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Inpatient vs. Observation - It's All in The Patient Story

When a clinical decision is made by the physician or other provider to hospitalize a patient, he/she must decide the level of care designated by "Inpatient" vs. "Observation." While the type of care is identical in nature whether inpatient or observation, there is certainly potential costs implications for the patient in terms of financial responsibility for copays and deductibles. For instance, patients are generally responsible for all self-administered drugs when placed in observation status. As all of us are aware, payers utilize commercially available licensed screening criteria such as Millman Care Guidelines or InterQual Level of Care screening criteria. Keep in mind that as the name implies, these are just screening criteria with other factors being potentially considered in the payer's decision to approve inpatient versus observation status for level of care. Vitally important is the patient story as toll, described, shown, reflected, depicted, and painted in the History and Physical.

How Proficient Are You in Communication of the Patient Story?

In the words of William Osler, the Father of Modern Medicine and confounder of the first medical residency program, John Hopkins Medical School, "A Good Physician Treats the Disease, a Great Physician Treats the Patient with the Disease." Dr. Robert Centor, Professor of Medicine at the University of Alabama, Birmingham, states it eloquently with the following quote: "I contend that the great physicians differ from the good physicians because they understand the entire story. Only when we understand and communicate the complete story do we make consistent diagnoses." The great physician understands the patient and the context of that patient's illness as reported and clearly reflected in the medical record, starting importantly within the History of Present Illness of the History & Physical. There are eight elements of the History of Present Illness with a minimum of four necessary to be reported to adequately communicate and report the patient's clinical condition: What did the patient look like, how did the patient clinically manifest, and what is wrong with the patient. The HPI is the prism in which medical necessity for inpatient versus observation begins, critical to the appropriateness of level of care designation ultimately decided by the physician or other provider. In short, the patient story as communicated by the provider plays a vital critically important role in the clinician's determination of level of care to order.


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Medicare's guidelines under the two Midnight Rule governing appropriateness of inpatient stay determination are worthy of note as follows from a documentation perspective:

- *Both the decision to keep the beneficiary at the hospital and the expectation of needed duration of the stay are based on such complex medical factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered*

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- *Medicare will continue to follow longstanding guidance to review the reasonableness of the inpatient admission for purposes of Part A payment based on the information known to the physician at the time of admission. The expectation for sufficient documentation is well rooted in good medical practice "supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required.*

- *The entire medical record may be reviewed to support or refute the reasonableness of the physician's expectation, but entries after the point of the admission order are only used in the context of interpreting what the physician knew and expected at the time of admission*

Bottom Line

A major controlling factor to accompany screening criteria utilized by payers in the physician's or other provider's clinical decision to hospitalize a patient with a designation of inpatient versus observation is the patient's severity of illness and contributing factors of comorbid conditions as reported and communicated within the History and Physical. How well the patient's clinical presentation is depicted and reflected within the History and Physical, the extent of the Physical Exam and Findings, results of diagnostic workup performed and available as documented with their clinical significance, and extent of clinical impression including what the provider knew at time of time of admission with clinical rationale thoughts and rationale accompanied by a rationale and reasonable plan of care, are strong determining factors in payer judgment of appropriateness of level of care determination.

Help the Case Manager/Utilization Review professionals involved in patient care help you help your patient by not overlooking the requirement for complete, accurate telling and describing of the patient story outlining your observations, tabulation, and communication of findings with clinical significance culminating in an encompassing assessment and plan of care!

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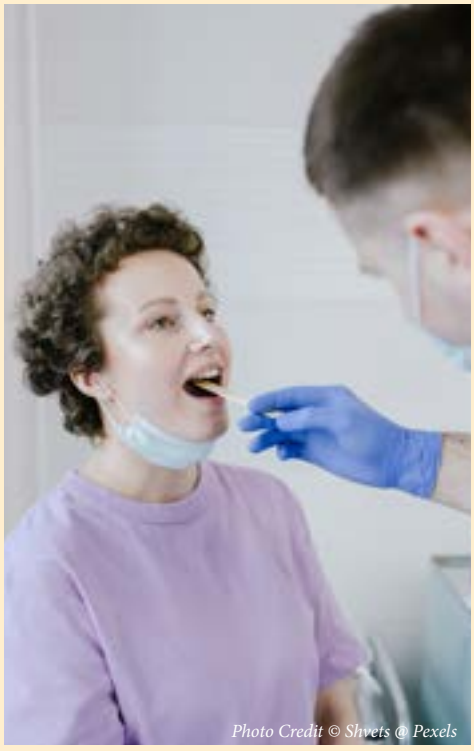

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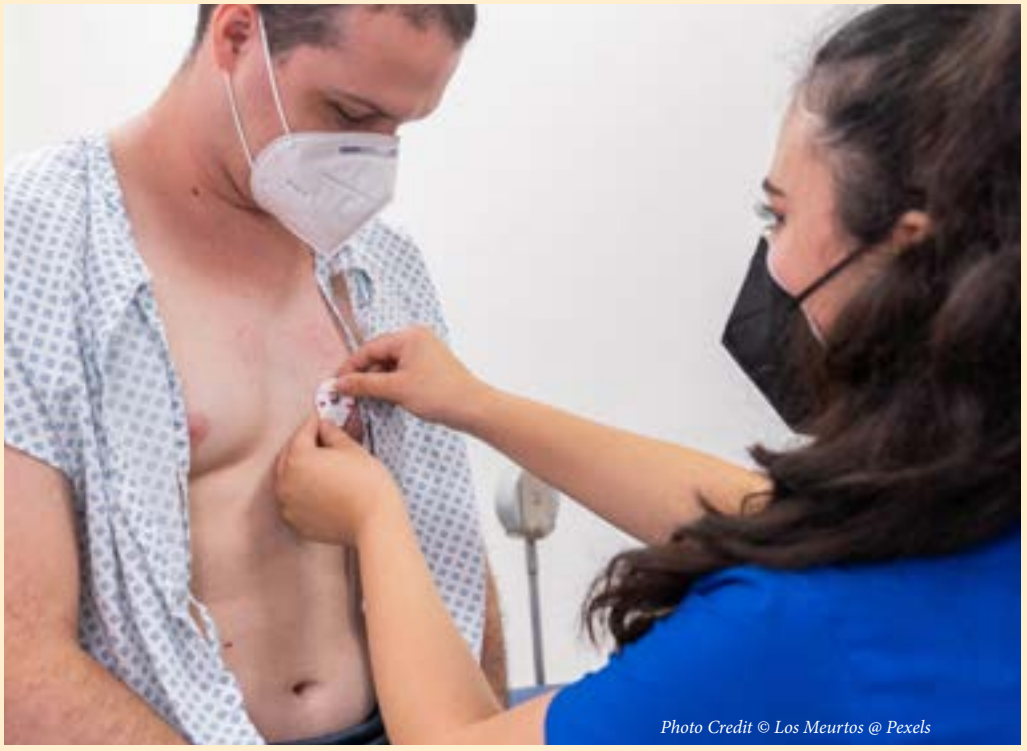

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