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Dedicated Observation Units Gain Ground Amid Concerns Over Compliance, Revenue

More hospitals are opening dedicated observation units to improve efficiency and quality of care, prevent claim denials and increase revenue. The numbers are growing as more Medicare and commercial-payer patients are treated in observation every year.

Between one-third and half of hospitals now have observation units of some kind, said Hossain Marandi, M.D., vice president of physician services for BayCare Health System in Florida, at a webinar sponsored by the Appeal Academy, American College of Physician Advisers and PACE Healthcare Consulting on June 3. There are a lot of forces moving them in this direction. The number of Medicare patients who were treated in observation rose by 88% — to 1.8 million — in 2012, up from 828,353 in 2006, he said. Observation stays that last longer than 48 hours rose from 1% to 11% during that period. This was partly a response to the proliferation of Medicare auditors, who often deny claims for inpatient admissions based on the site of service. In turn, CMS, worried about over-reliance on observation and its effect on the finances of patients, who pay 20% of outpatient services, implemented the two-midnight rule. The intention of the two-midnight rule is to push physicians and hospitals to decide whether patients need hospital care at all based on medical necessity, and then to admit them as inpatients only if they are expected to stay two midnights (or for inpatient-only procedures). CMS anticipates this will generate more revenue for hospitals because some observation patients cross the second midnight, but it may not turn out that way.

Observation Units Are Growing

Marandi said a study at the University of Wisconsin School of Medicine and Public Health "contradicted" some of CMS's assumptions about the impact of the two-midnight rule. In the 2014 inpatient prospective payment system regulation debuting the two-midnight rule, CMS said it figured the net effect would be 360,000 more observation cases and 400,000 more inpatient admissions, and used that to explain a 0.29% payment decrease. To evaluate the accuracy of that calculation, researchers applied the two-midnight rule retrospectively to inpatient and observation cases at University of Wisconsin Hospital and Clinics from Jan. 1, 2012, to Feb. 28, 2013. The findings: 7.4% more inpatient cases would have been reclassified as observation if the two-midnight rule were in effect at the time, Marandi said.

The study also found that whether patients are admitted or placed in observation depends on the time they presented at the hospital and the day of the week, Marandi said. "Patients admitted after 4:00 p.m. were admitted as inpatients 31% of the time. Patients who arrived before 8:00 a.m. were admitted as inpatients only 13.6% of the time," he said. If they came on weekdays, they were less likely to be admitted — 22.6% compared with 26.5% of patients who came on weekends.

MACs Review Patient Status

Because the volume of observation stays continues to increase and the volume of inpatient admissions continues to decrease, hospitals need "efficient delivery methods" that reduce costs, improve "throughput," provide high-quality care and promote compliance, Marandi said. Patient status remains a fixation of auditors. Under probe-and-educate reviews, Medicare administrative contractors (MACs) determine whether hospitals are complying with the two-midnight rule, and when recovery audit contractors (RACs) are back in the patient-status business, they will also focus on whether admitted patients — including those discharged earlier than expected — should have received outpatient or observation services instead.

Observation units are one solution to the regulatory, quality, revenue and patient-satisfaction challenges facing hospitals, Marandi said. They can ease overcrowding in emergency rooms, improve patient satisfaction by getting patients in beds faster and reduce readmissions and their associated Medicare penalties. Units also reduce liability by "closing the disposition donut hole," Marandi said.

Patients are typically treated in observation for chest pain; abdominal/gastrointestinal conditions; asthma/bronchitis; dehydration; congestive heart failure; syncope; head injuries/headaches/migraines; seizures; and transient ischemic attacks. But observation is not appropriate for many other situations. Don't let the units turn into a "dumping ground," he said. "It becomes one if

you let it." He listed the following "non-qualifier diagnoses for observation services":

- ***Routine preparation for surgery***
- ***Diagnostic tests***
- ***Recovery from a diagnostic procedure***
- ***Outpatient therapy/procedures***
- ***Normal post-procedure recovery***
- ***Convenience or custodial stays***
- ***Stays longer than 48 hours***
- ***Hold for placement in an extended care facility***

When they open observation units, hospitals have to decide whether to dedicate space and staff to observation or distribute observation beds throughout. With the dedicated model, "everyone involved belongs in that unit and is solely responsible for the outcomes in that unit," Marandi said. It's been amply demonstrated that the distributed model leads to longer hospital stays. A 2010 study found that average length of stay in a dedicated observation unit was 17.5 hours compared with 22.3 hours nationally for observation patients.

Before hospitals open observation units, they have to answer four questions and re-evaluate the answers annually, Marandi said:

(1) Where will the observation unit be located? In the ED? Next to it? Will it be virtual (i.e., dispersed)?

(2) How big will it be? That depends on its goals, the hospital's census and the size of the ED.

(3) How many beds will be in the observation unit? (Ninety percent have more than 16 beds; hospitals have an average of five observation beds per 30,000 to 50,000 ED visits annually.)

(4) Who will staff the observation unit? Hospitalists and/or ED physicians? Physician extenders (i.e., physician assistants and nurse practitioners)? Staffing should be one physician per 3,000 patients, and the recommended patient-to-nurse ratio is five to one, although four to one is preferred, he said.

To succeed, he said observation units also must have protocol-driven care, and policies and procedures that are reviewed annually. "You don't want to take every patient into observation," he said. "The more algorithms and standardization of care you provide," the better.

To evaluate the performance of their observation units, Marandi said hospitals should track and evaluate their volume and occupancy rate; length of stay in hours; percent of patients requiring hospitalization or discharged home (with a discharge-home goal of 80% or more); protocol and guideline compliance; direct and indirect net revenue; costs (variable, total and severity/diagnosis adjusted); and patient/provider satisfaction. The observation length of stay should be under 18 hours, and the inpatient admission rate from observation should be 15% to 40%.

Sometimes observation units fail. The reasons include a lack of strong leadership and failure of the administration to follow through with revenue after units are built, Marandi said. There have to be enough resources for staffing and equipment. If patients need an MRI or a consult, it shouldn't take 24 hours.

"Ancillary services and diagnostics can be a real killer for dedicated and distributed models," said Elizabeth Lamkin, CEO of PACE Healthcare Consulting in Bluffton, S.C., at the webinar. Observation time may drag on if the patient is placed there on a Sunday, but the services aren't available until Monday. If 30% of the patients receiving a certain ancillary service are observation patients, consider establishing treatment protocols. "You don't need to do a shotgun approach," she said. "Know which ancillaries you will need, and keep space open on the schedule. Have some staff who can react quickly to observation patients."

Building a "sustainable unit" also requires meaningful systems of utilization management (UM) that measure and report results (see box, p. 6), Lamkin said. "Utilization committees are one of the few committees that CMS mandates," and they are in a unique position because they bring together physicians and hospital administrators. "Make it something physicians want to participate in," she said. Use scorecards because "physicians love data. They are scientists." RAC results and billing compliance reports should be presented to the UM committee. "CMS expects the committee to deal with outliers," she noted.

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