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March 2023

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Editor's Note

Ronald Hirsch, MD, FACP, CHCQM-PHYADV, CHRI
Member, ACPA Advisory Board
Member, ACPA Government Affairs Committee
Editor, ACPA Update

Everyone excited for May 11th when the public health emergency ends and we lose the 3-day inpatient stay waiver for access to part A SNF coverage? I am hearing lots of things out there- “oh, our SNFs stopped accepting waiver patients a long time ago,” and “oh, our SNFs don’t have enough staff so they never have open beds,” and “we don’t have any COVID patients any more so we stopped using the waiver.” Let me look at bit deeper at these. First, the SNFs have every right to not accept the waiver but most do it because early in the pandemic their claims were denied without that 3 day inpatient stay. I don’t know if it was the lack of the DR condition code on their claim or a processing error by the MAC, but nonetheless they were not willing to risk non-payment again. The lack of staff and beds is certainly a huge issue and I wish I had a solution. Some think there are games going on in the SNF ownership world, with private equity and hidden ownership skimming profits and neglecting patients and staff. CMS recently proposed regulations about public reporting of ownership to try to address that. Having spent a lot of time in SNFs as a medical director at two in my area years ago, I know that being a nurse or aide there is hard work with little reward. Like teachers, we often do not recognize the true value our front line workers provide.

And the third excuse is something that is blatantly wrong. Way back in 2021, CMS addressed this, stating in writing that “The qualifying hospital stay waiver applies to all SNF-level beneficiaries under Medicare Part A, regardless of whether the care the beneficiary requires has a direct relationship to COVID-19.” Can’t get much clearer than that. No need for a COVID diagnosis, no need for the hospital to be overwhelmed with COVID cases. Any patient needing SNF care qualifies. Which brings me to another point. Will CMS eliminate this outdated rule? We all hope so. But the requirement is actually in the Social Security Act so it literally will take an act of Congress to remove it permanently. It will be interesting to see if it gets addressed.

So, on to this issue. We have some more great articles for you. I am sure every one of you has heard the term “tear down the silos.” It is easy to say that but hard to actually do it. But read the article by Shari Garceau about how to actually do it. Also read Andrew Maigur’s article about physician documentation with the 2023 E&M rules. Two weeks ago I visited 4 hospitals and did physician education and in all those sessions, only one doctor even heard of the new rules but didn’t know how to use them. What the heck? Someone (not you) needs to teach the rules; they are a gift to doctors!

Erica Remer talks about myocardial infarction and documentation, providing some excellent tips on how to sort it all out and how to teach your doctors the right way to document, along with the right way to pronounce the word referring to “after death.” And

even if you are not a pediatrician, take a look at the review of the pediatric observation cases from a few months ago. Every little bit of knowledge makes you better at your job.

Remember, ACPA is here for you. Tell us what you want, what you need, and what you can contribute. You can always contact me at **signaturedoc@gmail.com**.

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Is it the PAs Role to Teach the Experts?

Erica Remer, MD, CCDS
Member, ACPA Board of Directors
Chair, ACPA CDI Committee

When I was a physician advisor (PA), they paid me to think. I was hired by Health Information Services to be the PA for the clinical documentation integrity (CDI) team, so it is a bit different from those of you who are primarily Utilization Review/Case Management (UR/CM) PAs. Of course, I performed tasks, but what they really needed me for was thinking.

I thought about CDI and how to best convey the importance of what CDI did, to the medical staff. I investigated conditions which I might not have encountered frequently in my clinical practice, and I pondered about how to best teach providers [sorry, I know some of you hate this term, but I don't know another way to collectively say physicians and advanced practice practitioners (APPs), short of "physicians and APPs"] CDI. Why did we have problems getting providers to document this particular disorder? Which Diagnosis Related Groups (DRGs) were giving us trouble and why? How can we fix it?

As PAs, you are experts at certain things. If you are UR/CM, you are experts at status determination and medical necessity. If you do CDI, you are the authority in your institution on intersection of clinical and coding. There are likely certain topics which feel more

organic to you, depending on your original service line. But what about conditions which have implications for coding, quality, and reimbursement which are not in your wheelhouse of clinical practice? Are you entitled to weigh in? Do you really have to see one and do one to be able to teach one? The PA community is very diverse; can a current or ex-practitioner of pediatrics, emergency medicine, or radiology advise a hospitalist in their lane?

The answer is categorically yes. However, you need to put your own oxygen mask on before assisting others. Let's consider myocardial infarction and injury. The Fourth Universal Definition of Myocardial Infarction came out in August 2018. I was not a cardiologist, but I had the luxury of time to pore over the article and associated commentary, the intelligence to dissect it, and the superpower to be able to grasp the essence which needed to be taught for providers to change their behavior. What you can't do is cursorily review the literature and try teaching providers from the same level of knowledge that your CDISs or UR nurses have. You must be the theoretical expert in the condition as it applies to CDI or UR, even if you never treated the condition yourself.

Discussing and consulting the practitioners who do treat the condition is a prudent course of action. You don't want to be the brainiac who understands the concept but is clueless about execution. It was hard to take my genius 4-year-old completely seriously when he pronounced "posthumous," \ pōst- '(h)yü-məs \. But you don't have to wield a scalpel to be able to recognize that transecting a ureter is considered a complication of an appendectomy.

Make sure you are conferring with the right expert. There are two kinds of consultants; early adopters who are knowledgeable about the most current literature and practice, and old fogies (did you know the singular of that is "fogy"? I didn't) who are still practicing the way they learned it decades ago. It may be easier to teach the general hospitalist about Type 2 myocardial infarctions and acute myocardial injury than the early adopter cardiologist because the hospitalist may not question your expertise. However, teaching the old fogy supposed heart specialist how to use the most current codable terminology may be the most challenging. They may be affronted by your presumptiveness.

So, make sure you are well-equipped. Be sure you understand that:

- Myocardial injury is elevated cardiac troponin (cTn) with at least one value > 99th percentile upper reference limit (URL).
- ACUTE myocardial injury is when there is a demonstration of rising and/or falling of cTn (i.e., acutely changing). 20% variation or more indicates acute change.
- It is theoretically possible to miss the peak, but that thought process would need to be explicitly documented
- Acute myocardial injury due to ischemia is considered a myocardial infarction
- Evidence of ischemia is considered to be:

- *Symptoms (e.g., chest pain, dyspnea, diaphoresis, etc.)*
- *New ischemic EKG changes*
- *Development of pathological Q waves*

- *Imaging evidence of infarction*
- *Identification of a causative coronary thrombus*

- There is such a thing as asymptomatic ischemia in certain populations, like the elderly or diabetics. Women also may not read the textbook and may have unusual symptoms. These can still be entertained as ischemic myocardial injury IF THE PROVIDER DOCUMENTS IT APPROPRIATELY.
- If the ischemia and infarction is due to atherosclerotic blockage and/or thrombosis, it is a Type 1 MI
- STEMIs and NSTEMIs are Type 1 MIs
- If the ischemia and infarction is due to supply-demand mismatch, also known as demand ischemia, then the infarction is a Type 2 MI
- Although a Type 2 MI usually does not have ST-segment elevation, it is not supposed to be called "NSTEMI." That moniker is supposed to be reserved for a Type 1 MI.
- "Supply-demand mismatch" is a mechanism, not a condition. "Demand ischemia" is a mechanism, not a condition. Ischemia can lead to injury or infarction.
- Certain conditions can cause either acute myocardial injury or acute myocardial infarction, depending on whether the provider believes ischemia has ensued. For instance, heart failure can cause either, depending on severity. Is the HF serious enough to cause the heart muscle to not be adequately perfused, thereby causing ischemia?
- Constant elevated troponin (therefore not acute myocardial injury) can be due to chronic myocardial injury (like in chronic kidney disease)
- Type 2 MIs are not worked up or treated like Type 1 MIs. The treatment is aimed at the underlying causative condition.

That is the essence of myocardial injury and Type 2 MI. The CDI piece of it that the PA is expected to know and to be able to impart on their colleagues is:

- Myocardial injury has its own unique code. The title of ICD-10-CM code I5A is Non-ischemic myocardial injury (non-traumatic).
- The provider does NOT need to document "non-ischemic." However, if the provider believes acute myocardial injury has occurred from some type of ischemia, be it atherosclerotic/plaque-induced or supply-demand mismatch, it should be documented as an infarction, not injury.
- Whether the provider documents "acute," "chronic," or leaves it unspecified, the code happens to be the same, I5A.
- The provider shouldn't document, "Type 2 myocardial injury." That is an oxymoron. They shouldn't document, "Type 2 NSTEMI," even if that makes intuitive sense according to the words and acronym. However, if the provider does say, "Type 2 NSTEMI," the coders are instructed to assign the code for Type 2 MI: I21.A1 Myocardial infarction type 2.
- Documentation of any variation on the theme of troponinemia/elevated troponin results in a symptom code, R79.89, Other specified abnormal findings of blood chemistry. Providers shouldn't default to this code when the scenario is more accurately represented by acute myocardial injury or some type of infarction.

- Myocardial injury is a comorbid condition or complication (CC), and myocardial infarction is a major CC (MCC). Elevated troponin is bubkes (i.e., nothing, nada, no risk adjustment. Bubkes is believed to come from the Yiddish kozebubkes which literally means goat droppings.). We want risk adjustment to accurately reflect how sick and complex the patient is.

You don't need to be a cardiologist to facilitate the proper diagnosis and documentation of myocardial injury and infarction. You can be a well-informed PA, knowledgeable in the current literature. Defer to them on practice but inspire them to rely on you for guidance on best practice documentation. This is your lane; drive confidently in it.

References:

Fourth Universal Definition of Myocardial Infarction (2018) | Circulation (ahajournals.org)

Fourth universal definition of myocardial infarction. Selected messages from the European Society of Cardiology document and lessons learned from the new guidelines on ST-segment elevation myocardial infarction and non-ST-segment elevation-acute coronary syndrome - PMC (nih.gov)

Dr. Erica Remer is founder and president of Erica Remer, MD, Inc., consulting services for documentation, CDI, and ICD-10, in Beachwood, OH.

Breaking the Silos for Healthcare Success

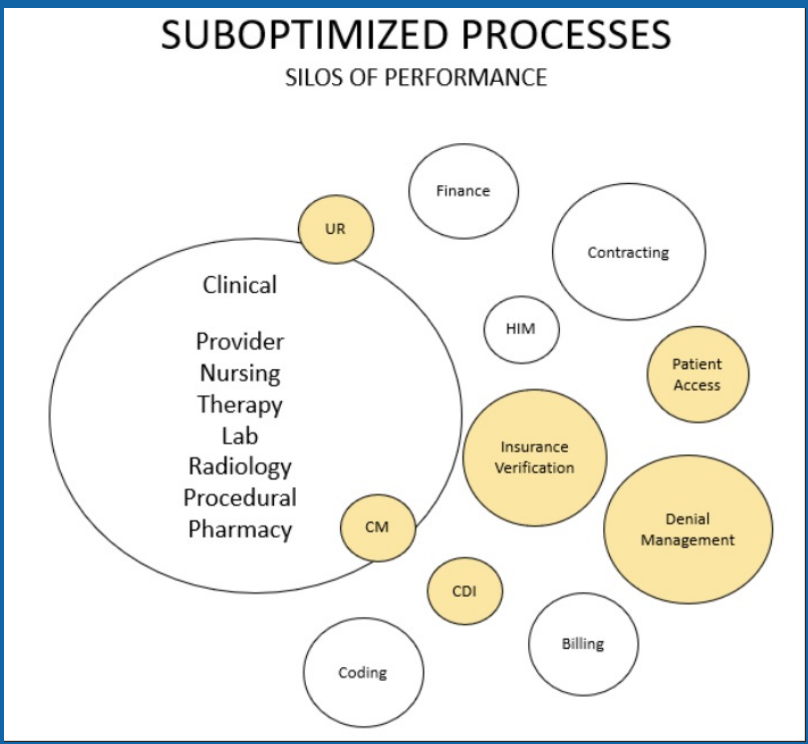
Shari Garceau, MSN, RN, CMAC, CCM, ACM-RN, CRCR, CLSSGB

Introduction

Historically, healthcare departments work with a focus on their specific roles and responsibilities. This practice negatively impacts business operations and the clinical teams, as exemplified by increased denial rates, length of stay, and back-end expenses related to work to correct work. In addition, this separation and silo system of work is suboptimal. It leads to a decrease in efficiency, duplication of effort, and potentially undoing of hard work put in place by one team by another without coordination of efforts. Developing strategies to improve processes within the Revenue Integrity Cycle, the team approach used in managing hospital functions from patient identification through reimbursement will drive financial stability and role satisfaction.

The clinical care departments depend upon each other to provide the highest quality of care for patients and traditionally work within a single silo in delivering care and utilize the Multidisciplinary Rounds (MDR) or Interdisciplinary Team (IDT) to coordinate efforts. On the contrary, the business operations teams, unfortunately, are not as dependent upon each other daily and have not optimized actions within a single silo. Therefore, business operations departments still need to fully identify their impact on alternate business operations and clinical departments.

The focus of this article is on the effect of silos on the Revenue Integrity Cycle and the throughput of patients with a specific focus on the negative impacts of suboptimization, or silos, of the Utilization Review (UR), Case Management (CM), Clinical Documentation Improvement (CDI), Patient Access, insurance verification, and denial management teams.



As part of the Revenue Integrity Cycle, payors have recognized the silo approach of healthcare systems and utilize that practice to their benefit in “winning” the denial game. Payors encourage one hospital department to work against another to perform their focused role to the highest quality. It is time to optimize and align the silo thinking and find ways to unite the critical departments as a united team to meet the changing rules of the

game.

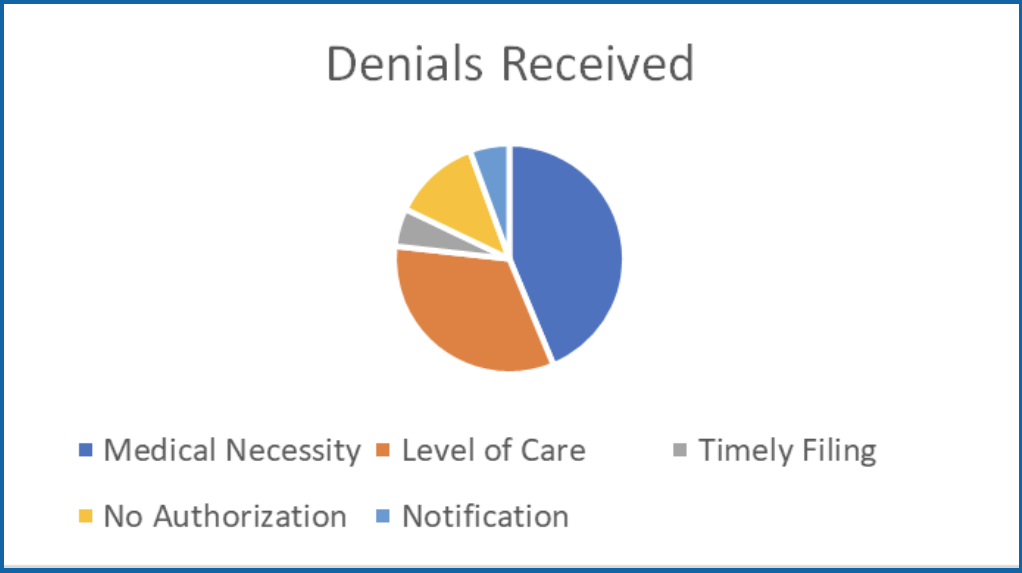
Methodology

Data Collection

Using the Electronic Medical Record (EMR) reports, spreadsheets, and denial information from payor information related to denial reasons, the timing of receipt, and length of stay, including discharge disposition, were analyzed and evaluated for opportunities.

Denial Receipt

Nine thousand (9,000) denial case data from various geographic locations, facility types, payor mixes, and DRG information collected over six years supports the coordination of efforts to mitigate denials and were compiled as data to review for this project. Key focus on Medical Necessity, Level of Care, Timely Filing, No Authorization, and No Notification denials reviewed.



Length of Stay Management

Inpatient (IP) actual length of stay (ALOS) information, as well as the geometric length of stay (GLOS) based on billing Diagnostic Related Group (DRG), was collected from 20 facilities in various geographic locations and settings. The data covers all service lines and patient level of service, and Inpatient level of care status. Additionally, the team further analyzed outlier length of stay cases for impacting factors and opportunities for process improvement to prevent future occurrences, if appropriate. The below table includes the total number of cases reviewed with the ALOS, GLOS and the variance between those identified. The outlier cases represent the cases that drove the total variance in length of stay. Those cases were further analyzed to identify opportunities for process improvement to prevent future cases, if appropriate.

Facility Cases	IP ALOS	IP GLOS	Variance
398	484.9	303.8	-181.1
Outlier Cases	**ALOS**	**GLOS**	**Variance**
135	164.5	103.1	-61.4

Analysis:

Optimal role focus

Patient Access – identify accurate, current payor source.
Insurance Verification – validate accurate payor source prior authorization of scheduled admissions and payor contact information regarding admission for all patients.

Utilization Review (UR) – reviewing documentation for medical necessity supported by nationally accepted criteria, payor-specific criteria, or CMS Two-Midnight Rule communicated with payors to obtain authorization currently; provide medical necessity status to CM/CC for MDR/IDT discussion; coordinate with CDI for documentation improvement to support medical necessity and alignment with DRG.

Case Management/Care Coordination (CM/CC) – assessment and coordination of patient care across the continuum of care, including hospitalization and post-acute services based on GLOS and medical necessity; provide MDR/IDT information to UR for payor communication.

Clinical Documentation Improvement (CDI) – review of documentation for accuracy and completeness to capture appropriate diagnoses to assist coding in the completion of the coding process; identity working DRG and GLOS and provide to CM/CC for MDR/IDT discussion; coordinate with UR for documentation improvement to support medical necessity and alignment with DRG.

Coding – review documentation for coding accuracy to drive billing; review CDI information aligning with UR medical necessity.

Billing – validation of billing accuracy based on coding, contractual guidelines, and compliance with regulatory agency requirements.

Denial Management – review denials to identify appropriate “buckets” of accountability; facilitate the interdisciplinary team to discuss denials and develop mitigation strategies.

Process Breakdowns/Gaps

A major data finding related to denial mitigation opportunities lies within the collaboration between UR and CDI/Coding. In 44% of Medical Necessity denials, 67.4% of those had concurrent authorization in place and received a retrospective denial as the medical

necessity for the billed DRG was not supported. Level of Care denials related to the same condition was 83.2%. The potential for collaboration between UR and CDI/Coding would have resulted in a 56.8% reduction in total denials. The potential financial impact of those cases was significant, $34,462,000.00. The financial impact increased due to the increased man-hours in back-end appeal costs.

Patient access and insurance verification verify incorrect payor source; verify incorrect prior authorized codes as incorrect codes provided or payor site limitations for code selection; the patient's current insurance is incorrect. (Notification denial).

UR identifies incorrect payor source after receipt of a denial, obtains authorization, overturns a concurrent denial, or identifies denials needing next-level appeal beyond reconsideration and peer-to-peer attempts (Notification, Medical necessity, level of care denial.).

CM/CC identifies incorrect payor source during discharge assessment. (Notification denial); lack of GLOS information guiding length of stay; lack of information regarding medical necessity for the continuation of stay (Medical necessity denial.)

CDI and Coding identify alternate DRG from the medical necessity DRG supported by UR documentation; working GLOS information is not shared with CM/CC to drive the length of stay. (Medical necessity, level of care denial.)
Bill finalization while the denial appeal is in process. (Medical necessity denial.) Bill held without payor notification related to appeal currently in process. (Timely filing denial.)

Denial Management accepts denial and recommends rebilling at a lower level of care or write-off potentially without a next-level appeal attempt.

Interventions:

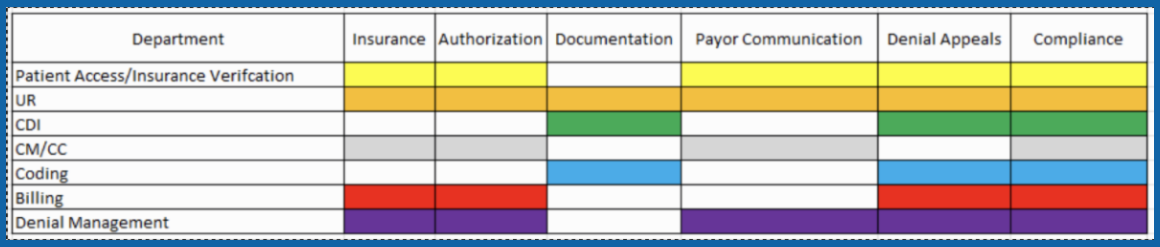
Mitigation Efforts Reducing Silo Suboptimization

Establishing a team consisting of representatives from the Revenue Cycle departments was established to develop a process that utilized each department's key responsibilities and information in a collaborative process which included: Contracting, Scheduling, Patient Access, Insurance Verification, HIM, Coding, Billing, Business Office, UR, CM/CC, CDI, Denial Management, Provider office management, and Physician Advisors (PA). Using a combination of process improvement approaches, the team will begin identifying gaps in the current process, areas of focus for improvement, and implementation of plans.

Implement a review process at all portals of entry for patients and initiate steps to get from access point to reimbursement discussed with crucial departments; learning from the interaction how their role impacted the roles of other team members, the silos began to crumble. The team approach began to take on a comprehensive communication and collaboration process empowering all departments to look beyond their area to see the loftier scope of the denial issue within the facility.

Alignment of the Team

While each department brings knowledge and skills to the team, aligning the entire team is the focus of any process improvement. Each piece fits together in the cycle that often is not a one-way road but a back-and-forth process to get to the final product. Communication openly and respectfully is needed to get the highest quality outcome, in this case, reimbursement of services and care rendered for patients. There are multiple areas where department work processes and accountabilities overlap. Below is a graph identifying the key areas for coordination of efforts is imperative. Departments with an overlap in any column need communication pathways to share and support each other to ensure alignment with the information presented to payors for reimbursement.



Department	Insurance	Authorization	Documentation	Payor Communication	Denial Appeals	Compliance
Patient Access/Insurance Verifcation						
UR						
CDI						
CM/CC						
Coding						
Billing						
Denial Management						

Denials Team

Collaboration between the Utilization Review, Clinical Documentation, Coding, and Billing is needed to ensure the record supports medical necessity and coding accuracy. Engaging the facility PA in addressing documentation from providers will add support to address improvement opportunities. Sharing the CDI working DRG will allow UR to review cases under that area of medical necessity. If the documentation does not support using that diagnosis, then UR should share the diagnosis used, which does support the medical necessity of the admission with the team. The PA, UR, and CDI teams can work with the providers to improve documentation and align the medical necessity with the selected DRG. Working together with a give and take that both departments are right or wrong, they have a different focus. Still, they can support each other in communicating consistently with the payor and reduce the retrospective denials resulting in further expense and time in appealing and receiving appropriate reimbursement.

CDI and Coding should work closely in aligning the concurrent CDI work with the retrospective coding and share any potential impact on the medical necessity with UR that may impact the concurrent authorization obtained. Again, while the focus of the roles vary, the goal is timely, appropriate reimbursement and reduction of denials requiring additional staff time and cost to appeal.

In cases where medical necessity and coding are not aligned, the additional support for the admission should be documented in the record to provide the retrospective denial team with all pertinent information in attempting a next-level appeal.

The alignment occurs with regular Denial Management team meetings with the process team to identify the actual root cause of denials, review for potential alignment and process improvement opportunities, and clarify the denials known to lead to multiple-level

appeals.

Engaging contracting with the outcomes of the deep dive into denials should guide future contract negotiations and regular payor-specific meetings to discuss consistent issues resulting in denials, inefficiencies, time use, and human resource expenses on both sides to conclude. This final alignment will be the most significant challenge and may result in only a partial alignment.

Patient Throughput

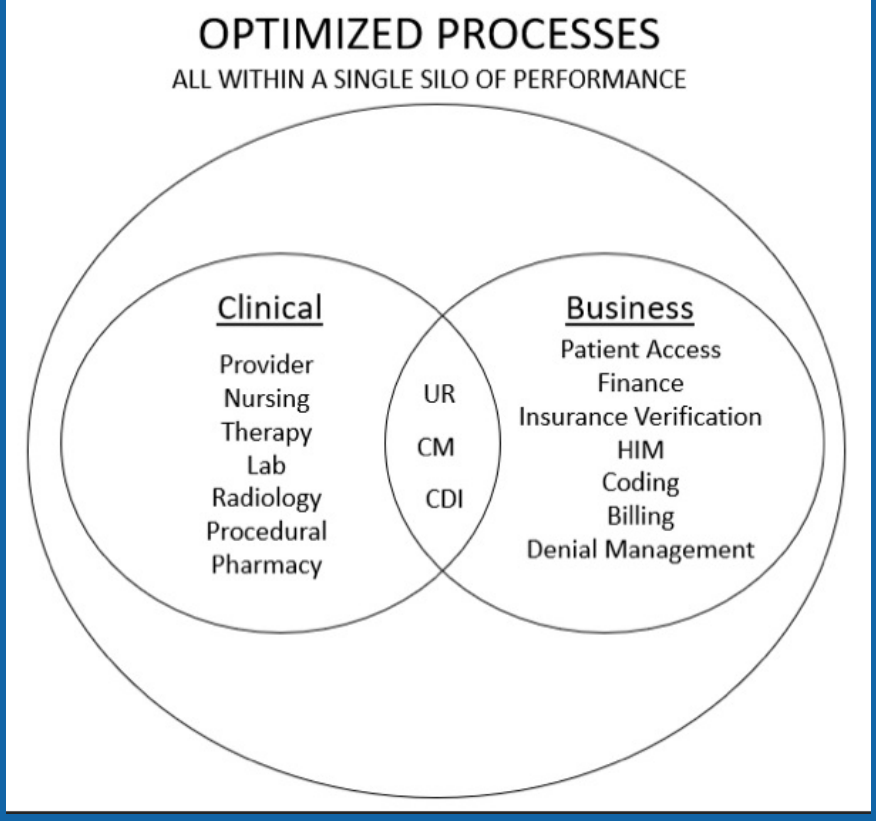
Coordination between providers, nursing, CDI, UR, and CM/CC is needed to improve the throughput of patients starting at the point of entry through post-acute services. CDI teams have the expertise in identifying the working DRG, including the GLOS for each DRG. The medical necessity documentation support reviewed by the UR staff, in addition to the GLOS, will guide the MDR/IDT in managing cases and identifying a goal, target discharge date, and needs to meet the individual patient. Managing the movement of each patient from the point of entry through hospital units and discharge to the most appropriate community providers takes the entire team communication. Working as a united entity will improve overall patient care, use of patient insurance benefits, and facility revenue.

Conclusion

It takes a team working towards a common goal with an open mind that change improves processes. Continually reviewing for opportunities to make adjustments to meet future challenges leads to further success. Optimizing the team processes and reducing the adverse silo effects positively impacts the quality of care provided and have a positive financial impact on both patients and the facility.

Denials and increased length of stay identify breaks or gaps in our processes. The team approach without the barriers of the silos will allow the facility to determine the gaps, develop strategies to fill those gaps, and improve the process.

Three teams are vital in tying the clinical and business operations together within the most optimized silo: UR, CM/CC, and CDI. Each department functions as part of both the clinical team, providing business information related to patient care and providing information to the business operations. The hospital will improve patient throughput and denial mitigation efforts by connecting the business operations and clinical team processes by performing work in lockstep and removing independent silo functionality.



Ms. Garceau is Executive Director of Innovative Strategies Case Management Consulting (ISCM), LLC

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Pediatric Observation Case 1 Survey Results with Expert Analysis

Sumana Narasimhan, MD, FAAP, CHCQM

Case 1: 9-year-old previously healthy female presents to the emergency department with 4 day history of low grade fever, sore throat, vomiting and myalgias. Previously on oral

antibiotic for pharyngitis started by PCP. In the interim she developed abdominal pain (usually around the time of receiving the antibiotic) and 2 bouts of non-bilious non-bloody emesis. Also had increased thirst, headache, occasional blurry vision and myalgias. Pertinent labs in the ED- US Appy: Negative - UA: Specgrav > 1.03, pH 6.0 - VBG: 7.36/pCO2 44.6/HCO3 26 - BMP: 124 Na, Chloride 90, Bicarb 15.9, Glucose 189 - CMP: Albumin 2.8, AST 63 - CBC:WBC 14.6, HgB 21.0, HcT 60.5, Plt 428 - Urine Na < 20, UOsm847 Found to be positive for influenza A. Serial sodium measurements approximately every 4 hours as follows:126-128-129-128-130-131-132-134-135. Due to the hyponatremia out of proportion to the degree of vomiting along with hypochloremia and metabolic acidosis, the team focused on a gastrointestinal process but remained cognizant of other potential diagnoses including several endocrinopathies. Hospital stay: 2 days, approximately 60 hours

Committee Analysis of Responses:

Thank you for your responses. We received a total of 19 responses of which 74% favored INPATIENT level of care and 26% favored OBS. Most of the responders commented on the fact that patient had dehydration with significant hyponatremia that met IQ criteria for inpatient stay. A few responders favored OBS as she did not have any other serious complications and because there is a reasonable likelihood of viral syndrome with dehydration correcting quickly. When asked about appropriate status
when repeated sodium measures showed persistent hyponatremia, 84% of responders favored INPATIENT status; mostly due to persistence of symptoms past OBS period and continued need for intensive monitoring. When asked if insurance (Medicaid vs commercial) would influence decision of INPT vs OBS, the majority (78.9%) answered that insurance coverage would NOT affect their decision regarding status.

DISCUSSION of responses: This case is of a young girl with dehydration and significant hyponatremia that did not respond to corrective measures beyond 24 hrs. Hyponatremia is the most common electrolyte abnormality in hospitalized children, affecting 15-30% of acutely ill patients. This could be due to AVP release from vomiting/ pan/ stress, leading to an SIAD like state. In this patient, hyponatremia and hypochloremia are out of proportion to the duration and intensity of the illness,
raising the question of other differential diagnoses such as adrenal insufficiency. Children with hyponatremia require meticulous fluid and electrolyte replacement to avoid neurological injury from hyponatremia; hence meeting the IQ criteria for inpatient at the start of the admission, as some of our responders noted. As Physician Advisors, our teams continually assess the progress of hospitalized patients and determine if their improvement (or lack thereof) justifies switching to inpatient stay from
initial OBS. In this case, the serum sodium was slow to respond, raising concern of other differentials such as adrenal insufficiency, especially given the history of vomiting. Hence the change in patient status to INPATIENT would be justified due to non- improvement by hospital day # 2. Of course, clinical documentation by the attending team is vital in cases such as this patient, highlighting the need for education of caregivers at all levels regarding the importance of documentation. This is another area where we as physician advisors can help bridge the gap.

The most interesting response is the one regarding the insurance attribution affecting decision of OBS vs INPT. Most of responders rightly said their decision would not be affected by Medicaid vs commercial. However, it is important to note, as some responders said, that patterns of denials in a certain region where we serve, could potentially affect our decision regarding status. Some managed care Medicaid deny outright any hospital stays less than 48 hrs. This is a major issue in pediatrics, where most of the hospital stays are 48 hrs or less. As physician advisors, we can help encourage accurate documentation to support correct status and apply pediatric clinical care guidelines to our decision making, knowing that the published criteria that insurance refers to may not do justice to the littlest patients we have the privilege to serve.

References:

Feld LG, Neuspiel DR, Foster BA, Leu MG, Garber MD, Austin K, Basu RK, Conway EE Jr,
Fehr JJ, Hawkins C, Kaplan RL, Rowe EV, Waseem M, Moritz ML; SUBCOMMITTEE ON FLUID AND ELECTROLYTE THERAPY. Clinical Practice Guideline: Maintenance IntravenousFluids in Children. Pediatrics. 2018 Dec;142(6):e20183083. doi: 10.1542/peds.2018-3083.
PMID: 30478247.

Gruskin AB, Sarnaik A. Hyponatremia: pathophysiology and treatment, a pediatric perspective. Pediatr Nephrol. 1992 May;6(3):280-6. doi: 10.1007/BF00878379. PMID: 1616842.

Dr Narasimhan is Enterprise Physician Advisor, Medical Operations in the Section of Pediatric Endocrinology at Cleveland Clinic.

Pediatric Observation Case 2 Survey Results with Expert Analysis

CASE 2: 5-week-old female presented with 4 days of cough and congestion, with worsening work of breathing on the day of presentation. Oral intake was fair, and the baby had normal wet diapers and stooling. There are several sick contacts in the household. Upon presentation to the emergency department a desaturation to 86% with sleep was noted. Supplemental oxygen was started, and the patient admitted for further supportive care. Birth history was unremarkable. Physical examination revealed a crying but consolable infant. VS HR 144, Temp 36.9 rectal, RR 60, BP 103/62.Respiratory exam revealed a tachypneic baby with tracheal tugging and coarse breath sounds in all fields. Viral panel was positive for RSV. Hospital course: On HD #1 (approximately 16 hours after arrival to the floor) a trial of room air failed, with desaturation to 84% with sleep, so oxygen was reinstated. A second trial of room air was attempted about 14 hours later. After about 10 hours of monitoring the child was discharged.

Committee analysis of responses:

Thank you for all your responses and comments. A total of 19 responses were received.

The first question was INPT vs OBS. More than half responders (52.6%) favored INPT, citing young age, RSV infection, respiratory distress with tracheal tug and hypoxia meeting MCG criteria as the reasons to support INPT. A significant percentage (31.5%) favored OBS. In response to the question," If initially observation, would you change to inpatient when the trial of room air failed", 37% respondents agreed to make the change (in addition to the 53% who had initially responded in favor of INPT status from the start), while 10% still favored OBS despite failure of trial of room air. The next two questions addressed the issues surrounding utilization of health care resources and the effect of bed shortages on medical decision making. The question," With high patient volumes and the need to free up beds, how long would you monitor after the second trial of room air" received the following response rates: 15.7% (<6 hrs); 36.8 % (6-12 hrs); 36.8 % (12-24 hr) and 10.5% (>24 hr). The question, "Are there other ways to support this patient in your system?" elicited the following responses: ED Boarder (40%), Peds Obs Unit (33.3%), Conversion of surgical recovery areas to short stay unit (6.7%) and 'Other' (20%).

DISCUSSION: This is a young infant, just 5 week old with cough, respiratory distress and significant hypoxia on room air due to RSV infection. RSV is an important cause of death in infants and young children. Globally, RSV is estimated to cause as many as 2.3 percent of deaths among neonates 0 to 27 days of age (Ref 2) The physical signs of respiratory distress in young infants can be subtle, as they are abdominal breathers; tracheal tugging is a significant sign of moderate respiratory distress, when considered in addition to significant hypoxia (86% O2 sat on RA) warrants increased intensity of service, close monitoring for signs of deterioration. At least 52.6 % favored inpatient from the start, considering young age, significant respiratory distress and hypoxia. The committee notes at least 31.5% favored OBS. It is important to consider the severity of presentation and high risk factors (age 5 week old) that warrant inpatient stay. It is unfortunate that some payors may deny all inpatient stays < 48 hrs. However, with proper documentation of severity, these denials can be prevented or overturned on peer to peer for medical necessity, as some responders had noted. Hence, we would advise the decision INPT vs OBS to be based on medical necessity rather than payor denial patterns.

Furthermore, the very young infant has a higher risk of worsening quickly compared to the older child/adolescent; hence interpretation of MCG/IQ criteria be nuanced, factoring in the very young age. The second question addressed the issue of flipping to inpatient when the baby failed trail of room air. There was much more consensus on this issue; agreeing that continued hospitalization and inpatient stay warranted due to continued need for supplemental oxygen. The last two questions are very relevant in this time of staffing shortages combined with a severe flu and RSV season we are experiencing. Decisions regarding duration of monitoring after second trial of room air was mostly based on the medical necessity and young age, with responders correctly pointing out that the duration to observe after second trial on room air would also depend on other factors such as clinical exam, oral intake, social factors and whether observed in sleeping or awake state.

In our role as Physician Advisors, we collaborate with the attending physician whose decision making frequently takes into account numerous factors that may not always be obvious/ documented (feeding, social factors etc). As Physician Advisors, we can educate the clinicians at the bedside about documentation that accurately reflects their decision making and could make all the difference on a peer-to-peer discussion.

The last question touched upon the 'Elephant in the room' – the problem of bed shortages leading to increasing utilization of the ED for the care of very sick infants such as the one in the vignette. "ED Boarders" utilize many more resources than a bed on a pediatric nursing unit. Providers, nursing, ED equipment and infrastructure are frequently 'adult sized' in most hospitals that don't have dedicated Peds ED. An acutely ill infant with RSV as the one in the vignette can be a huge strain on staffing at a hospital, especially since they need isolation to protect other vulnerable patients sharing ED space from nosocomial RSV. Other creative ways to expand pediatric bed space include conversion of surgical recovery areas to short stay units- only 6.7% respondents were in favor of this option. Peds Obs Units are an option that at least a third of respondents agreed as a way to support this patient. Dedicated Obs units have been shown to be effective in reducing length of stay by being focused on the Obs appropriate patients- detailed discussion is beyond the scope of this analysis.

References:

Simões EAF. The Burden of Respiratory Syncytial Virus Lower Respiratory Tract Disease in Infants in the United States: A Synthesis. J Infect Dis. 2022 Aug 15;226(Suppl 2):S143-S147. doi: 10.1093/infdis/jiac211. PMID: 35968867; PMCID: PMC9377025.

Shi T, McAllister DA, O'Brien KL, et al. Global, regional, and national disease burden estimates of acute lower respiratory infections due to respiratory syncytial virus in young children in 2015: a systematic review and modelling study. Lancet. 2017;390(10098):946-958. doi:10.1016/S0140-6736(17)30938-8

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Providers - Now is the Time to Change How We Document!

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While most of us rang in the New Year either with friends and family or caring for our patients at the bedside something changed in the regulatory world of healthcare with considerable impact on provider revenue. As of January 1, 2023, CMS' (Centers for Medicare and Medicaid Services) OPPS (Outpatient Prospective Payment System) 2023 Final Rule went into effect. To reduce the administrative burden on providers CMS revised the E&M (Evaluation & Management) coding guidelines for Inpatient Providers. Substantial changes were made, including the elimination of observation E&M codes and combining inpatient and observation hospital E&M services into a single existing E&M code set. Understandably this created a great deal of confusion with providers assuming that observation status had now been abolished. I would like to clarify that observation status has **not** been eliminated, the 2-midnight rule is still in effect for Medicare patients and commercial payers will continue to use commercial criteria to determine admission status. Physician Advisors now is your chance to educate and to advocate for tweaks in documentation practices.

A tremendous change for the inpatient E&M code set is the elimination of required elements for the HPI (History of Presenting Illness), ROS (review of systems), family history, social history, PE (Physical Exam) and the bulk of the weight now falls on MDM (medical decision-making). Now more than ever medical necessity documentation will play a vital role. Clearly spelling out the reason for hospitalization, enumerating potential medical risk to the patient if the condition were not treated in the hospital and supporting daily hospitalization with medical necessity, adds to the complexity of MDM.

CDI (Clinical Documentation Integrity) positively impacts MDM, e.g., symptoms like "altered mental status" versus a diagnosis of "Acute Metabolic Encephalopathy" influences the complexity and severity. Document using descriptive words such as acute, chronic, severe, moderate etc. Link diagnosis to possible etiologies, document treatment options, comorbidities that affect treatment & their clinical impact on patient outcomes. Avoid using generic words like "stable" which is subjective rather use "improving but not at baseline" indicates the need for continued care in the hospital. Collaborate with the CDI & Coding teams to enhance your documentation, CDI/Coding queries are not meant to question your clinical judgment but rather to improve the specificity of your documentation which in return impacts your E&M coding.

Now is also the time to address the copy and paste (C&P) and copy forward functionality in the EMR (Electronic Medical Record). While we all agree copy and paste is an efficient time saving tool, when not used compliantly can lead to inaccuracies, misrepresentation, and potential regulatory and medico-legal challenges. CMS concurs stating, "*healthcare professionals have stated that copying and pasting notes can be appropriate and eliminate the need to create every part of a note and reinterview patients about their medical history. However, HHS–OIG (The US Department of Health and Human Services Office of Inspector General) identifies illegitimate use of cut and paste record cloning as a problem*." In the new E&M guidelines C&P material when not updated/edited to accurately reflect the care provided during the encounter would not necessarily count toward medical decision making. Also, C&P of test results without any analysis demonstrating clinical significance does not contribute towards level of data to review and analyze. Rather than copying forward a physical exam, document a fresh medically necessary exam with pertinent findings for each patient encounter.

These guideline changes further bolster efforts to curb note bloat. Links that pull in historical labs, imaging test results and procedure notes do not contribute towards MDM. Simply declaring the specific test results, medical records reviewed and the clinical significance to the current episode of care would be sufficient. Several health systems have leveraged technology within the EMR and created specialty specific standardized note templates. Using the functionality of hyperlinks, the provider can access distinct parts of the EMR from their note without pulling in extraneous data into the note, while keeping their note open. The ability to create disappearing tips with rule-based decision-support serves as real time reminders to address documentation deficiencies that impact quality metrics and reduce the number of Coding and CDI Queries thus limiting interruptions in workflows.

The medical record serves as a communication/hand off tool between providers and other members of the care team and is also accessible to our patients, health-insurance payers, auditors, attorneys etc. As physician advisors we have a unique opportunity to collaborate with our Informatics, CDI, Coding & HIM departments to effect change. Now more than ever we as a physician advisor community have a responsibility to educate and inform our provider colleagues, so feel free to share this article with your medical staff.

References:

https://www.ama-assn.org/practice-management/cpt/what-physicians-need-know-about-em-code-changes-coming-jan-1

https://www.the-hospitalist.org/hospitalist/article/33857/business-of-medicine/e-m-coding-changes-for-2023/

Dr. Maigur is System Director of the Premier Health Physician Advisor Program.

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American College of Physician Advisors

President's Corner

March 2023

The ides of March is upon us…don't I know it! However, in this instance, it's also something to look forward to because March 15th puts us at just about a month before the 2023 National Physician Advisor Conference (NPAC) starts at the Loews Portofino Bay Hotel in Orlando, Florida.

It's funny…back when I was preparing to graduate from my pediatric residency and failed to be accepted into a Pediatric Emergency Medicine fellowship (that was my originally intended career path – thank goodness it did not come to fruition! EM would not have been a good match for me, no pun intended), a mentor of mine suggested I apply for

"some new position called a pediatric hospitalist." While adult hospitalists had been around for a couple of decades, there was still a very strong culture of children remaining under the care of their primary pediatricians – the doctors who many times had followed the patient since just after birth – even when the kiddo was hospitalized. But, as more and more community hospitals established Neonatal and Pediatric Intensive Care Units into their service lines and pediatric patients with complex acute and chronic conditions no longer required transfer to a tertiary center in a large metropolitan area, the role grew.

A decade later, I found myself entering yet another newish and burgeoning field – that of physician advisors involved in hospital case/utilization management and clinical documentation integrity. Like many of you, immersion into the work involved not many understanding what specifically was supposed to be accomplished. Was something like, "we were told by a consultant that we needed to have a physician in this position," one of your first introductions to the role? If so, you're not alone.

Most physicians don't get into medicine for the business aspect, they are looking to heal. Raise your hand if you remember your training as a physician or nurse involving how you should never, EVER take finances or insurance coverage into account when assessing and treating a patient. I know I do. Which is why it was such a wake-up call when as a practicing peds hospitalist, I learned the H&H (hemoglobin and hematocrit) test I was ordering to monitor anemia in some of my patients was three times more expensive to run than a CBC (complete blood count). My initial thinking was spot-on – all I needed to know was what the hemoglobin and hematocrit were, I didn't need information about platelet count, white blood cell count, etc. It made sense to think a test that checked only two values would be more cost-efficient than the one which checked a dozen. But, for reasons I am not completely sure about, it most certainly was not.

Similarly, who remembers when they discovered the out-of-pocket cost to the patient for a "Medrol dose pack" was more than if you took the time to write out the same dosing schedule for methylprednisolone? (Mind you, perhaps it's different now, but this was the case back in the early 2000s.) These are the same kind of "aha moments" physician advisors illustrate to their administration and providers every day.

"You mean, we DON'T get paid for every test and imaging study we perform during the hospital stay?"

"The case manager can just fix the status to whatever is right the next morning, can't they? If it's eventually correct, who cares?"

"There's no more reimbursement for this planned surgical case if they stay overnight versus going home the same day from PACU?"

While the importance of the physician advisor within hospitals and health systems continues to grow and happily, I see more light shed on this topic in journals, webinars, chapter and national conferences every week, there remains a sense of isolation most in our field experience on some level. What does it mean to be a doctor who doesn't perform their role clinically? How can we say we positively impact the provision of health care of

hundreds if not thousands of patients a day without touching a single one? When success involves ensuring compliance or pro-actively saving a hospital from millions of dollars of lost revenue, how can that be translated into an ROI?

This is why you should come to NPAC next month. If you have been on the fence about registering for the conference, now's the time to jump off. Join us. Join your tribe. Learn from the best, and evolve as a mentor for those who are just starting on the path. Together, let's witness the upward trajectory of our field.

Juliet B. Ugarte Hopkins, MD
(Pronouns: She/Her)
President, ACPA

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