What Does Documentation to Support Inpatient Look Like…Thru the Eyes of Appeal Writing

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First things first

- Is there an order to Admit to Inpatient?
  - *admit 'to inpatient,' 'as an inpatient,' 'for inpatient services,' or similar language?*
  - Was it signed before discharge (CMS 2-midnight rule)?
  - Was it changed to OP – did the players apply Condition Code 44 correctly?

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R234BP.pdf

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What's an inpatient?

- CMS 2-midnight rule
- Managed Medicare – not the 2-midnight rule
- Commercial or Medicaid – whatever they want it to be

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CMS 2-Midnight Rule

- What's required
  - Order
  - Expectation of 2 midnights
    - Does not need to be a pre-defined statement
    - Must be supported by documentation in the medical record
  - Consideration of the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

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Exceptions to the Rule

Easy Peasy

- Death
- AMA
- Transfer to Hospice
- Transfer to another facility
- Mechanical Ventilation Initiated During Present Visit

Not Easy Peasy

- Unexpected quick recovery

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Provide a Roadmap/2 MN Rule

ADMISSION ORDER: A physician order is present in the medical record and supported by the physician admission and progress notes, and signed prior to discharge by a practitioner familiar with the case and authorized by the hospital to admit inpatients. Federal Register /Vol. 79, No. 217 /Monday, November 10, 2014 /Rules and Regulations; XVI. Revision of the Requirements for Physician Certification of Hospital Inpatient Services Other Than Psychiatric Inpatient Services and 42 CFR 412.3
Please cite title of document and page numbers that support this guideline (if applicable).
2 MIDNIGHT EXPECTATION: There is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary required medically necessary care spanning at least 2 midnights. Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations. Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A.
Please cite title of document and page numbers that support this guideline (if applicable).
DECISION TO ADMIT: The admission decision is supported through documentation by the admitting provider of consideration of complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event and consideration of various other factors, including the beneficiary's age, disease processes, and the potential impact of sending the beneficiary home. FREQUENTLY ASKED QUESTIONS, 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013
Please cite title of document and page numbers that support this guideline (if applicable).

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Decision to Admit

However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf

Managed Medicare

- How do Medicare Advantage Plans define an inpatient?
  - Not the 2-midnight rule
  - Treat like a Commercial payer

Managed Medicare

UHC Medicare Advantage Coverage Summaries

https://www.unitedhealthcareonline.com

UnitedHealthcare®

Coverage Summary		
Hospital Services (Inpatient and Outpatient)		
Policy Number: H-006	**Products:** UnitedHealthcare Medicare Advantage Plans	**Original Approval Date:** 07/16/2008
Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee		**Last Review Date:** 08/16/2016
Related Medicare Advantage Policy Guidelines:		
• Hospital and Skilled Nursing Facility Admission Diagnostic Procedures (NCD 70.5) • Surgical or Other Invasive Procedure Performed on the Wrong Body Part (NCD 140.7)		• Surgical or Other Invasive Procedure Performed on the Wrong Patient (NCD 140.8) • Wrong Surgical or Other Invasive Procedure Performed on a Patient (NCD 140.6)

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UHC Medicare Advantage Plan

Inpatient Hospital Services

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
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- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Commercial Payers

- How do Commercial Payers define an inpatient?
  - Whatever they want it to be.

AETNA

AETNA:
Medical Clinical Policy Bulletins (CPBs)
The services and procedures considered medically necessary

CPBs are based on:

- Peer-reviewed, published medical journals
- A review of available studies on a particular topic
- Evidence-based consensus statements
- Expert opinions of health care professionals
- Guidelines from nationally recognized health care organizations

ANTHEM BCBS

ANTHEM BCBS:

- Medical policies generally apply to all of Anthem's plans
- Local variations may exist
- Anthem has developed clinical UM guidelines
- Anthem is also licensed to use MCG™ guidelines
- Anthem also has the right to customize MCG™ guidelines based on determinations by its Medical Policy & Technology Assessment Committee

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UNITED HEALTHCARE

UNITED HEALTHCARE:

- Uses generally accepted standards of medical practice
  - Credible scientific evidence published in peer-reviewed medical literature
  - Generally recognized by the relevant medical community
- Standards based on physician specialty society
- Recommendations or professional standards of care
- Other evidence-based, industry-recognized resources and guidelines, such as the Milliman Care Guidelines®

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What's it all mean in the end?

- It all comes down to what is the standard of care in the medical community according to peer-reviewed journal articles/physician specialty groups.

Can you make an argument for current standard of care?

- Amputating fingers for paper cuts – not the standard of care.
- Admitting patients with life-threatening acute respiratory failure – winning.

HCFA (CMS) Ruling 95-1

HCFA Ruling 95-1 states:

“Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association.“

https://www.cms.gov/Rulings/downloads/hcfar951.pdf

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http://www.acc.org/

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http://www.acep.org/clinicalpolicies/

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http://www.guideline.gov/

National Guideline Clearinghouse

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Guidelines

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Guidelines by Topic

Browse topics to find guidelines represented in NGC that are linked to a particular term derived from the U.S. National Library of Medicine's (NLM) Medical Subject Headings (MeSH), a controlled vocabulary for disease/condition, treatment/intervention, and health services administration. MeSH is one of the controlled vocabularies included within the Unified Medical Language System (UMLS) (what's this?)

MeSH terms are arranged hierarchically ranging from broad headings to more narrow concepts. For example, the general concept "Nervous System Diseases" can be followed through the MeSH hierarchy down to the concept "Myasthenia Gravis, Neonatal;" the broad concept "Diagnostic Techniques, Digestive System" can be followed through "Endoscopy, Gastrointestinal" to the narrow concept "Sigmoidoscopy."

Create Topic E-mail Alerts

Disease/Condition

- **Anatomy** (16)
- **Organisms** (41)
- **Diseases** (2488)
- **Chemicals and Drugs** (18)

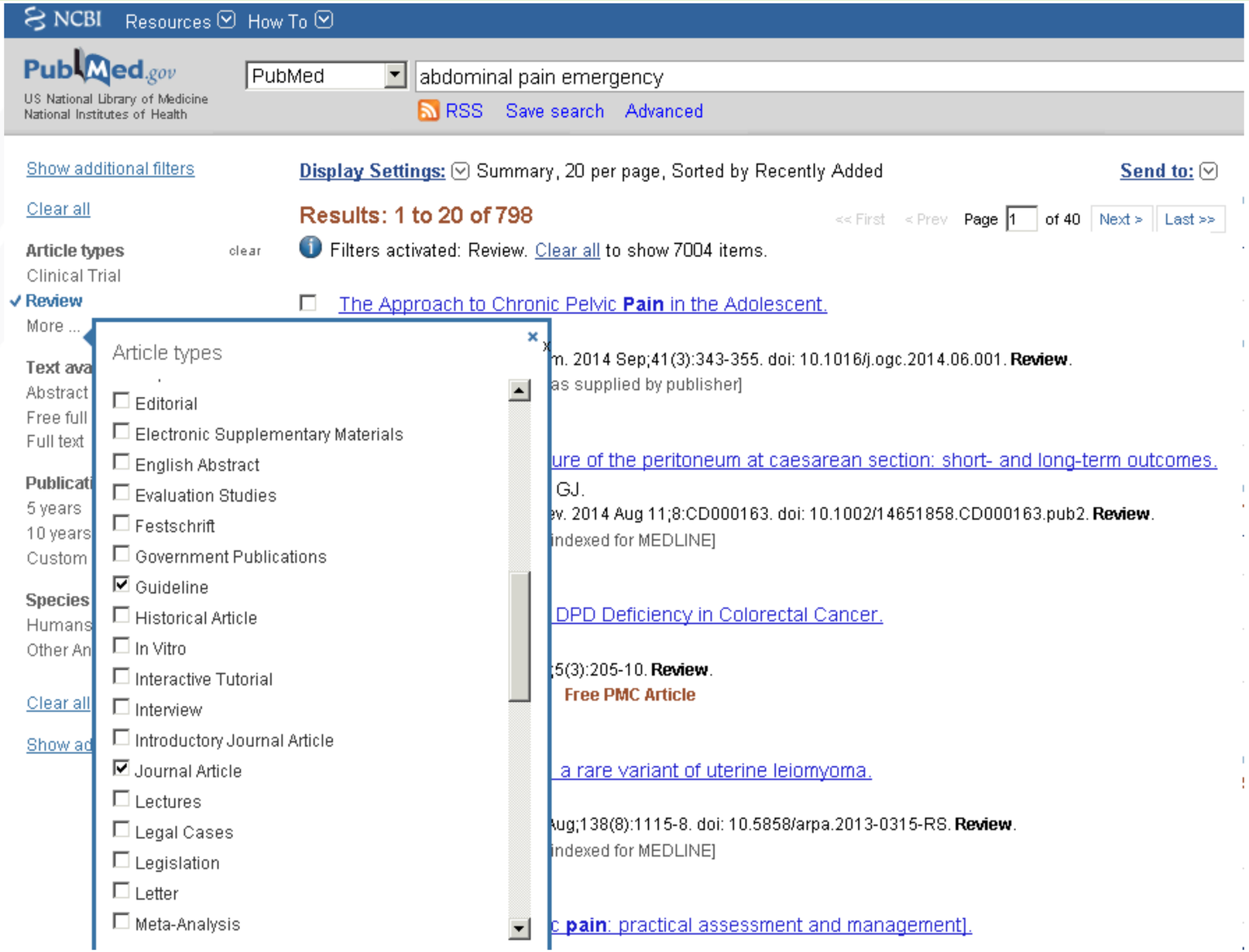
Treatment/Intervention

- **Anatomy** (87)
- **Organisms** (50)
- **Diseases** (169)
- **Chemicals and Drugs** (1830)

Health Services Administration

- **Chemicals and Drugs** (5)
- **Analytical, Diagnostic and Therapeutic Techniques and Equipment** (118)

http://www.ncbi.nlm.nih.gov/pubmed



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Community Acquired Pneumonia

Mandell LA, et al. (2007). Infectious Diseases Society of America/American Thoracic Society Consensus Guidelines on the Management of Community-Acquired Pneumonia in Adults. Clinical Infectious Diseases 2007; 44:S27–72. Infectious Diseases Society of America. As found on:
https://www.thoracic.org/statements/resources/mtpi/idsaats-cap.pdf

- The main reason for admitting a patient with CAP is the risk of death. [pp. 10-11]
- 2 of the following 3 conditions present at admission: tachypnea, diastolic hypotension, and an elevated blood urea nitrogen (BUN) level, increased the risk of death by 21-fold. [p. 10]
- Leukopenia (white blood cell count < 4000 cells/mm3) resulting from CAP has consistently been associated with excess mortality, as well as with an increased risk of complications such as acute respiratory distress syndrome (ARDS) [p. 13].

Community Acquired Pneumonia

- Minor criteria (the threshold for ICU admission was felt to be the presence of at least 3 minor criteria).
  - Respiratory rate ≥ 30 breaths/min
  - PaO2/FiO2 ratio ≤ 250
  - Multilobar infiltrates
  - Confusion/disorientation
  - Uremia (BUN level ≥ 20 mg/dL)
  - Leukopenia (WBC count < 4000 cells/mm3)
  - Thrombocytopenia (platelet count, <100,000 cells/mm3)
  - Hypothermia (core temperature, < 36 degrees C)
  - Hypotension requiring aggressive fluid resuscitation
- Major criteria
  - Invasive mechanical ventilation
  - Septic shock with the need for vasopressors [p. 12-13]

Medical Record Documentation

PRIMARY

- Physician Orders – first. If it's not there, we won't appeal
- ED Notes
- History and Physical
- Progress Notes
- Test Results
- Discharge Summary

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Medical Record Documentation

SECONDARY

- Nursing Notes – pain, confusion
- MAR – pain, IV meds
- Social Services/UM/Case Management – placement issues, safe discharge
- Therapy Notes

Commercial Inpatient Denial

AETNA:

We reviewed information received about the member's condition and circumstances. We used the MCG care guidelines for Inpatient and Surgical Care; Based on MCG guidelines and the information we have, we are denying coverage for this hospital admission. The requirements for coverage are: **(1) progression or no improvement with at least 48 hours of treatment with adequate antibiotics and/or other interventions;** (2) outpatient intravenous therapy isn't appropriate; (3) limb-threatening infection; **(4) high-risk comorbid condition such as uncontrolled diabetes**, cirrhosis or symptomatic heart failure; (5) bacteremia; (6) severe or persistent altered mental status (7) hemodynamic instability; **(8) suspected necrotizing soft tissue infection**, orbital or severe periorbital infection, cutaneous gangrene, perineal infection, and/or associated surgical procedures; (9) high fever (103 or higher); (10) compartment syndrome monitoring; (11) need for isolation; (12) urgent need for skin graft or bone/joint debridement; or **(13) severe pain or other care requiring inpatient intervention.** The member doesn't meet any of these requirements.

Commercial Inpatient Appeal

This gentleman with a history of diabetes presented to the hospital Emergency Department directly from his podiatrist's office on 1/27/17 with an open and draining wound on his right medial ankle. He had been prescribed Augmentin on 1/23/17 for cellulitis and the open area on his ankle but **failed outpatient treatment with antibiotics** (Emergency Physician Record, pp. 47-49). He was found to be suffering from hyperglycemia with **a blood glucose of 525 (H)** [83-110]. In the ED he was treated with IV antibiotics Clindamycin and Vancomycin, **Insulin and IV Morphine for pain** (Complete ED Record, pp, 60-61). **The ulcer was full thickness penetrating to the capsule of the ankle exposing the medical malleolus bone. Necrotic tissue was debrided** (Progress Note, p. 83).

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Clinical (Diagnosis) Validation

United Healthcare

Clinical Logic

The Uniform Hospital Discharge Data Set requires that all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay be reported as other diagnoses. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded from DRG billing. A review of the medical records submitted did not validate the secondary diagnosis of J96.20 Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia for this admission OR clinical documentation did not support J96.20 Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia as a secondary diagnosis for this admission. The secondary diagnosis code is one of the determining elements for MS-DRG assignment and payment. Supporting coding guideline(s): ICD-10-CM Coding Guidelines, Section III: Reporting Additional Diagnoses.

Clinical (Diagnosis) Validation

- Is it a coding denial for improper inclusion of Acute and Chronic Respiratory Failure as a secondary diagnosis?
- Or, is it a clinical validation denial challenging whether the clinical picture of Acute and Chronic Respiratory Failure is supported by the documentation in the medical record?

Clinical (Diagnosis) Validation

- History of COPD with chronic respiratory failure with hypoxia; On home oxygen 2-4 l/m
- Hypoxic with oxygen saturation down to 70's on 4 l/m oxygen; RR 25
- CXR: Moderate interstitial edema superimposed on COPD
- Treated in ED with nebulizer therapy and BiPap

Favorable Outcome

- We decided that our decision to deny the claim for the services is incorrect. It is Optum Insight's decision to overturn this denial. Per documentation submitted by provider and review it has been determined that billed charges meet coverage criteria. Therefore, the plan will overturn with the plan outcome reason meets coverage criteria per additional information received.

30-Day Readmission CMS

CMS Hospital Readmissions Reduction Program (HRRP)

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to **reduce payments to IPPS hospitals with excess readmissions,** effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

In the FY 2012 IPPS final rule, CMS finalized the following policies with regard to the readmission measures under the Hospital Readmissions Reduction Program:

- Defined readmission as an admission to a subsection (d) hospital **within 30 days of a discharge from the same or another subsection (d) hospital;**
- Adopted **readmission measures for the applicable conditions of acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN).**

In the FY 2014 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2015 program to include:

(1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease **(COPD);** and

(2) patients admitted for elective **total hip arthroplasty (THA) and total knee arthroplasty (TKA).**

In the FY 2015 IPPS final rule, CMS finalized the expansion of the applicable conditions beginning with the FY 2017 program to include patients admitted for **coronary artery bypass graft (CABG) surgery.**

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30-Day Readmission Commercial

ANTHEM:

SERVICE: DRG Readmission
DIAGNOSIS CODE & DESCRIPTION: ICD10-R21 Rash and other nonspecific skin eruption

Dear Hospital:
We recently became aware that the above mentioned member has been readmitted to your facility. We have determined this to be a related readmission after a covered DRG admit, therefore based upon your contractual agreement with us, additional payment has not been approved.

According to your agreement with Anthem, you have agreed not to bill the member for services. Therefore, please do not bill the member for the above referenced admission.

30-Day Readmission Commercial

Although the patient presented similar symptoms on a previous admission, the main concern during the previous admission was respiratory failure and CHF. On this admission, the patient presented with a different chief complaint, that of extremely painful rash with blisters all over his body. Generalized rash is amongst the most common conditions presented to practicing General Practitioners and common differentials include contact dermatitis, atopic eczema, sun-induced damage, drug eruption and general manifestations of systemic diseases or infections.

Physicians often have difficulty diagnosing a generalized rash because many different conditions produce similar rashes and a single condition can result in different rashes with varied appearances.

This admission can not be considered a readmission.

Summary

- Is there an order to admit to inpatient?
- What's an inpatient in the eyes of the payer?
- Is inpatient admission the standard of care or does the admission meet criteria for the 2-midnight rule?

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