Emergency Department Documentation for Medicare Compliance

Understanding Inpatient and Outpatient Observation Status Determination

Focusing on Chest Pain, TIAs, Syncope and Dizziness
"Louis, I think this is the beginning of a beautiful friendship."
“Don’t expect someone to do something for you unless it is in their interest to do it and it furthers their goals, aspirations and needs”

Professor, University of Pennsylvania

Compliance, Revenue Integrity for the Hospital, It is the right thing to do
The Emergency Department & the High Performance Medicare Compliance and Revenue Integrity Machine

Emergency Dept. Documentation Fuels the Process
Our High Performance Car needs Highly Refined Gasoline
We need your help

The Continuum of Care Department must Evaluate Every Patient who is Hospitalized
This includes patients hospitalized from the ED, Direct Admits, Same Day Surgery and Cardiac Procedures
I am here today to ask that your documentation be highly refined fuel.

What am I talking about? I am asking for Precise Diagnosis and Comments of your Level of Concern for Serious Life Threatening Diagnoses.

Example: 85 year old female with cardiac stents comes to ED with substernal chest pain that she describes as burning.

You would document: “Assessment: Chest pain which could be GERD but my level of concern for unstable angina is medium to high because of this patient’s history of coronary stents.”
An actual case from Monday

69. Year old male with dull chest pain worse on movement and relieved by nitro. PMH of Stents and AAA Repair.

“My clinical impression is Chest Pain” (this is not good documentation)

What we need: My clinical impression is chest pain due to muscle strain or atypical angina. My concern for angina is medium because of this patients PMH and the fact that it was relieved by nitroglycerin. Therefore admit to inpatient
Today’s Presentation

Medicare Compliance: Inpatient versus Outpatient Observation
  The Structure and Logic of the System
  Taking Control
Documentation
  The History of Present Illness
  Precise Diagnoses
  Level of Concern for Serious Diagnoses with Significant Risk for Adverse Events
Documenting Certain Patient Types
  Chest Pain
  The Dizzy Patient
    Acute Neurologic Symptoms which could be CVA or TIA
    Syncope and Near Syncope
The Challenge
  Documenting a Detailed HPI
  Documenting a Precise Diagnosis
  Documenting a Level of Concern for an Adverse Event
  Seeing Many Patients per Hour when the ER is Busy
Working Together to Solve our Mutual Challenges
  The Continuum of Care Department and The Emergency Department
  The Future
Medicare Compliance

Inpatient Admissions & Outpatient Observation Monitoring

How Physicians Can Reclaim Control of this Critical Element of Patient Care

Jeffrey E. Epstein, MD
Medical Director, Continuum of Care Program
Morristown Memorial Hospital, Atlantic Health Systems
June 9, 2010
NewsFlash: Medicare Compliance is Logical and Easy to Understand!

Today’s Presentation:

The Structure of Medicare Compliance, The Logic of the System and the Rules of Engagement

Understanding the Compliance Universe
“Man tries to make for himself ... in a fashion that suites him best ... a simplified and intelligent picture of the world; ... he then tries ... to some extent ... to substitute this cosmos of his for the world of experiences ... and thus to overcome it. This is what the painter, the poet, the speculative philosopher, and the natural scientist do ... each in his own fashion.”

-- Albert Einstein
### Words, Vocabulary and Speaking the Same Language

Compliance Vocabulary

**List of Compliance Vocabulary Words**

- Inpatient
- Outpatient
- Observation
- Procedure
- Extended Recovery Monitoring
- Admit
- Hospitalize
- Place

### Volcano Vocabulary

**List of Volcano Vocabulary Words**

- Aa
- Active
- Andesite
- Ash
- Ashfall
- Ashflows
- Ash Plume
- Avalanche
- Basalt
- Blast
- Blowdown
- Breadcrust Bomb
- Bulge
- Caldera
- Cascade Range
- Cinder Cone
- Conduit
- Crater
- Crater Lake
- CVO
- dacite
- Debris dam
- Deformation
- Dome
- Dormant
- Earthquakes
- EDM
- Ejecta
- Elk
- Energy
- Era
- Eruption
- Etna
- Fault
- Fissure Zone
- Fuji
- Fumarole
- Fume
- Gas
- Geology
- Graben
- Gold
- Hand lens
- Harmonic Tremor
- Hawaiian
- Hazards
- Hood
- Igneous
- Kilauea
- Lahar
- Land
- Lapilli
- Lassen
- Lava
- Lava Flows
- Lava Fountain
- Lava Lakes
- Lava Tube
- Lobes
- Loihi
- Loowit
- Mafic
- Magma
- Magnitude
- Mauna Loa
- May
- Molten
- Monitoring
- Mount Rainier
- Mount St. Helens
- Mudflows
- Mudline
- Observatory
- Obsidian
- Olivine
- Pahoehoe Flows
- Pele
- Phreatic
- Pillow Lavas
- Plate
- Prisms
- Pumice
- Pyroclastic
- Rate
- Richter
- Rift Zone
- Ring Of Fire
- Risk
- Rocks
- Scoria
- Seismic
- Seismometer
- Shasta
- Shield
- Silica
- Silt
- Singe
- Steam
- Stratovolcanoes
- Streamgaging
- Talus
- Tephra
- Tilt
- Topographic Maps
- Tuff
- Ulu
- USGS
- Vents
- Volcanoes
- Vulcan
- Vulcanologists
- Wind
- Wizard Island
WORDS MATTER
I like my rhymes atrocious
Supercalafragilisticexpialidocious
"I came as quickly as I could."
The Only Phrases You Need to Use

• Admit to Inpatient

• Place on Outpatient Observation Monitoring
Language must be Used Precisely to Minimize Confusion

• **INPATIENT:** “Admit to Inpatient”
  – Admit means “Admit to Inpatient”
  – “Admit to Observation” means “Admit to Inpatient”
  – Only use the word “ADMIT” when you want to ADMIT the patient at the “Inpatient Status”

• **OBSERVATION:** “Place on Observation Monitoring”
  – This is an Outpatient Status NOT an Inpatient Admission
  – Use the work “Hospitalize” or “Monitor” rather than “Admit”
  – “Observation” or “Outpatient Observation” are Equivalent

• **“Place in Outpatient Procedure Monitoring”**
  – This is an Outpatient Procedure Status
  – **DO NOT** use the phrase “ADMIT TO”. Use the word “PLACE IN”
  – Place in “Extended Recovery Monitoring”

WORDS MATTER
The Different Types of Outpatient Care

Outpatient Observation

Outpatient Procedure

Outpatient: Home, Office ...
Inpatient, Outpatient, Observation Language

**Words (Status) Associated with the Hospital**

- Inpatient
- **Outpatient**
- Observation
- Procedure

**Words (Status) NOT associated with the hospital**

- **Outpatient**
- Home Care
- Doctor’s Office
- Rehabilitation (acute, subacute)
- Long Term Care (custodial)

Words Matter
Observation is a TYPE of Outpatient Care

“Observation” and “Outpatient” are NOT interchangeable words!
What makes a patient appropriate for Admission to Inpatient Status?

The Top Three Reasons ... Risk, Risk & Risk
Inpatient Considerations

The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs. Factors to be considered when making the decision to admit include such things as:

- The Severity of Signs and Symptoms
- The Medical Predictability of something adverse happening
- Need for further diagnostic studies

Source: Medicare Benefit Policy Manual
Chapter 1, Section 10
Criteria Summary for Inpatient Admissions

• **Medical History**
  – Most Important: History of Present Illness (HPI) and PMH

• **Current Medical Needs**
  – Tests, Consults & Treatments

• **Severity of Illness**
  – How Sick is the Patient

• **Predictability of an adverse event**
  – Risk of serious complications (morbidity) and death (mortality) if not in the hospital

• **Need for further diagnostic studies**
  – Are they available in another setting in a timely manner

• **Availability of diagnostic procedures**
  – Can they be accomplished in an alternate setting in a timely manner
Observation Considerations

The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.

- Observation services are those services furnished by a hospital on the hospital’s premises
- Including the use of a bed and at least periodic monitoring by a hospital’s nursing or other staff which are reasonable and necessary
  - to evaluate an outpatient’s condition
  OR
  - determine the need for a possible admission to the hospital as an inpatient
• Chest Pain
• Dizzy
• GI Bleed
• Abdominal Pain
• Same Day Surgery
• Interventional Cardiac Procedures (ICP)
• Cellulitis
• Laparoscopic Cholecystectomy
Key Concept: The SERVICES that both patient receive may be identical and the TIME spent in the hospital may be identical, but one clearly meets Inpatient Criteria while the other is best placed on Outpatient Observation Monitoring

• Inpatient
  – 80 year old male with cardiac stents and a history of CABG with typical OR atypical chest pain

• Outpatient Observation
  – 45 year old male with a history of DM and HTN with atypical chest pain symptoms

Chest Pain
**“Doc, I am Having Chest Pain”**

### Differential Diagnosis

<table>
<thead>
<tr>
<th>Category</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac:</td>
<td>MI, Unstable Angina, Stable Angina</td>
</tr>
<tr>
<td>Cardiac:</td>
<td>Aortic Dissection, Pericarditis</td>
</tr>
<tr>
<td>Pulmonary:</td>
<td>PE, Pneumothorax, Pneumonia/Pleurisy</td>
</tr>
<tr>
<td>GI:</td>
<td>Gastritis, Esophagitis, Esophageal Spasm, Ulcer</td>
</tr>
<tr>
<td>GI:</td>
<td>Gallbladder, Pancreatitis</td>
</tr>
<tr>
<td>Musculoskeletal:</td>
<td>Costochondritis, Rib Fracture</td>
</tr>
<tr>
<td>Psych:</td>
<td>Anxiety, Functional</td>
</tr>
</tbody>
</table>
What is the Likely Cause of the Chest Pain?

- Pain gets better when leaning forward
- Pain is worse with deep inspiration
- The pain is ripping and tearing
- The pain is better with eating or antacids
- The pain bores through to the back
- The pain is brought on by fatty foods
- The pain is very well localized. You can point to it with one finger
- The pain only lasts a few seconds
- The pain builds gradually and then goes away gradually
- The pain is better with Nitroglycerin
- The pain comes on with exertion and gets better with rest
- The pain can be reproduced by pressing on the chest wall
- The pain is worse with movement
- The pain feels similar to the pain that the patient had when they had their MI
The 15 Clarifying Questions of the History of Present Illness (HPI)

1. **Characterizing the Symptom**: Is the pain dull, sharp, burning or squeezing?
2. **The Timing of the Onset**: Did it start a month ago, a year ago, last week?
3. **The Mode of Onset**: Did it start suddenly or gradually?
4. **The Location**: Where is it? Chest, Abdomen, right arm?
5. **The Severity**: What would you rate the pain on a scale of 1-10?
6. **Disability**: The pain is so bad that I can’t get out of bed, the pain keeps me from jogging 10 miles per day, I can only work for 2 hours, then I need to go home.
7. **Periodicity**: The pain is constant or it comes and goes.
8. **Aggravating and Relieving Factors**: What makes the pain better and what makes it worse?
9. **Precipitating Factors**: Was there an initiating event?
10. **Course of Illness**: Is the pain getting better or worse, more frequent or less frequent?
11. **Associated Symptoms**: nausea, vomiting, diaphoresis, dyspnea
12. **Radiation**: Does the chest pain radiate to the neck or the arms?
13. **Urgency**: Why did the patient come to the Doctor now rather than last week?
14. **Concerns**: What is the concern of the patient. Cancer? Heart Attack?
The most intense S U S P E N S E . . . E X C I T A M E N T . . . E M O T I O N ever generated by a motion picture!

 Paramount Presents V I S T A V I S I O N M O T I O N P I C T U R E HIGH-FIDELITY


 A L F R E D H I T C H C O C K A L E C C O P P E L & S A M U E L T A I L O R
Dizzy

Vertigo
  TIA, Vestibular Dysfunction

Near Syncope
  Cardiac, Vasovagal

Disequilibrium
  Multisensory Deficit Disorder

Non Specific Dizziness
  Depression and Anxiety
An 87 year old Male comes to the ER complaining of feeling Dizzy whenever he sits up from lying down and turns his head to the side.

An 87 year old Male comes to the ER after the acute onset of Dizziness associated with blurred vision (really double vision), slurred speech, difficulty swallowing, facial pain, loss of temperature and pain sensation on the side of the body opposite from the facial pain and difficulty walking (ataxia).

An 87 year old Male comes to your office complaining Dizziness when he walks. When he holds onto something like a cane or walker, he feels fine.

An 87 year old Male complains that he feel Dizzy all of a sudden when he is standing or sitting and this is associated with a feeling of fast heart beats. Sometimes it goes away after a few minutes and once he woke up on the ground.

An 87 year old Male feel Dizzy all the time. He describes the Dizziness as wooziness and “you know- “dizzy”.”
What do we need from YOU?

We need a Precise Diagnosis and Precise Documentation of how you arrived at this Diagnosis

- For certain complaints the precise diagnosis comes directly from a detailed HPI
- The level of concern for adverse events comes directly from the Diagnosis

Example #1, the complaint is Dizziness

The detailed HPI reveals spinning sensation when moving head associated with ear pain and a red bulging TM on exam
The Precise diagnosis is Vertigo due to inner ear infection
The concern for serious adverse event if not hospitalized is low
The status is appropriately Outpatient Observation or Outpatient HOME

Example #2, the complaint is Dizziness

The detailed HPI reveals spinning sensation associated with weakness of the left side of the body, difficulty speaking and other symptoms which came on suddenly and then resolved within 30 minutes
The Precise diagnosis is Vertigo probably due to a brainstem TIA
The concern for a serious adverse event even if not hospitalized is high
The status is appropriately Inpatient
Active Collaboration
Dizzy: History of Present Illness Questionnaire

How would you describe your symptoms?
   Spinning, Lightheaded, Off Balance, Woozy, Hard to Discribe, Just Dizzy
When did this start?
   An hour ago, yesterday, last week, a month ago, last year
Did it start gradually or suddenly?
Is it constantly there or does it come and go?
   How long does it last?
   How often does it come back?
Does it come on suddenly or does it gradually build over time?
Does it come and go completely or does it wax and wane?
Is the dizziness mild or severe?
When you are dizzy, are you able to function?
What makes the dizziness better? What makes it worse? What brings it on?
Was there an event which brought the dizziness on the first time? Precipitating event?
Have your symptoms been getting better or worse over time?
Is there any associated symptoms like nausea, vomiting, blurred vision, double vision, weakness, confusion, difficulty speaking, pain?
Why are you seeking medical attention now rather than earlier (if symptoms started a number of days ago?)
What do you think is causing the dizziness? Do you have any specific concerns?
   Relative had a stroke when experiencing dizziness?
Chest Pain: History of Present Illness Questionnaire

How would you describe the chest pain?
   Squeezing, heavy, burning, sharp, ripping, tearing, dull, someone sitting on my chest
Where is the chest pain?
   Can you point to the pain with one finger?
Does the pain radiate anywhere?
   Neck, arm, jaw, abdomen, back
What makes the pain better? What makes it worse?
   Exercise, Rest, Antacids, Nitroglycerin, Deep Breath
When did the pain first start?
   Today, yesterday, last week, last month, last year
Why are you seeking medical attention now (if it started more than a few days ago)?
Is the pain getting better or worse? Is it coming on more frequently or less frequently?
What are your concerns?
   Heart Attack, Collapsed Lung
Does the pain start gradually or does it come on suddenly?
How severe is the pain?
When you have the pain, can you still function?
Did something happen recently which caused the pain?
   Trauma and now chest wall is tender or pain is worse with deep breath
Are there any associated symptoms?
   Nausea, vomiting, shortness of breath, sweating
The Future of the Emergency Room and the Continuum of Care Departments

1. Continue to discuss specific cases
   Friendly and collaborative relationship with positive and productive feedback

   Process Improvement Feedback: Nonjudgmental and Collegial:

2. Help develop Admission Decision Logic
   Become part of our Physician Email Group Discussion
   Specific cases are discussed in a round-table email format
   Internists, Family Doctors, Hospitalists and Emergency Room Physicians

3. More Presentations like this, case discussions or Brainstorming Sessions

4. Iron out wrinkles of the Rapid Treatment Unit

Jeffrey.Epstein@atlantichealth.org
BlackBerry: 973-309-2274
AND THIS LAST HANDOUT EXPLAINS WHY THERE ARE SO DARN MANY HANDOUTS.
Specific Cases from the ER Record (EDIM)
The Emergency Department and the Continuum of Care Department

"Louis, I think this is the beginning of a beautiful friendship."
In summing up, I wish I had some kind of affirmative message to leave you with, I don't. Would you take two negative messages?

Woody Allen, The Comedy Years
THE END