The One Day Stay Medical Necessity Challenge

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Hospitals will be facing even greater scrutiny from the Centers for Medicare and Medicaid Services (CMS) Program Integrity Contractors and the Office of Inspector General to ensure that the admission and/or services provided to beneficiaries for acute and post-acute settings are appropriate for the level of care as well as medically necessary. There will be a focus on the documentation within the medical record and whether it accurately reflects the severity of the patient's illness along with intensity of the resource consumption to justify MS-DRGs. According to CMS, inappropriate or unnecessary admission to acute care facilities account for more than 10 billion dollars annually in improper payments.

Under the 8th Scope of Work, CMS placed the Hospital Payment Monitoring Program (HPMP) with the Quality Improvement Organization (QIO), which produced the Payment Error Prevention Program Report (PEPPER) for each hospital with a focus on targeted one day admission. The *HPMP Compliance Workbook* contains the following quote from the *OIG Supplemental Guidance* (2005) in chapter 3, page 27: "Often the status of patients at admission or discharge significantly influences the amount and method of reimbursement hospitals receive. Therefore, hospitals have a duty to ensure that admission and discharge policies are updated and reflect current CMS rules." These reports emphasize the importance of educating the clinical staff and providers about the financial risk and vulnerabilities regarding one day stay inpatient admissions.

Nationwide, the hospitals responded with a significant reduction in one stay admissions, over the course of the three year program from 2005 through 2008. Some hospitals have even reported consistently with zero one day admissions for chest pain for 2008. The 2008 year end nationwide target area summary analysis showed significant reductions in admissions and cost savings to the Medicare Program in the areas of Heart Failure and Chest Pain. However, Metabolic Disorders/Nutritional and Renal areas have seen an increase in one day admissions.

Short-Term, Acute-Care Hospitals Report
Nationwide Target Area Summary Analysis

Discharges through Q4 2008

1DS Heart Failure	FY 2005	FY2006	FY2007	FY2008
MS-DRGs 291, 292, 293 One-Day Stays Discharges	40,566	38,910	36,260	33,825
All MS-DRGs 291, 292, 293 Discharges	667,444	629,770	588,779	542,269
Proportion of Target to Denominator Discharges	6.1%	6.2%	6.2%	6.2%
Average Medicare Payment for Target	$4,851	$5,067	$5,268	$5,129
Sum of Medicare Payments for Target	$196,770,664	$197,169,696	$191,010,815	$173,481,159
1DS Chest Pain				
MS-DRG 313 One-Day Stays Discharges	99,169	90,972	86,987	77,490
All MS-DRG 313 Discharges	233,826	217,712	207,247	182,054
Proportion of Target to Denominator Discharges	42.4%	41.8%	42.0%	42.6%
Average Medicare Payment for Target	$2,476	$2,589	$2,641	$2,614
Sum of Medicare Payments	$245,514,140	$235,550,907	$229,730,749	$202,558,813
1DS Esophagitis/Gastroenteritis				
MS-DRGs 391, 392 One-Day Stays Discharges	53,702	55,087	50,474	44,540
All MS-DRGs 391, 392 Discharges	374,213	400,411	322,425	284,734
Proportion of Target to Denominator Discharges	14.4%	13.8%	15.7%	15.6%
Average Medicare Payment for Target	$3,406	$3,667	$3,537	$3,736
Sum of Medicare Payments for Target	$182,896,265	$202,018,950	$178,502,519	$166,389,830
Medical Back				
MS-DRGs 551, 552 Discharges	99,394	96,764	94,309	88,615
All Discharges	12,033,598	11,603,647	11,298,010	10,980,066
Proportion of Target to Denominator Discharges	0.8%	0.8%	0.8%	0.8%
Average Medicare Payment for Target	$3,716	$3,869	$4,178	$4,466
Sum of Medicare Payments for Target	$369,309,529	$374,412,697	$394,025,083	$395,777,157
1DS Nutritional/Metabolic Disorders				
MS-DRGs 640, 641 One-Day Stays Discharges	32,750	29,682	31,829	33,020
All MS-DRGs 640, 641 Discharges	289,391	244,526	261,499	245,468
Proportion of Target to Denominator Discharges	11.3%	12.1%	12.2%	13.5%
Average Medicare Payment for Target	$3,368	$3,440	$3,658	$3,905
Sum of Medicare Payments for Target	$110,298,248	$102,119,873	$116,427,695	$128,954,329
1DS Renal Failure				
MS-DRGs 682, 683, 684 One-Day Stays Discharges	10,094	12,085	14,298	14,929
All MS-DRGs 682, 683, 684 Discharges	203,943	231,366	258,928	261,904
Proportion of Target to Denominator Discharges	4.9%	5.2%	5.5%	5.7%
Average Medicare Payment for Target	$7,043	$6,632	$6,665	$6,642
Sum of Medicare Payments for Target	$71,094,834	$80,142,367	$95,296,310	$99,150,979

Since the introduction of Medicare Severity Diagnosis Related Groups (MS-DRGs), hospitals have begun to focus on the clinical documentation that would accurately reflect the severity of the patient's condition. Addressed in Table II, target medical MS-DRGs with Complications and Comorbidities (CC) or Major Complications and Comorbidities (MCC) have greatly increased from FY 2007 compared to FY 2008 and the Medicare payments have nearly doubled for those target areas.

The focus on improved documentation has brought about new governmental interest in the documentation supporting the MS-DRG, insuring that the admission was medically necessary and appropriate for inpatient services. As hospitals begin to manage their one day admissions, the focus needs to shift from one day stays to the appropriateness of all admissions. Focus will be on short stay admissions, which are usually less than three (3) days, and transfers to skilled nursing facilities to ensure medical necessity is met.

Table II

Medical MS-DRGs w/CC or MCC	FY2005	FY2006	FY2007	FY2008
MS-DRGs w/CC or MCC Discharges	2,812,988	2,774,332	2,711,833	3,648,375
All MS-DRGs with or without CCs or MCCs Discharges	3,424,427	3,322,070	3,250,361	6,335,900
Proportion of Target to Denominator Discharges	82.1%	83.5%	83.4%	57.6%
Average Medicare Payment for Target	$4,847	$5,040	$5,246	$7,377
Sum of Medicare Payments for Target	$13,635,927,735	$13,983,284,503	$14,227,089,189	$26,912,684,536
1DS Medical MS-DRGs				
One-Day Stay Medical MS-DRGs Discharges	860,479	832,778	819,849	794,702
All Medical MS-DRGs Discharges	8,485,117	8,134,868	7,969,550	7,818,398
Proportion of Target to Denominator Discharges	10.1%	10.2%	10.3%	10.2%
Average Medicare Payment for Target	$3,937	$4,057	$4,200	$4,311
Sum of Medicare Payments for Target	$3,387,427,555	$3,378,663,820	$3,443,714,314	$3,426,094,764
Sepsis				
MS-DRGs 870, 871, 872 Discharges	287,842	309,825	327,764	365,320
All DRGs 689, 690, 870, 871, 872 Discharges	545,831	567,388	582,919	624,885
Proportion of Target to Denominator Discharges	52.7%	54.6%	56.2%	58.5%
Average Medicare Payment for Target	$9,086	$9,858	$11,305	$11,980
Sum of Medicare Payments for Target	$2,615,280,062	$3,054,317,410	$3,705,345,891	$4,376,702,552

The hospital's first line of defense in preventing inappropriate/unnecessary admissions is the Utilization/Case Management Departments. Under CMS Conditions of Participation (CoPs) for hospitals, it defines the utilization review department to ensure that each Medicare or Medicaid admission is appropriate and medically necessary. In addition, the department is responsible for ensuring that all consultants and ancillary services are medically necessary for the condition in which the patient required inpatient services; therefore, validating the severity of illness and intensity of services and assigning appropriateness of the admission and/or setting. Here are some tips that can reduce your exposure to medical necessity concerns:

- Have an admission (emergency department, recovery room and direct admission) care manager to assist physicians with appropriate status assignment;
- Have a physician advisor (often outsourced) be readily available to assist a care manager with any reviews requiring medical judgment;
- Perform prompt and deliberate reviews for medical necessity, over or under-utilization of observation status; and
- Coordinate with Clinical Documentation Specialist to follow up on missing documentation to support the setting and/or appropriateness of care.

The hospital's last line of defense is the Clinical Documentation Improvement Specialist. These teams collaborate with the clinical/financial departments of the hospital to work in tandem to ensure that the clinical documentation within the medical record will support continuous medical necessity for the medical condition, severity of illness, and accurate coding of MS-DRG that is reflective on the documentation.

In light of the significant changes occurring in the healthcare industry, integrity requires greater specificity in medical documentation, case management and coding. It is vital that these professionals are knowledgeable in the current regulatory focus and the financial impact of inappropriate/unnecessary admissions, and able to identify and address your organizational barriers for compliance. Now is the time to implement the hospital's line of defense to ensure success under scrutiny.