented this date for intractable pain and constipation. 10-25 1409

OBS: placed for intractable pain and constipation. Treated with IV meds, IVF, nausea medication. 10-25 1841

Inpt order: 10-27 1543 for continued IV pain and nausea medication.

Then placed back into obs: 10-30 1201 with no notation other than the order. She underwent a kyphoplasty 11-2 and was discharge 11-3 as obs.

No documentation for CC 44 if accurate.

Is this an inpt? Why or why not?

What confusing factors were present?

What is the MA's definition of an inpt?

Sort this one out and advise on multiple status changes, if appropriate.