A physician’s perspective

The clash of clinical vs. coverage/payment concerns

by Trey La Charité, MD

An emergency department (ED) physician diagnosed a patient with pneumonia. He was concerned about a possible nosocomial etiology given the patient’s recent hospital discharge for problems related to atrial fibrillation. Because the patient’s Pneumonia Severity Index score was 4 and his CURB-65 score was 2, the ED physician wanted to admit the patient to the hospital for treatment with broad-spectrum intravenous antibiotics. However, after discussion with the ED physician, the admitting hospitalist denied the admission on the grounds that the patient did not meet either InterQual or Milliman criteria for inpatient admission.

According to the hospitalist, the patient had a normal white blood cell count, was not tachypnic or tachycardic, had a normal temperature, and had an oxygen saturation of 98% on room air. While the patient had an extensive past medical history, the only new objective abnormality was an obvious infiltrate on the chest x-ray. The patient looked fine on paper, at least healthy enough to be sent home, the hospitalist said. After discussion, the ED physician agreed and discharged the patient.

I am the hospitalist in this tale. What should I have done? Should I have:

» Admitted the patient to the hospital, risking the future inpatient denial and the subsequent exhausting appeal process?

» Placed the patient in observation status, trusting that the patient would be discharged in a timely manner and knowing that reimbursement from the payer would not cover the cost of the care provided?

» Discharged the patient home with oral antibiotics and close outpatient follow-up with either his primary care provider or through a return visit to our ED?

Virginia chapter embraces giving, too

When Virginia ACDIS chapter leader Sequana Webb, RN, CCDS, CDI specialist at the University of Virginia Health System in Charlottesville, heard about local chapter charitable initiatives, she was excited about the idea. The Virginia ACDIS group was about to hold its first meeting, and Webb thought it would be great to incorporate the act of giving from the very beginning.

The Virginia group is informal in nature, rotating its events to host facilities throughout the state on a quarterly basis. The host for each meeting gets to pick the charity and lets participants know how they can help once the meeting agenda is finalized. Typically, hosts choose area food banks and invite meeting participants to bring a non-perishable item from their home to donate.

Since Webb’s facility hosted its most recent meeting, she chose The Haven, a Charlottesville nonprofit day shelter that, among other services, provides meals, showers, shelter, and computer access to the region’s poor and homeless (www.thehavenatfirstandmarket.org).

“The idea [of giving back] has really been well received,” says Webb. “People really do participate and seem to feel good about doing so. It really isn’t too much to ask them to grab something out of the cupboard on their way to the meeting, and it can really make a difference for some of these charities.”

By providing an opportunity for local chapter participants to give back to the community, Taylor and Webb say they are responding to an inherent trait of CDI professionals.

“Typically, we’re nurses who chose to be nurses because we wanted to help people, to serve people,” Taylor says. “When you step back from bedside care to become a CDI professional, you really tend to miss that interaction, that immediate awareness that you’ve had an impact on someone’s life. This allows us to feel that a little bit.”

“You never know how your actions are going to affect someone,” say Webb. “Giving back, trying to make a difference is really what the heart of our profession is all about.”

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Because the patient clinically “looked good” according to the ED physician, I made the suggestion to try outpatient treatment first. The patient received an initial dose of broad-spectrum intravenous antibiotics in the ED and was discharged home with 10 days of oral antibiotics, with a return visit to the ED scheduled in two days’ time.

I’d like to report that the patient returned drastically improved. He didn’t. When he returned 48 hours later he was floridly septic. Fortunately, the patient responded very well to aggressive treatment; two days after the initial admission to an intermediate care unit, he was medically stable for transfer to a general medicine ward. He was eventually discharged back home with home health care.

My gravest concern is that I made a decision I would not have made a little over a year ago. In hindsight, it is blatantly obvious that I allowed my medical judgment to be negatively impacted by my recent experiences fighting medical necessity denials in my role as a physician advisor to CDI and coding.

In the aggressive post-discharge auditing environment where I now find myself practicing medicine, I and my colleagues are subject to heavy scrutiny by CMS and private insurers. Observation versus inpatient status review is the new focus of these nonclinician auditors and has become the reason for the vast majority of my facility’s denials.

This new auditing pressure we all face stems from the completely noble idea that reductions in fraud, abuse, and improper payments will preserve resources for those who truly need medical care. Sadly, as with many commendable aspirations, the execution is poor and often produces a dismal result.

As the physician advisor for CDI, I have been diligently educating every physician at my institution about ensuring the medical necessity of our inpatient admissions. But while CMS asserts that the admitting physician is solely responsible for status selection (i.e., inpatient, outpatient, or observation status), admission status for the physician has no clinical relevance. Physicians do not recognize “conditional” or “partial” admissions, which observation status implies. As far as physicians are concerned, their patients either medically need something or they don’t. Physician education focuses on the development of skills that allow one to discern whether a patient can be safely sent home.

The rules concerning inpatient versus observation status selection are not newly created; CMS’ vague guidelines for appropriate status selection have been around for years. The difference is that CMS and other payers suddenly discovered that they can extend their existing financial resources by “enforcing” those rules.

Payers and their related auditing agents have traditionally avoided the question of whether a patient actually needed the medical care that was provided. Instead, they simply point to inappropriate status selection and deny the associated claim. The issue is whether physicians should be contemplating a patient’s admission status at all.

I have always prided myself on the belief that I do what is best for the patient before me. I never look at the patient’s registration sheet because I do not want to inadvertently be prejudiced by his or her insurance status. Yet the admission judgment I made for the patient described in this introduction was affected by my recent experiences with medical necessity denials.

As a society, do we really want our physicians to be faced with these simultaneous worries? Should nonclinicians be influencing my bedside practice patterns? I am concerned that other physicians will face this same scenario in the future. Is this what we want from our healthcare system? Is this what I want for my family’s medical care?

I understand that financial resources for medical care in this country are finite. I understand that not all care provided in this country is medically necessary and that some individuals take advantage of the current system. However, most entities caring for patients in the United States are simply doing the best they can to comply with today’s regulatory environment while still trying hard to provide the high-quality medical care that their patients trust them to deliver.

One day, I will be a patient, and I hope that the physicians taking care of me at that time do what is in my best interest as opposed to having their clinical judgment influenced by nonmedical considerations such as government audits, threats of fraud, or worries about reimbursement.

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