Dr Watson and the Case of Observation-Level Care

Sherlock Holmes accused Dr Watson of seeing but not observing. Were Dr Watson a pediatric hospitalist, utilization reviewers would accuse him of observing but not hospitalizing or, more technically, of providing “observation-level care” rather than “inpatient-level care.” In this issue of Pediatrics, Fieldston et al\(^1\) convincingly demonstrate that there is no consistent difference between these 2 levels of care as applied to the pediatric population. Having excluded all potential rational explanations for these differences in billing status, the sole remaining conclusion (“no matter how improbable,” as Holmes would say) is that this is an arbitrary distinction used by payers to decrease reimbursement to both hospitals and physicians. Because pediatric hospital stays are frequently \(\leq 2\) days, hospitals caring for children, pediatricians, and families of hospitalized children are put at increased financial risk from this reduced reimbursement. Instead of spending our energy fighting each individual designation of observation-versus inpatient-level care, the pediatric community should lobby aggressively to change what is a fundamentally flawed construct.

Fieldston et al\(^1\) analyzed 2010 Pediatric Health Information System billing data for \(~200\,000\) patient stays of \(\leq 2\) days at 33 large children’s hospitals. Their assessment revealed marked variability in the use of observation status across hospitals (range: 2\%–45\% of all 2-day stays designated as observation status) and within individual hospitals according to diagnosis (range: 2\%–55\% [most \(> 25\%\)]) (Fig 3 in the article by Fieldston et al). There was significant overlap in resource utilization between stays coded observation versus inpatient status,\(^1\) confirming the intuitive perception of physicians who admit patients with diagnoses such as asthma, bronchiolitis, acute gastroenteritis, and seizure; we know the children are sick with an illness that generally lasts 1 to 2 days, but we cannot predict who will respond quickly to therapy and be discharged, and who will need to stay longer in the hospital.

When observation codes were first introduced, they were used for stays of \(\leq 24\) hours while physicians (prospectively) monitored a child’s progress to determine whether the child would require continued care in the hospital. Physicians were no more prescient than we are now, but the 24-hour metric was clear and understandable for patients, physicians, hospitals, and payers alike. The new application of observation-level care as a lower acuity, less resource intense level of service seems to be a reasonable distinction in theory. In practice, it turns out to be arbitrary, inconsistent, and obfuscatory. The data of Fieldston et al\(^1\) are conclusive. The variable use of observation status across hospitals and diagnosis-specific variability within hospitals demonstrate marked inconsistency. This finding is not surprising given that the distinction is based on payer-specific criteria. Here, pediatrics suffers from the variability across state Medicaid programs compared with uniform federal Medicare.

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guidelines. In addition, the criteria were not developed for pediatrics but were modified (without evidence) from adult criteria. Most interesting perhaps is the severity-adjusted cost analysis for the 4 selected diagnoses. Although nonroom costs are lower for patients with a diagnosis of seizure, bronchiolitis, or asthma, nonroom costs were higher by $155 for patients with gastroenteritis (Table 2 in the article by Fieldston et al). But with a P value of .7, this finding is clearly a random variation. It is not that observation status patients are sicker and require more resources than inpatient status patients, but rather that the null hypothesis holds. There is no difference between observation and inpatient status patients. The $155 difference is a result of sampling error.

In light of this analysis, the pediatric community is left with 2 choices. One is to work within the current system through vigorous documentation and appeals. We can thoroughly record each individual encounter to emphasize features that justify inpatient status. This action does not mean artificially elevating acuity by continuing intravenous fluids and/or medications in a patient who does not need them but rather carefully and completely documenting patient status, parental concerns, current therapies, and medical decision-making. In addition, we can aggressively appeal payer decisions that deny inpatient status in favor of observation status. As someone who has reviewed pediatric InterQual criteria for >5 years, I have been told that the criteria are intended for nonphysician utilization review professionals to apply to ~85% to 90% of cases. Exceptions are anticipated that will require review by the medical director. A 10% to 15% additional review/appeal rate is expected, and the pediatric community has a right and a responsibility to challenge each individual decision that seems inappropriate.

But this approach only nibbles around the edges of a fundamentally flawed distinction. I favor a second choice. The pediatric community should unite to eliminate observation status for hospital stays >24 hours and return to the original construct that “observation” refers to an initial 24-hour assessment period for children whose acuity and treatment needs may or may not require a longer hospital stay. A new metric should be developed to distinguish between low-, medium-, and high-acuity stays >24 hours that reflects and accurately distinguishes between low, medium, and high resource utilization.

This approach is similar to one that many patients and providers in the adult community are advocating. Medicare enrollees are eligible for care in skilled nursing facilities when hospitalized under inpatient status for at least 3 days. However, when patients stay in the hospital 3 days under observation status, the patients pay for skilled nursing facility services. The financial ramifications are obvious, and frequently unexpected and/or delayed. Neither patients, their families, nor physicians can reliably predict which 3-day stays are “inpatient” and which are “observation.” Initial determinations may be reversed on further review. For seniors, 3 days in the hospital is a hospitalization, pure and simple. The distinction is home versus hospital, not observation versus inpatient. Fortunately, seniors have the political clout to attack the underlying problem and do not have to nibble around the edges. The AARP and the American Medical Association have endorsed eliminating the distinction between observation and inpatient status for purposes of skilled nursing facility eligibility through the Improving Access to Medicare Coverage Act.

Congressman Joe Courtney, one of the bill’s bipartisan sponsors, calls it a “common sense change … of an arbitrary federal policy.”

The nation’s children, their families, and the physicians and hospitals caring for them deserve equal treatment. As some would say, “The solution is elementary, my dear.”

REFERENCES

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