Utilization Management: CMS Guidelines for Observation and Inpatient Services

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What is Utilization Management (UM)?

• UM is an evidence-based, clinical support process designed to assist physicians in evaluating the use of medical services based on:
  – Medical necessity
  – Appropriateness
  – Efficiency

• Multiple disciplines apply to the UM process, including:
  – Quality
  – Transition Management (case manager, social worker, discharge planner)
  – Insurance management (insurance verifiers, financial counselors)
  – Precert Nurses (Elective authorizations)
  – Access/Patient throughput
Vanderbilt University Hospital (VUH) UM Team

**Associate Hospital Director**
William Fulkerson

**UM Medical Director**
Kevin Flemmons, MD, SFHM

**Physician Advisors**
Bennett Spetalnick, MD
Henry Jennings, MD
Allen Kaiser, MD
Walter Merrill, MD

**UM Director**
P. Michelle Wyatt, MSN, RN, CPHM

**RN Team Lead**
Kim Brownlow, RN

**UM Staff**
20 – Day RNs
2 – Weekend RNs
1 – Night ED RN
Appeals, AA, Office Assist
VUH UM Observation/Inpatient Review Process

1. UM Admission Request Submitted by Physician
   - UM Level 1 Review Request Reviewed by UM RN Using InterQual Criteria
     - Admission Criteria Met
     - Admission Criteria Not Met
   - UM RN Provides a Continued Stay Review Every Seven Days

2. UM Level 2 Review
   - EHR Review
   - RISK Assessment
   - Evidence-Based Medicine
   - Admission Criteria Not Met

3. Admission Criteria Not Met – Additional Information Needed
   - Team Conversation
     - RISK Assessment
     - Documentation Review
   - Status Change
     - Inpatient to Observation
     - Observation to Inpatient

4. (CC 44) Physician Advisor
   - Order Changed
   - Patient Notified
   - Documentation of Communication and Change

5. Physician Team
   - Order Changed
   - Patient Notified
InterQual Criteria Overview

- Level 1 review is based on InterQual Criteria
- InterQual Criteria provides evidence-based clinical decision support guidelines to ensure care decisions are:
  - Clinically appropriate
  - Consistent throughout VUH
  - Provided in the most appropriate care setting
  - Based on current clinical best practices, data, and medical literature
- InterQual Criteria cannot be used to deny a request – only physicians can determine the clinical inappropriateness of requests
Why is UM Needed?

• The Centers of Medicare & Medicaid (CMS) states that the process of admitting a patient with an inpatient status is a complex medical judgment and should be determined by a physician based on:
  – The severity of the signs and symptoms exhibited by the patient
  – The need and availability of diagnostic studies
  – Medical probability of an adverse outcome (RISK) for the patient

• UM assists physicians in determining the appropriate care for patients based on patient-specific information, evidence-based medicine, and current industry best practices

• UM helps reduce the overuse of inappropriate or unnecessary services
MEDICARE
WANTS TO KNOW

Does the clinical care of your patient require a stay of less than or more than two midnights?
When to “Place as Outpatient/Observation”

• For CMS Medicare Part A patients, orders should be documented as “Place as Outpatient/Observation” if:
  – Physician anticipates the patient evaluation and treatment will require a stay **less than two midnights** in length
  – Discharge is anticipated **prior to two midnights**
  – A time prediction of the length of stay is difficult to determine
  – Patient’s procedures only require short-term monitoring post-op
  – Physician is uncertain of the need for inpatient admission
  – It is a “social admission” (**ex. admission to qualify for skilled nursing care placement**)
  – **Services are not on the CMS inpatient-only list**
    • Patients can be admitted as inpatient if a stay over two midnights is anticipated based on patient-specific factors, such as patient condition, history, severity of signs and symptoms, and/or comorbidities
When to “Admit as Inpatient”

• For CMS Medicare Part A patients, orders should be documented as “Place as Inpatient” if:
  – Patient’s evaluation and treatment requires at least two midnights
  – Improvement is not anticipated for the patient within two midnights
  – Physician’s expectation of care surpassing two midnights is based on complex medical factors, such as patient condition, history, severity of signs and symptoms, and/or comorbidities
  – Physician believes the patient is at RISK for a serious outcome if the patient is not closely monitored on admission (ex. head injury, ACS, severe pneumonia, etc.)
  – Delineation of failed outpatient management exists (ex. infection, CHF, etc.)
  – Delivery of care is not feasible on an observation/outpatient basis
  – Services are on the CMS inpatient-only list
  – Notation can be provided that the standard of care is being met
CMS Inpatient Documentation Guidelines

- As a condition of payment for hospital inpatient services for Medicare Part A beneficiaries, physician documentation must include:
  - Physician certification that such services were provided on an inpatient basis due to medical necessity
  - Physician certification that inpatient services were reasonable and necessary, with supporting medical documentation
  - Physician orders to admit the patient for inpatient services and that services were in accordance with the CMS *two midnight* benchmark

- CMS issued guidance to Medicare review contractors to ensure inpatient information is appropriately documented to determine inpatient appropriateness versus observation/outpatient treatment

- *Note*: Part A payments for inpatient patients staying less than two midnights can still be made in certain situations, such as unforeseen circumstances, patient death, unexpected improvement, and departure against medical advice
Vital Inpatient Documentation Information

- Appropriate clinical documentation justifying inpatient admission is vital for Medicare Part A reimbursements, including information on severity of illness and intensity of services.

  - Severity of illness examples
    - Degree of sickness
    - Main clinical issue
    - Abnormal vital signs
    - Presence of pain with location and cause
    - Neurological status (alert to obtunded)
    - Description of diagnostic tests (abnormal labs, x-rays, etc.)

  - Intensity of services examples
    - Treatment performed (IVF, IV diuretics, IV ABX, neurological checks, IV antiemetics, etc.)
    - IV medications
    - IV PRN medications (nausea, pain, etc.)
    - Frequency of medications
    - Blood or blood products
    - Oxygen (FiO2 and route, ABGs completed or O2 saturation)
    - Other treatments or therapies administered
Appropriate Documentation Examples

**DX: uncontrollable post-operative pain**
**Risk of Adverse Event:** Risk of continued pain resulting in worsening hypertension. Risk of possible overdose from outpatient oral pain medication.

**DX: Partial small bowel obstruction**
**Risk of Adverse Event:** Risk of complete small bowel obstruction and rupture.

**DX: Grade 2 spleen laceration**
**Risk of Adverse Event:** Risk of worsening of spleen laceration requiring spleenectomy.

**DX: Head injury**
**Risk of Adverse Event:** Risk of continued intracranial bleeding and need for surgical interventions.
Thank you for your participation.

Questions?