Observation Questions and Answers

(November 2016)

1. **What is "Observation Medicine"**

   Perhaps the greatest point of contention around observation status must do with its definition: is observation ascribed to the length of stay (ie. The new 2-mid-night rule) or to the clinical status of the patient? The best available evidence points to observation as an appropriate level of care for patients whose disease status is evolving, and, therefore, may either react to treatment quickly or require further evaluation prior to inpatient admission.

   Medicare defines observation as "outpatient hospital services, including the use of a bed and periodic (usually hourly) monitoring by the hospital's staff or other staff, that are reasonable and necessary to evaluate an outpatient's condition or to determine the need for possible admission to the hospital."

   That the care and evaluation must fall within a 23 to 48-hour window is more of a regulatory and reimbursement overlay to the clinical considerations. Thus, when thinking about ruling patients into observation status, the clinician must think through both the patient's disease progression and the appropriateness of treatment and/or testing that will be ordered in the ensuing 23-48 hours.

2. **Why should I care about admitting patients to "observation" in the emergency department?**

   In December 2005, the Center for Medicaid and Medicare Services (CMS) announced it had uncovered $9.5 billion in fraud during that calendar year. They targeted one reason: a lack of medical necessity for inpatient stays. In response, the US Congress increased their scrutiny of "inpatient" short stay admissions, and required hospitals to participate in the Hospital Payment Monitoring Program (HPMP). This program identified frequent errors in one-day admissions, regardless of the size of the hospital or percentage of one-day admissions. In addition, the Healthcare Financial Management Association (HFMA) found that observation is overused an average of 45% of the time. Each patient incorrectly classified as an observation case costs the hospital roughly $4,700 in lost revenue.

   According to HFMA if one observation error is made each day, that results in $1.7 million in lost revenue per year for a hospital. Incorrect use of observation poses compliance risks as well. Because most Case Management staff are not educated on the financial or compliance liability of incorrect classification, hospitals may expose themselves to risk at key points in the clinical decision-making process. Further, because most hospitals are not doing case management seven days per week, 24 hours a day, there is great variability in how observation is assessed and applied.

Adding to these issues, in 2006 CMS changed the reimbursement methodology for observation stays. As the revenue models changed, hospitals recognized the need to evaluate their own observation practice for compliance and operational improvement opportunities.

In 2009 the institution of Recovery Audit Contractor (RAC) began retrospective reviews of short stay inpatients and denied payment has resulted in significant institutional financial risk and penalties.

In 2012 pre-pay Medicare audits were instituted in 6 states to look specifically at short stay inpatients and determine if the patients had been properly classified for medical necessity. This has resulted in denials for payment and a hospital's need to re-bill at a lower level of care.

In 2013 CMS implemented the 2 mid-night rule, which basically places importance on identification of potential patient length of stay (LOS) as a factor to determine level of care. Determination of a patient's potential LOS exceeding 2 mid-nights requires the patient to be placed as an inpatient level of care, less than 2-mid-nights to be observation. Observation time does not count towards inpatient LOS if the patient converts to an inpatient or as a component of the 3-day qualifying stay for nursing home referral. Documentation regarding the need for inpatient level of care must be well defined by the admitting provider.

In 2016 CMS developed a C-APC 8011 for the reimbursement to hospitals for Medicare fee for service patients of approximately $2400 per case. This is a bundled APC and this incorporates the hospitals payment for all services rendered that have a facility fee component attached - EKG's, labs, drugs, x-rays, stress tests, MRI's etc.

The ED provider has become a gate-keeper in the decision-making process of the patient's level of care designation. Getting this right has profound implications to the hospital. Compliance, revenue, cost issues, LOS, capacity management of the hospital are all considered factors. Getting it right and streamlining the patients care process in a USACS designed observation unit can have significant positive impacts on the emergency department. Reduced boarding time, reduced LWBS rates, improved patient satisfaction and reduced diversion hours. Hospitals that know we understand and get this right acquire significant positive benefits both financially and operationally.

3. Is there a downside to admitted patients to observation?

Not really. However, placing too many inappropriate patients in observation status can have significant impact on hospital operations. These include multiple re-works on the patient's level of care, artificially reduced LOS of inpatients and excessive use of resources to move patients within the hospital to the correct bed placement. Hospitals which use a scatter-bed approach to manage observation patients will routinely have a LOS of a day or longer than in a USACS managed closed observation unit. This has significant impacts on overall hospital costs, capacity and compliance.

4. **Can I admit patients to "observation" in the emergency department even if they are not going to be admitted to the hospital?**
   Yes. However, if the patient is placed in observation services certain issues arise around documentation, self-referral, and billing of professional fee's. Only 1 E/M code of the same specialty can be bill out in a 24-hour period. So, if the patient was seen in the ED at 10 am and placed in observation status and discharged at 8pm that night, only 1 E/M code could be billed. Either the ED pro-fee or the observation pro-fee. The trigger for additional billing opportunities is mid-night. So, if the patient is seen in the ED at 10pm and then placed in observation at 2am, both E/M codes for the ED visit and the observation care can be billed out. Issues arise if the provider placing the patient on one day and billing the ED pro-fee is now dispositioning the observation patient on the second day-i.e. self-referral. There are also documentation constraints that must be clearly met to bill observation.

5. **What if they end up getting admitted to the hospital, can they still be admitted to observation in the ED prior to admission?**
   Yes. Several constraints around billing, documentation and compliance.

6. **What kinds of patients should I be admitting to observation?**
   The first thing an ED provider should do in determining a patient's level of care is data review. Vital Signs are reviewed for significant abnormalities, then abnormalities documented on the physical exam are reviewed, then any laboratory tests performed on the patient and finally an additional testing such as plain x-rays, CT or MRI, EKGs or USN. Compiling this information provides the ED provider with a clear picture of the patient's condition, severity and intensity of service required to care for the patient and an expected length of stay. Once completed the patient is then identified as an inpatient or an observation patient. Here is an example.

   Chest pain – normal troponin, EKG normal or unchanged, Other serious condition ruled out – PE, dissection or pneumothorax. Lack of ongoing chest pain thought to be cardiac in origin – Observation.

7. **What kind of patients should I not admit to observation?**
   Same example – Chest pain – Elevated troponin, abnormal or EKG with new changes thought to be ischemic, other serious condition identified – PE, dissection or pneumothorax. Ongoing chest pain thought to be cardiac in origin (i.e. unstable angina)

8. **What do I have to do to admit a patient to observation?**
   Once the decision is made to place a patient in observation several scenarios can occur:
   - In a USACS run observation unit, you simply call the observation provider
   - In a Hospital with a scatter bed approach, you call the receiving provider – hospitalist or private internist

The ED provider's responsibility is then to identify in the EMR a placement status of the patient into observation and the receiving provider.

If the patient remains in the ED under observation, then the following may need to occur:

- Dropping the ED pro-fee and billing only for observation services
- Billing for observation services because the patient is seen in the ED before midnight and then placed in observation services after midnight. To bill observation requires a new separate H & P including HPI, ROS, PE and medical decision making. Other documentation features may be pulled from the ED record but are requirements and include—PMH, PSH, SH, FH.

9. What do I have to do to discharge them?

You are required to write a discharge note which describes when the patient was placed in observation, why, what was done and the expected plan at discharge. A focused physical exam must be documented as well as a final diagnosis.

10. What documentation is important in between admission and discharge from observation?

CMS states that frequent documentation should occur on observation patients on why they remain in observation status. Time frames are not given but are assumed to be approximately every 8-10 hours. For a 24 hour stay that would mean an H & P, a progress note and a discharge note.

11. Is the observation admission covered by the patient's insurance?

The variety of insurance contracts and associated co-pays can be challenging for anyone to decipher. Most commercial insurers will pay for observation services since it's cheaper than an inpatient DRG. Medicare fee for service patients will have a 20% co-pay for their bill and the rest will be covered.

12. What are the pitfalls that will keep me from successfully utilizing "observation" in the emergency department?

There are many:

- Space constraints – if ED beds are used for patients with an average 20 hour LOS then overall ED bed footprint will be reduced with impact on ED operational flow.
- Proper selection – placing the wrong patients in observation status can simply end up wasting time and resources
- Oversight – making sure providers who manage these patients understand the documentation requirements, the potential impact on professional fee billing and the issues around self-referral

13. **Any other thoughts/important points related to observation medicine in the ED?**
    Yes. Take advantage of the expertise we now have in USACS observation service line to determine how your ED and hospital partner can best manage this unique population of patients.