Emergency Department Directors
Academy – Phase II

May 19-23, 2014
Dallas, TX

Breakout Session I: Billing/Coding/Observation

A detailed analysis of the major driver of ED revenue, Facility EM leveling, including a review of the common coding systems and problems will be explored. Additionally, the charges for medication administration will be reviewed along with strategies to optimize correct charge capture of these key services. Facility quality programs will be reviewed along with their direct reimbursement impact. With an eye towards the future a review of CMS sentiment and new bundling edits will provide clarity regarding the CMS vision for future payment methodologies.

Objectives:

- Describe the methodology for facility reimbursement and areas for potential improvement.
- Analyze the different models for assigning facility E/M levels.
- Identify opportunities for correcting Medication Administration charge capture deficiencies.
- Review the impact of increased ED service packaging.

5/22/14
3:45 PM - 5:00 PM
Course Number: TH-23
Trinity Ballroom I
ED Leadership and Optimizing Facility Revenue
EDDA 2 May 2014
Michael A. Granovsky MD CPC FACEP President LogixHealth

Shared Goals

- ED Directors and Nurse Managers share common goals
- Smooth functioning Emergency Department
- Adequate Resources
- Top notch clinical care
- Satisfied patients
  …Requires adequate revenue
ED Realities

- We care for anyone, with anything, at anytime
- We do it all…sometimes with very little

“I have been doing so much for so long with so little I can now do anything with nothing.”
*Ancient proverb…*

No…Average ED team after a busy Monday

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Enough Resources
...To Get The Job Done
ED Perception by The Hospital

- Business reality
- Resources follow revenue
- Emphasize the Role of the ED as a profit center
  - not an economic problem area
- ED revenue matters and can be impacted and optimized
- Optimize revenue ➔ increase resources ➔ improve staffing ➔ better work environment
- Retain higher quality employees... Better patient care!

ED Facility Revenue Chain Impact Points

- Facility E/M Leveling
- Medication Capture
- Quality Programs
  - HCAHPS and CORE
  - Value Based Payment
- Regulatory update - Packaging of Services
- Observation
“CMS has instructed hospitals to report facility resources for clinic and emergency department visits using CPT E/M codes and to develop internal hospital guidelines to determine what level of visit to report for each patient.”

OPPS Final Rule
Four Facility E/M Scoring Models

- Number and Type of interventions
- Time staff spent with patient
- Point system based on Time and Intensity
- EMR algorithm

ACEP Interventional Model is most common and in use in a majority of EDS

Facility Level Guidelines

- Facilities must develop their own guidelines
- Must relate to resource use and be consistently applied

Options
- Home grown versions
- Point systems
- ACEP Guidelines
- EMR—not able to put it over the finish line
  - Nurses use free text areas so automated suggested coding can be unreliable
  - Infusions/injections
ACEP Model

- Uses common ED interventions determine E/M
  - Procedures
  - Monitoring
  - Transportation
  - Tests
  - Complexity Of Discharge Instructions
- Developed by: The American College of Emergency Physicians
  - Interventions
  - Examples
- Established nationally applied guidelines

99282

Interventions
- Tests by ED Staff:
  - Urine dip
  - Accucheck
- Visual Acuity
- Simple DC Instructions
- Simple procedures
  - Minor laceration
  - Simple abscess

Examples
- Localized skin rash
- Ear Pain
- Urinary frequency
  - without fever
- Conjunctivitis
- Simple Trauma
  - No X-rays
### 99284

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plain X-ray multiple areas</td>
<td>Dehydration requiring treatment</td>
</tr>
<tr>
<td>MRI, CT, VQ Scans, US</td>
<td>Vomiting requiring treatment</td>
</tr>
<tr>
<td>Cardiac Monitoring</td>
<td>Dyspnea -requiring meds</td>
</tr>
<tr>
<td>Multiple Reassessments</td>
<td>Non-menstrual vaginal bleeding</td>
</tr>
<tr>
<td>Parenteral Medications</td>
<td>Musculoskeletal Trauma</td>
</tr>
<tr>
<td>2 Nebulizer treatments</td>
<td>Respiratory Illness 2 nebs</td>
</tr>
<tr>
<td>Pelvic Exam</td>
<td>2 diagnostic tests</td>
</tr>
<tr>
<td>Parenteral medications</td>
<td>– Abdominal Pain</td>
</tr>
<tr>
<td>Discharge Instructions Complex</td>
<td>– Chest pain</td>
</tr>
</tbody>
</table>

### 99284 Vignette

- 37 year old with right flank pain
- IV pain medication given
  - non-narcotic
- CT Scan of abdomen/pelvis
  - No nurse monitoring required during study
- Prescription provided for Percocet
Case Experience
Updating A Time Based System

- 40,000 visit ED
- ED Charges assigned by nursing
- HIM Using an Old Algorithm
- Significant dollars lost
- Application of appropriate EM scoring tool
  - Interventions and Intensity

Impact of Facility Guideline Coding System Outpatient
APC Task Force Model Experience

- 70,000 visit ED
- Level 1 trauma center
- ED coding using institutional specific guidelines
- Partial use of EMR
- No updating of processes
- No consistent coder training or QA process

Task Force Model Impact
E/M Distribution Outpatient
Economic Impact
APC Task Force Facility Coding System

- Increase in over $40 per patient
- Over $3,500,000 in additional charges
- ED revenue center went from a $2m loss to a $1.1M profit
- Changed the entire economic perception of the ED

Trauma Activation

- Requires pre hospital notification
  - 2 way communication
- State or ACS trauma designation
- Typically critical care
- Specific Code
  - G0390
  - $961
Facility Procedure Charge Capture

- ED procedures are reported by the facility using CPT codes
- Not an area of focus for HIM coders who work with DRGs
- ED physician and consultant procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>51702</td>
<td>Foley</td>
<td>$98</td>
</tr>
<tr>
<td>10061</td>
<td>Abscess</td>
<td>$160</td>
</tr>
<tr>
<td>12052</td>
<td>Facial laceration</td>
<td>$199</td>
</tr>
<tr>
<td>32551</td>
<td>Chest tube</td>
<td>$485</td>
</tr>
</tbody>
</table>

Hydration Injection and Infusion Services
Services Defined

- Injection/Push-IV medication given over less than 15 minutes
- Infusion-IV medication given over 15 minutes or more
- Hydration-prepackaged fluids given through an IV (NS, D5W, LR, D5 ½ NS) – 31 minutes to 1 hour

Hierarchy: Hydration, Injection, Infusion

- Three services:
  - Hydration
  - Injection
  - Infusion
CMS Medication Payments

<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>96360</td>
<td>Hydration</td>
<td>$105.90</td>
</tr>
<tr>
<td>96361</td>
<td>Hydration +</td>
<td>$29.50</td>
</tr>
<tr>
<td>96365</td>
<td>Infusion</td>
<td>$172.18</td>
</tr>
<tr>
<td>96366</td>
<td>Infusion +</td>
<td>$29.50</td>
</tr>
<tr>
<td>96374</td>
<td>Injection</td>
<td>$105.90</td>
</tr>
<tr>
<td>96375</td>
<td>Injection +</td>
<td>$43.78</td>
</tr>
</tbody>
</table>

Revenue Issues

- Must document all medications provided
- Chart construct should support Hydration, injection, or infusion
- Pay attention to time
- Time Based Codes!
- Adjust nurse documentation tool
- Train the nurses
- Review 50 records
Revenue Issues
Time Based Codes

- These are time based codes
- Need start and stop times!

Hydration:
- 96360 – hydration 31- 60 minutes
- 96361 – hydration additional hours up to 8

Infusion:
- 96365 Infusion up to 1 hour
- 96366 Infusion additional hours up to 8

Revenue Issues
Multiple Injections

- First Injection pays $105.90
- All additional Injections…$43.78
- Must capture all injections!
Hydration Vignette

- 3 year old 20KG child presents to the ED with vomiting and diarrhea and is treated for gastroenteritis with IVF followed by a physician and nurse reassessment.
  - Nurse’s notes document a total of 600ml of IVF and code 96360 is reported…$105.90
  - Nurse’s notes document a 400 ml bolus over 1 hour followed by 2 hours of hydration @ 1 ½ times maintenance

\[
96360 \text{ and } 96361 \times 2 = 105.90 + 2(29.50) = 164.90
\]

56% Increase in revenue

Infusion Vignette

- Patient with rapid A fib controlled on a Cardizem drip is admitted to tele and in the ED awaiting a bed for 4 hours.
  - Nurse’s notes document the cardizem drip… report code 96365…$172.18
  - Nurse’s notes document a start time for the cardizem and a stop time upon transfer to the floor

\[
96365 + 96366 \times 3 = 172.18 + 3(29.50) = 260.68
\]

51% increase in revenue
Infusion Injection Confusion

- A patient with pneumonia is treated in the ED with IV Azithromycin.
  - Definitive Guidance given that an injection is 15 minutes or less. An infusion must last more than 15 minutes.
  - The coder does not know how long it takes to run in the Antibiotics and reports an injection: $96374 $105.90

  Should be an infusion: $96365 $172.18
  Loss $66.28...greater than 38%

REGULATORY UPDATE
### 2014 Big Facility Reimbursement Increases

<table>
<thead>
<tr>
<th>APC</th>
<th>Descriptor</th>
<th>Payment 2013</th>
<th>Payment 2014</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>609</td>
<td>Level 1 Type A Emergency</td>
<td>$52</td>
<td>$56</td>
<td>8%</td>
</tr>
<tr>
<td>613</td>
<td>Level 2 Type A Emergency</td>
<td>$92</td>
<td>$101</td>
<td>10%</td>
</tr>
<tr>
<td>614</td>
<td>Level 3 Type A Emergency</td>
<td>$143</td>
<td>$167</td>
<td>17%</td>
</tr>
<tr>
<td>615</td>
<td>Level 4 Type A Emergency</td>
<td>$229</td>
<td>$294</td>
<td>28%</td>
</tr>
<tr>
<td>616</td>
<td>Level 5 Type A Emergency</td>
<td>$345</td>
<td>$456</td>
<td>32%</td>
</tr>
<tr>
<td>617</td>
<td>Critical Care</td>
<td>$536</td>
<td>$692</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Facility Observation Reimbursement Increasing

<table>
<thead>
<tr>
<th>Year</th>
<th>CMS Payment</th>
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<tbody>
<tr>
<td>2010</td>
<td>$705.27</td>
</tr>
<tr>
<td>2011</td>
<td>$714.33</td>
</tr>
<tr>
<td>2012</td>
<td>$720.64</td>
</tr>
<tr>
<td>2013</td>
<td>$798.47</td>
</tr>
<tr>
<td>2014</td>
<td>$1,199.00</td>
</tr>
</tbody>
</table>
2014 Increased $$
What’s The Catch?

- Many status indicator X ancillary services now packaged into the primary service
  - All typical ED Lab studies
  - Some Ultrasound services
- Many “add on services”
  - CPT “+” codes such as additional centimeters of complex lacerations, MCS add on +99150, US guidance +76937
- Add on codes for Hydration, Infusion, Injections escaped packaging for now

Impact of Lab Packaging

- CMS is telegraphing the vision of increased bundling
- Packaging of labs rewards those hospitals which are resource conscious
- There is cost for labs but no additional payment
- Proposal to bundle all HII services

Are you measuring ancillary utilization?
CMS Value Programs: Hospitals

- Hospital
  - Outpatient Quality Reporting
    - 2% non reporting penalty
  - Inpatient Quality Reporting $$$
    - Median Time to Fibrinolysis and time to PCI
  - Value Based Payment 1.25% DRG withhold
    - 70% CORE/30% HCAHPS
  - Re-admissions
    - 30 day readmission for AMI CHF Pneumonia
    - CY 2014 2% at risk hip/knee replacements/COPD

Hospital Compare Website

- Public Reporting of Core Measures
- Timely and Effective Care
  - Time before patients with chest pain got an ECG
  - Time before patients needing PTCA were transferred
  - % of patients receiving lytics within 30 minutes
  - Pneumonia measures
  - ED throughput measures
- Readmissions Complications and Deaths
  - 30 day readmission (AMI/CHF/Pneumonia)
- Use of Medical Imaging-
  - Brain/sinus CT, abdomen or chest w/ and w/o Contrast
- Survey of Patient’s Experience-
  - HCAHPS Survey
The hospital quality meeting is now a big one- $$$ at stake
- Engaged groups need a quality leader
- Patient flow pathways with hospital investment re: lytics/PCI/Pneumonia patients
- CORE measure – order sets with physician and nurse education and case specific feedback
- Aspirin for MI example: given by EMS
  - On run sheet
  - Not in hospital record
- Readmissions- We are not the problem but can be part of the solution
  - EMR flags, MD coordinator, home health

EM Opportunities: Hospital Value Programs

Observation
Why is Obs Important Now?

- CMS RACs focusing on inpatient DRG payments vs. observation status
- Hospitals under pressure to cut costs
  - Global contracts/ACOs/directly insuring communities
- ED groups ideally suited to run efficient units with short lengths of stay
  - We have the throughput mindset!

DRG Basics

- 751 Inpatient DRGs based on patient’s diagnosis
  - Simple pneumonia or complex pneumonia
- Patient is a formal inpatient
- Medicare pays a fixed amount for inpatient care
- Typically a large amount
  - Much more than the observation payment
- DRG has a mean expected length of stay
  - Simple Pneumonia
    - Length of stay: 3 days
    - Payment: $3,893
Increased Obs Use Will Create Significant Savings?

Greater Use of Observation: Save $3.1 Billion a Year:
Estimated savings for increased use for patients staying less than twenty-four hours:
CMS estimated:
- Average cost savings per patient = $1,572
- Annual hospital savings = $4.6 million
- National cost savings = $3.1 billion.

Conclusion: Future policies should include support for observation unit care as an alternative to short-stay inpatient admission.

Whacked by RAC

- RACs collected more than $2 billion from hospitals in 2012 and 2013
- AHA’s RACTrac Survey
  - 63 percent of hospitals spending at least $40,000 in 2013 for RAC-related defense costs
  - 46 percent > $100,000 in defense costs
  - 28 percent > $200,000
  - 10 percent > $400,000
- SHORT-STAY DENIALS: Largest Area of Investigation
  - 62% of short-stay denials were because the care was provided in the wrong setting, not because the RAC considered the care medically unnecessary... Inpatient vs Obs
RAC Impact and Hospital Response

- Hospitals pressured to avoid short-stay inpatient admissions
- Increased use of “observation status”
- Initially, a billing change...now a delivery model change
- Current and future opportunities for cost efficiency
- Accelerated throughput yields cost savings

Top RAC DRG Targets and Denials

- TIA 6% (DRG 69)
- Chest pain 8% (DRG 313)
- Syncope 16% (DRG 312)
- COPD (uncomplicated) 5% (DRG 312)
- Pulmonary edema 4% (DRG 189)

Are you analyzing care provided for these cases?

RAC review of one-day stays: 78% of claims were denied due to the service being provided in an inappropriate setting... **Obs vs Inpatient**
OIG Top 10 Inpatient Short Stay Diags.

Most Common Reason for Short Inpatient Stays

<table>
<thead>
<tr>
<th>Most Common Reasons for Short Inpatient Stays</th>
<th>Number of Short Inpatient Stays</th>
<th>Percentage of Short Inpatient Stays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>49,716</td>
<td>4.3%</td>
</tr>
<tr>
<td>Coronary stent insertion</td>
<td>45,658</td>
<td>4.0%</td>
</tr>
<tr>
<td>Irregular heartbeat</td>
<td>38,961</td>
<td>3.4%</td>
</tr>
<tr>
<td>Digestive disorders</td>
<td>37,649</td>
<td>3.3%</td>
</tr>
<tr>
<td>Syncope</td>
<td>32,656</td>
<td>2.8%</td>
</tr>
<tr>
<td>Circulatory disorders</td>
<td>29,515</td>
<td>2.6%</td>
</tr>
<tr>
<td>Loss of blood flow to the brain</td>
<td>25,355</td>
<td>2.2%</td>
</tr>
<tr>
<td>Nutritional disorders</td>
<td>24,624</td>
<td>2.1%</td>
</tr>
<tr>
<td>Red blood cell disorders</td>
<td>20,977</td>
<td>1.8%</td>
</tr>
<tr>
<td>Irregular heartbeat (medium severity)</td>
<td>20,064</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Source: OIG analysis of CMS data, 2013

Your Hospital’s DRG Profile
The Pepper Report

- Complex Medicare Report
- Supplies hospital data related to potentially improper DRG payments
  - Number of discharges per DRG
  - Payments per DRG
  - Length of stay per DRG
    - Highlights hospital LOS ≤ 1 calendar day
  - RAC focus for DRG take backs
Who Should Be In Obs?

Which Obs patients will an ED group be successful with?

- Select patients with diagnoses that have clinical protocol
- Expedite throughput
- Achieve decreased length of stay

The Spectrum of Complexity

<table>
<thead>
<tr>
<th>Easier</th>
<th>Harder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>Closed head injury</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>Vertigo</td>
</tr>
<tr>
<td>Headache</td>
<td>Hematuria</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Hypertensive urgency</td>
</tr>
<tr>
<td>Pyelonephritis</td>
<td>Pancreatitis</td>
</tr>
<tr>
<td>Asthma</td>
<td>SOB</td>
</tr>
<tr>
<td>Dehydration</td>
<td>CHF/COPD</td>
</tr>
<tr>
<td>Renal colic</td>
<td>Pseudotumor</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>Coagulopathy</td>
</tr>
<tr>
<td>Allergic reaction</td>
<td>GI Bleed</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td></td>
</tr>
</tbody>
</table>
Challenging Conditions

- Extremes of age
- Multiple illnesses and diagnoses
  - CHF with severe Htn, BS 405, uremia, mild confusion
- Substance abuse
- Psychiatric conditions
- Chronic pain

Selection Is Important

- Hospital observation status is based on Interqual type standard
- We will not achieve success with complex patients
- ED run units are based on evidence based criteria and protocols
- Goal: expedited care and safety
- If we cast the net too wide we may fail
Length of Stay Improvement

<table>
<thead>
<tr>
<th>Metric</th>
<th>CDU</th>
<th>In Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay</td>
<td>25.6 hrs</td>
<td>61.2 hrs</td>
</tr>
<tr>
<td>Cost</td>
<td>$890</td>
<td>$1,547</td>
</tr>
<tr>
<td>Full testing</td>
<td>97%</td>
<td>91%</td>
</tr>
</tbody>
</table>

Source: Ross, MA An Emergency Department Diagnostic Protocol for Patients with Transient Ischemic Attach: A Randomized Controlled Trial Annals of Emergency Medicine Vol. 50, Issue 2, Pages 109-119

Goals

- Efficient quality care with decreased length of stay
- Create hospital bed capacity
- Value-added hospital partner

Short LOS with great care is the paradigm
Large Multi-Site Group Data

- Eight complaint specific protocols at 70k visit ED
- Baseline Avg Inpatient LOS 38 hours
- Obs Unit LOS down to 19 hours
- Treated 3500 patients first year
- $3,500 \times 19 = 66,500$ hour reduction in length of stay
  
  Created 2,770 hospital bed days  
  Saved 2,770 days of hospital staffing/resource cost

How Many Patients?

- Varies by department acuity and your Obs protocols
  - How wide you cast the net
- Basic benchmarks
  - As high as 5% - 10% for many groups
  - 1 out of 3 admissions
  - Chest pain most common...typically a third
- Most groups have a 10% - 20% failure rate
  - Converted to inpatient
2014 Big OPPS Changes

- New Obs composite APC 8009
- Single payment
  - Obs and ED visit combined into a single payment
- APC 8002/8003 retired

CMS Facility Observation Reimbursement

Big 2014 Reimbursement Changes

- The composite APC (8009 ED + Obs) is reimbursed as a single payment
- 2013 Obs APC 8003 payment was $798.47
  - 2013 payment for 99285 was $344.71
  - Observation added $453.76 in additional reimbursement
- 2014 APC 8009 payment is $1,199
  - 99285 is $455.93
  - Observation adds $743.07 in additional reimbursement
The Obs Pendulum: Financial Risk/Reward

- Risks: underuse of observation
  - Inappropriate inpatient admissions
  - Short inpatient stays and CMS compliance… RAC target, CERT audits, OIG work plan issue, MAC concern
  - Short inpatient stays: decrease CMI, payment denials

- Risks: overuse of observation
  - Financial - lower payment to the hospital vs. inpatient
    - $5142 vs $1741 (looking at top 10 diags.)
  - Loss of 3 day qualifying inpatient stay for SNF coverage
  - Potential higher out-of-pocket expense for patients
    - Though very case specific
  - Increased average inpatient LOS and profiling implications

Conclusions

- Facility E/M coding is a key driver of department finances
- Hydration/Injection/Infusion charges are complex
  - Require chart construct, nurse, and coder training
- There may be significant “low hanging fruit”
- CMS Value programs will continue to expand
- More packaging is coming
- Obs will be a key part of our future
Contact Information

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Educational Appendix
2014 Packaging of Medication Services

- Proposal to continue payment for the primary drug administration services
  - “Initial” injections and infusions status indicator (SI) S
    - procedure or service that is separately paid
- Will package the add-on codes
  - SI = N (packaged, no APC or payment).
- Significant increase in payment for primary service
  - 2013 therapeutic infusion (96365) and additional hours (96366) are $146.24 and $27.01 respectively
  - 2014 payment 96365 $201.73 (+$18) .....96366-packaged ($0)
    Strategy- throughput, efficiency, resource pressure
    ...ED value

CMS Proposes Expanded Packaging

- Many Clinical diagnostic laboratory tests when provided on the same date of service
  - Previously have been paid on the Clinical Lab Fee Schedule
- Procedures described by add-on codes
  - Such as each additional hour codes, additional injections, additional/sequential infusions proposed to be packaged
  - CMS will only pay for what it calls the main/primary procedure or the initial service codes in the case of drug administration
- Diagnostic tests on the bypass list
- Device removal procedures
- Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test
- Drugs and biologicals that function as supplies or devices when used in a surgical procedure
CMS 2014 OPPS Proposed Rule Addendum P Packaged HII Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>96361</td>
<td>Hydrate iv infusion add-on</td>
<td>N</td>
</tr>
<tr>
<td>96366</td>
<td>Ther/proph/diag iv inf addon</td>
<td>N</td>
</tr>
<tr>
<td>96367</td>
<td>Tx/proph/dg addl seq iv inf</td>
<td>N</td>
</tr>
<tr>
<td>96368</td>
<td>Ther/diag concurrent inf</td>
<td>N</td>
</tr>
<tr>
<td>96370</td>
<td>Sc ther infusion addl hr</td>
<td>N</td>
</tr>
<tr>
<td>96371</td>
<td>Sc ther infusion reset pump</td>
<td>N</td>
</tr>
<tr>
<td>96375</td>
<td>Tx/pro/dx inj new drug addon</td>
<td>N</td>
</tr>
<tr>
<td>96376</td>
<td>Tx/pro/dx inj same drug adon</td>
<td>N</td>
</tr>
</tbody>
</table>

July 2013 OIG Report and HHS Letter Precursor To The 2 Midnight Rule

- CMS and members of Congress have raised concerns
  - Beneficiaries spending long periods of time in Obs without being admitted as inpatients
  - Obs is technically an outpatient status
  - Concerned beneficiaries may pay more as outpatients than if they were admitted as inpatients
    - 80/20 co-insurance under part B
    - 2014 part A deductible $1,216 per benefit period
  - If not inpatient then pt. is responsible for SNF charges
    - In 2012, 11% of Obs was > 3 days
The Differences Obs vs Inpatient

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Fee - $1,184 deductible</td>
<td></td>
</tr>
<tr>
<td>- After day 60 co-insurance of ~$290</td>
<td></td>
</tr>
<tr>
<td>Medications $0</td>
<td></td>
</tr>
<tr>
<td>Labs- part of DRG</td>
<td></td>
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<tr>
<td>Physician services- part B 80/20</td>
<td></td>
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<tr>
<td>Radiology services- covered once deductible met</td>
<td></td>
</tr>
<tr>
<td>- MD portion 80/20</td>
<td></td>
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<tr>
<td>20% of APC 8003/8009</td>
<td></td>
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<tr>
<td>- ~$269</td>
<td></td>
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<tr>
<td>Medications – no coverage</td>
<td></td>
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<tr>
<td>Labs- ? Part of APC 8009</td>
<td></td>
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<tr>
<td>Physician services – 80/20</td>
<td></td>
</tr>
<tr>
<td>Radiology services – some ?part of APC 8009</td>
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</tr>
</tbody>
</table>

Winners and Losers vary by scenario
Short Inpatient stay patient gets hit with deductible
Long Obs stay Meds, co pays and co insurance can add up

Most agree Obs should qualify for SNF coverage

SNF Patient Financial Considerations

- SNF
  - Obs stay…no qualifying SNF Medicare coverage
    - Patient may be entirely responsible
    - Typical stay starts at roughly $250 per day
  - Qualifying inpatient stay spanning 3 nights
    - No patient SNF cost sharing for first 20 days
    - After 20 days co-payment is $145 per day
OIG Concerns: The 2 Midnight Rule Is Born
2014 Inpatient Final Rule

2 Midnight Rule

- **The Benchmark:** We are specifying that for those hospital stays in which the physician expects the beneficiary to require care that crosses 2 midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. (2014 IPPS Final Rule 60/2225)

- For Hospital stays in which the physician expects the patient to require care less than 2 midnights, payment under Medicare Part A is generally inappropriate. (IPPS Final Rule 60/2225)

2 Midnight Rule Conclusions

- Physicians can use all the time a patient may spend in the hospital as an outpatient when considering the two-midnight threshold for inpatient status
  - < 2 midnights observation
  - > 2 midnights inpatient admission
  - However, outpatient time not included for SNF qualification
- Will create added throughput pressure for Obs
  - Cinderella effect: Obs completed before the second midnight
  - ED run/ ED culture streamlined protocol driven units have increased value
Contact Information

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