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Symptoms Aren't Enough for Admission; Leaving AMA Causes Confusion

By Nina Youngstrom

As long as physicians explain why inpatients recovered faster than expected and therefore were discharged before the second midnight, their Medicare Part A claims have a good chance of surviving an audit under the two-midnight rule. But it's not good enough for physicians to state only that patients are safe for discharge earlier than anticipated. The same goes for simply documenting a symptom without putting it in context. Auditors tend to consider symptoms in isolation as appropriate for observation services.

These insights have emerged from reviews of short hospital stays by Livanta and KEPRO, two quality improvement organizations (QIOs), says Nancy Perilstein, senior manager with Deloitte Advisory .

Some QIO Reasons for Claim Denials After Admission Reviews

Here are the explanations given by Livanta and KEPRO, the two quality improvement organizations (QIOs) reviewing short hospital stays under the two-midnight rule, in a handful of actual cases. They were shared by Nancy Perilstein, senior manager with Deloitte Advisory. Contact her at nperilstein@deloitte.com.

Diagnosis/Issue	KEPRO denial rationale	Livanta denial rationale

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Total knee arthroplasty (TKA)	The patient had elective knee surgery with no complications and an unremarkable postoperative course. She was in the hospital for one midnight. The medical record does not support the admitting physician's determination that the patient required inpatient care, despite not meeting the two-midnight benchmark. The operation and postoperative care could have been done in outpatient status. Please refer to www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf.	Patient with a past medical history of coronary artery disease (CAD), hypertension (HTN), myocardial infarction (MI), and right knee degenerative joint disease was admitted for an elective right total knee arthroscopy (TKA). The patient had one or more procedures that were not on the 2018 Centers for Medicare & Medicaid Services (CMS) Inpatient-Only List (27447). The patient was low risk for postoperative issues, and the documentation at the time of admission did not support the reasonable expectation of a two midnight hospital stay, nor was there documentation of complex medical factors that would require the patient needing inpatient care despite not meeting the two-midnight benchmark.

Diagnosis/Issue	KEPRO denial rationale	Livanta denial rationale
Radical prostatectomy	The patient was admitted for elective prostate surgery. The surgery was without complications, and the postoperative course was unremarkable. The patient was in the hospital for one midnight. The medical record does not support the admitting physician's determination that the patient required inpatient care. The surgery and postoperative care could have been done in outpatient status. Please refer to www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf.	Patient with a past medical history of CHF, peripheral vascular disease, HTN, MI, and COPD with known prostate carcinoma was admitted for an elective robotic radical prostatectomy, lymph node dissection, and laparoscopic lysis of adhesions. The patient had one or more procedures that were not on the 2018 CMS Inpatient-Only List (55866, 38571, and S2900). Postoperatively, he suffered minimal nausea that was managed with appropriate medications. The documentation at the time of admission did not support the reasonable expectation of a two-midnight hospital stay, nor was there documentation of complex medical factors that would require the patient needing inpatient care despite not meeting the two-midnight benchmark.

Diagnosis/Issue	KEPRO denial rationale	Livanta denial rationale
Missing orders	Not approved due to lack of valid inpatient order. Upon careful review of the submitted documentation, KEPRO concluded that the documentation did support the medical necessity of the admission. However, the admission order was not authenticated or written prior to discharge. Therefore, the claim is not currently payable under Medicare Part A. Please refer to the Medicare Benefits Policy Manual, Chapter 1, Section 10.2 (rev 234). KEPRO would agree that the documentation supports payment under Medicare Part A if the following can be provided: an appropriate order, confirmation that the midlevel providers have autonomous admitting privileges at your facility, or documentation of authentication of the order prior to discharge.	The claim has been identified as a billing error because there was not verification of a signed physician's order to admit an inpatient. The Medicare requirements for an inpatient admission were not met.

With patients who recover faster than expected, physicians have to spell out the reasons why. Suppose a patient with cellulitis is admitted as an inpatient after failing to improve with oral antibiotics, but IV antibiotics allow a safe discharge before crossing two midnights. The documentation should elaborate on the initial treatment and its ineffectiveness, the change to IV antibiotics and the patient's improvement, Perilstein says.

With symptoms, auditors expect physicians to explain why they require an inpatient admission. "Symptoms usually equate to an observation level of care, although if they're severe enough—for example, if the patient is being ventilated, that would meet inpatient admission. But abdominal pain, chest pain and near syncopal episodes are classic observation services," she explains. Physicians may have an expectation of a two-midnight stay if they're concerned the abdominal pain is pancreatitis or small bowel obstruction, but they have to put it into words.

According to feedback from QIOs, it wouldn't take a lot more documentation to support the expectation of a two-midnight stay, Perilstein says. It just has to be more specific. "We're talking one or two sentences," she says. For example, instead of stating the patient recovered more quickly than anticipated, they should document that the patient responded to steroids or antibiotics, for example. Other persuasive phrases include "patient presents with suspicion of X"; "I have a concern for diagnosis X"; and "He/she is at risk for X."

In another interesting development under the two-midnight rule, physicians are raising questions about

patients who leave against medical advice (LAMA). They are an exception to the two-midnight rule, which means hospitals are permitted to bill Medicare Part A even when the patient doesn't stay two midnights. But there has been some confusion about whether physicians may still order services for patients who are halfway out the door.

"A pattern I have seen recently was that many physicians think if the patient leaves against medical advice, they cannot order home care or durable medical equipment or perhaps they shouldn't give them all the prescriptions they would give them if they were discharged," Perilstein says. That's not the case. "It's equally important to give them all of that if they leave against medical advice. It's a quality of care and liability issue." And follow-up post-acute care, prescriptions and DME are covered by Medicare for patients who LAMA, Perilstein says. "Everything is the same whether they are discharged or LAMA."

This is a challenging area, with implications for quality of care and readmission penalties, says Paul Ossman, M.D., an academic hospitalist at UNC Health Care in Chapel Hill, North Carolina, and lead physician adviser for its clinical documentation integrity program.