



Information for Healthcare Improvement



# Case Review Connection

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## *Observation versus Inpatient*

Medicare is in the process of launching the Recovery Audit Contractor (RAC) program to find payment errors in hospital claims. One area that hospitals can improve is unnecessary admissions. Many beneficiaries may need continued hospital monitoring but may not meet the criteria for an inpatient admission. The use of outpatient observation is appropriate when the physician is unsure about the patient's need for inpatient admission and requires additional time to evaluate the patient. The physician may also anticipate that the patient's condition can be evaluated/treated within 24 hours and/or rapid improvement of the patient's condition can be anticipated within 24 hours.

An outpatient observation stay can be converted from observation to inpatient admission if the patient has an acute condition that requires treatment in an inpatient setting. A physician order is required. The physician should document the medical necessity of admission in the medical record. Admission criteria should be met at the time the inpatient order is written.

If the hospital determines after admitting the patient that he or she did not require an acute level of care, use Condition Code 44. (For more information, go to MLN Matters Number SE0622, release date - September 10, 2004.)

The PEPPER Report will soon be available again to monitor your discharges that are at high risk for payment errors. The next release is scheduled for around February 2, 2010. The file will be available by My QualityNet secure file exchange. For more information, go to [www.pepperresources.org](http://www.pepperresources.org).

The PEPPER Resources website also has many tools available to help determine if an inpatient admission is appropriate. Click on the Tools tab at the above website.

FMQAI will soon have brochures for beneficiaries and physicians related to observation status available at our web site [www.fmqai.com](http://www.fmqai.com).



## *Utilization*

**Present on Admission (POA) Fact Sheet:** The POA indicator should not be used as the sole criteria for the assignment of the principal diagnosis. For more information, please visit:

<http://www.cms.gov/HospitalAcqCond/Downloads/POAFactsheet.pdf>

**ICD-9-CM Official Coding Guidelines provide guidance for the assignment of the principal diagnosis. For 2010 Official Coding Guidelines, please visit:**

[http://www.cms.gov/ICD10/Downloads/7\\_Guidelines10cm2010.pdf](http://www.cms.gov/ICD10/Downloads/7_Guidelines10cm2010.pdf)

## *ADR*

The Alternative Dispute Resolution (ADR) Program offers a variety of pathways to reaching resolution of a beneficiary's concerns. One of these pathways is called External Resolution. In External Resolution, Medicare offers the opportunity for the QIO, beneficiary, and provider to be highly creative in how to approach the issue of concern, and in determining what resolution is most fitting. Although mediation offers similar prospects, External Facilitation eliminates the need for direct contact between the provider and beneficiary by utilizing the QIO as a form of *ex parte* mediator. As many physicians and facilities have extremely busy calendars, this pathway is often far more feasible and attractive to providers. Likewise, beneficiaries often prefer External Resolution as they are either emotionally unable to directly speak with providers or feel that they are unsure as to how to best advocate for resolution of their concerns. In either case, External Resolution offers the opportunity for the QIO to build rapport with both beneficiaries and providers, determine the true essence of the concerns, and guide the resolution towards a successful end utilizing its knowledge and experience.

One recent case exemplified the qualities that necessitate External Resolution. In this case, the beneficiary received a surgical implant to assist with his incontinence. While the beneficiary did

## *ADR (cont.)*

receive therapeutic benefits from this implant, he also found the implant to be a constant source of pain, as due to its location, it gave him minor electrical shocks whenever he sat or had any contact with its location. Prior to contacting FMQAI, over a period of two years, this beneficiary did attempt his own resolution by telling his surgeon about his discomfort. As a result, the surgeon offered to remove the device and eliminate the source of his pain. He declined this option as he did not wish to relinquish the therapeutic benefit for his incontinence, but he was still left feeling unsatisfied with his outcome. Through several conversations with QIO staff, the beneficiary expressed his sense that further self-advocacy would be futile and that mediation would not bring about resolution as it would not eliminate his daily pain. It was finally determined that he simply wished to have the device placed deeper into the tissue so that the device would no longer be activated by his movements. As this was the case, the Conflict Resolution Coordinator advised that advocacy on behalf of the beneficiary by the QIO would be the best approach, and the beneficiary agreed. The QIO then contacted the surgeon, informed him of the beneficiary's concerns, advocated for further consideration of the situation, and requested that the surgeon make a determination as to whether or not the repositioning surgery would be medically appropriate in this case. The surgeon willingly participated and determined that a repositioning surgery would best serve this beneficiary. The surgery was recently successfully completed, and the beneficiary is now enjoying pain free benefits from his implant.

In this case, the QIO, beneficiary, and provider all three worked collaboratively to bring this case to a resolution. This case is a true example of the success that can be achieved through better communication. Often, especially in the elderly population, patients feel that either they are unsure as to how to voice their concerns to their providers or that their providers do not demonstrate genuine concern for their wellbeing. This was the case for this beneficiary. He felt fearful about how to advocate more stringently for his needs while also feeling that his surgeon did not care about his quality of life. The External Resolution Pathway of the ADR process simply gave him a voice and through that voice, improved his quality of life.

## *Hospital Discharge Appeals FAQs*

- Q.** Is the patient ID number on the *Important Message from Medicare* the Medicare number?
- A.** No. It can be an ID number that identifies that patient such as a medical record number. The number should not be, nor contain, the Social Security number.
- Q.** Does the *Important Message from Medicare* need to be issued to beneficiaries who have Medicare as a secondary payer?
- A.** Yes. It must be issued if Medicare is the secondary payer.
- Q.** Should a beneficiary receive the *Important Message from Medicare* while in the emergency room or in observation status?
- A.** No. The *Important Message from Medicare* is only for beneficiaries who have been admitted as an inpatient.
- Q.** When should the *Detailed Notice* be delivered?
- A.** The *Detailed Notice* should be delivered as soon as possible after an individual requests a QIO review, but no later than noon of the day after the QIO notifies the hospital of the appeal.
- Q.** Where are all the forms and instructions available?
- A.** The forms and instructions are available at **[www.cms.gov/BNI](http://www.cms.gov/BNI)**.

## *FAQs (cont.)*

- Q.** What if a beneficiary misses a deadline for filing a request for an appeal? Is there an “untimely” review?
- A.** Yes. There is a “non-expedited” review process. For traditional Medicare beneficiaries, QIOs are still obligated to accept requests for review from beneficiaries after the midnight deadline. In this situation, the 72-hour deadline for the QIO’s decision and the liability protection afforded under the normal process do not apply. For Medicare Advantage beneficiaries, they are referred back to the plan.
- Q.** What should a provider do if the beneficiary refuses to sign the *Important Message from Medicare*?
- A.** If a beneficiary refuses to sign the *Important Message from Medicare*, the provider must note the refusal and place the date of refusal in the final date blank. The provider may also choose to have the refusal witnessed, indicating the circumstances and persons involved.

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