Operationalizing the Onsite Physician Advisor Program



© 2026 Streamline Solutions Consulting, Inc. All rights reserved. Licensed for individual use only. Redistribution prohibited.

Inpatient vs. Observation

What's The Difference

Copyright 2026 - All Rights Reserved

Agenda

- Learning the Difference
- What is Observation
- What is Inpatient
- Medicare Regulations and Guidance
- The Role of Documentation

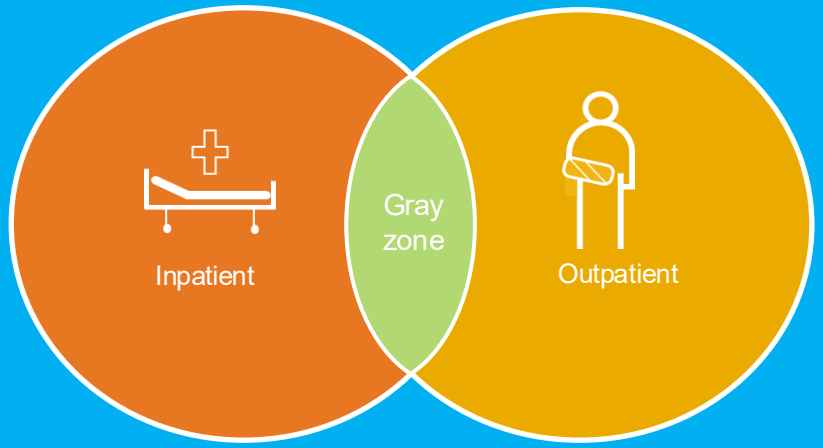
Copyright 2026 - All Rights Reserved

Learning The Difference

Copyright 2026 - All Rights Reserved

“Gray” or Uncertain Medical Necessity

Cases that may be appropriate for Inpatient setting *(screening required)*



Cases that may be appropriate for Outpatient/OBS setting

“Gray” Zone – Cases that require individual assessment due to unclear Medical Necessity:

Revenue/Compliance Risk:

Copyright 2026 - All Rights Reserved

What is Observation

Copyright 2026 - All Rights Reserved

Is Observation A Status?

In the Medicare world, there are two statuses:

- Inpatient (Part A)
- Outpatient (Part B)

Observation is not a status.

Observation is a service that is provided to an Outpatient in a Hospital Bed.

Copyright 2026 - All Rights Reserved

Definition of Observation

"Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. When a physician orders that a patient be placed under observation, the patient's status is that of an outpatient. "

Medicare Benefit Policy Manual, Chap 6
20.6 - Outpatient Observation Services
(Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)

Copyright 2026 - All Rights Reserved

Coverage of Outpatient Observation Services

"Observation services are covered only when provided by the **order** of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours."

Medicare Benefit Policy Manual, Chap 6
20.6 - Outpatient Observation Services
(Rev. 215, Issued, 12-18-15, Effective, 01-01-16, Implementation: 01-04-16)

Copyright 2026 - All Rights Reserved

Physician Advisor Decision Signal: Prolonged Observation

- Observation beyond 24–48 hours should trigger PA review
- Prolonged observation often reflects:
- Unresolved medical necessity
- Documentation failure
- Delayed admission decision
- Under the Two-Midnight framework:
- Ongoing hospital-level care spanning ≥2 midnights generally supports inpatient consideration
- The PA's role is **early intervention**, not post-hoc justification

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

Copyright 2026 - All Rights Reserved

2014 IPPS Final Rule:
2 Midnight Expectation

Copyright 2026 - All Rights Reserved

Benchmark vs. Presumption

“Benchmark of 2 midnights”
“the decision to admit the beneficiary should be based on the **cumulative time spent at the hospital beginning with the initial outpatient service**. In other words, if the physician makes the decision to admit after the beneficiary arrived at the hospital and began receiving services, **he or she should consider the time already spent receiving those services in estimating the beneficiary’s total expected length of stay**.”

Page 50946, IPPS

“Presumption of 2 midnights”
“Under the 2-midnight presumption, inpatient hospital claims with lengths of stay greater than 2 midnights after formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts **absent evidence of systematic gaming, abuse or delays in the provision of care**…”

Page 50949, IPPS

Copyright 2026 - All Rights Reserved

What is Inpatient

Copyright 2026 - All Rights Reserved

What Makes an Inpatient?

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services... Generally, a patient is considered an inpatient if formally admitted* as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.
MBPM Chapter 1, Section 10

*It should noted that an inpatient order is no longer required as a condition of payment, but best practice is the presence of an order.

42 CFR § 412.3(a) — CMS revised this section in the 2019 IPPS Final Rule to eliminate the specific payment condition that inpatient orders *must* be present and authenticated in the record to get Part A payment.

Copyright 2026 - All Rights Reserved

Inpatient Requirements

Factors to be considered when making the decision to admit include such things as:

1. The severity of the signs and symptoms exhibited by the patient;
2. The medical predictability of something adverse happening to the patient;
3. The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
4. The availability of diagnostic procedures at the time when and at the location where the patient presents.

MBPM Chapter 1, Section 10

Copyright 2026 - All Rights Reserved

Two-Midnight Rule — Core Exceptions

- **Case-by-case inpatient admission (< 2 midnights)**
  When hospital-level care is required and outpatient care is not reasonable
  (Requires clear, contemporaneous documentation)
- **Unforeseen early termination of stay**
  - Death
  - Transfer to another acute-care hospital
  - Patient left AMA
  - Faster-than-expected clinical improvement
    (Original expectation still governs)
- **Mechanical ventilation initiated**
  Strong indicator of inpatient-level care, even if LOS < 2 midnights
- **Inter-facility transfers**
  Time spent at the transferring hospital **counts toward the 2 midnights**
- **Key PA Principle:**
  The decision hinges on **physician expectation at the time of admission**, not hindsight.

Copyright 2026 - All Rights Reserved

Physician Advisor Judgment — Applying Exceptions Safely

High-Risk Areas Requiring PA Oversight

- Inpatient admissions with **< 2 midnights**
- Prolonged observation approaching 2 midnights
- Reliance on “case-by-case” justification
- Mechanical ventilation cases with rapid improvement
- Transfers with incomplete documentation of prior hospital time

What Is *Not* an Exception

- Bed availability or throughput issues
- Delayed testing or consults
- Social admissions
- Discharge inefficiencies
- “This is how we’ve always done it”

Copyright 2026 - All Rights Reserved

Why Getting Patient Status Correct is Important

Inpatient side:

- Compliant billing – False Claims Act
- Risk of audit
- Loss of Revenue

Outpatient/Observation side

- LOS and Mortality rates will be artificially elevated with overuse of OBS
- SNF qualification
- Financial burden – part B payments

It's about getting it right!

Copyright 2026 - All Rights Reserved

Why Physicians Might Order Observation?

Potential compliance issues:

- Commercial payer financial incentives to put patients into OBS
  - Is this a Stark Law violation?
  - Physicians erroneously use this concept for FFS Medicare patients

Do not have to provide a discharge summary for OBS patients

Thinking certain diagnoses are “always” OBS

- This concept is also believed by administrators, UM, and payers
- Based on high denial rates from RACS in the past
- Generally, the symptom diagnoses are:
  - Chest pain, syncope, TIA’s, and more
  - But these diagnoses also have a DRG – implies IP!

Copyright 2026 - All Rights Reserved

How to Compliantly Determine When a Patient Belongs in Observation?

Copyright 2026 - All Rights Reserved

Importance of Utilization Review

Must all cases be reviewed?

UM Committee is one of the only committee required by Medicare in the Conditions of Participation

Medicare does not say ALL cases have to be reviewed, but Medicare does say **ALL billing claims have to be accurate**

The best way to ensure claims are accurate is by using a **compliant and consistent UR process** that ensures appropriate review and documentation to support the claim

Copyright 2026 - All Rights Reserved

False Claims Act — Quick Synopsis

The **False Claims Act (31 U.S.C. §§ 3729–3733)** is the federal government's primary tool to combat **fraud against federal programs**, especially Medicare and Medicaid.

What It Prohibits

The FCA makes it illegal to **knowingly**:

- Submit a **false or fraudulent claim** for payment to the federal government
- Cause someone else to submit a false claim
- Use false records or statements to get a claim paid
- Retain government overpayments without returning them ("reverse false claims")

Key point: "Knowingly" includes **actual knowledge, deliberate ignorance, or reckless disregard** — intent to defraud is *not* required.

Copyright 2026 - All Rights Reserved

Recommended UR Review

Copyright 2026 - All Rights Reserved

Why Are My Observation Rates Going Up?

Areas to Review

- What is my UR Process?
- Do I have 7 day/week coverage?
- Is every Medicare case getting reviewed?
- Are cases failing an IP criteria-based review getting a physician-based review?
- Are CM Criteria reviews consistent?
- Are CM making decisions beyond the scope of their license?

Copyright 2026 - All Rights Reserved

Only A Doctor Can Legally Admit Patients To A Hospital

42 CFR 482.12(c)(2)

"Patients are admitted to the hospital *only on a recommendation of a licensed practitioner permitted by the State to admit patients to a hospital.*"

Medicare State Operations Manual

"In no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate."

Hence, the need for the UR Process!!!

Copyright 2026 - All Rights Reserved

Medicare Regulations and Guidance

Copyright 2026 - All Rights Reserved

UM Responsibilities

The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

PART 482_CONDITIONS OF PARTICIPATION FOR HOSPITALS--
Table of Contents

Subpart C - Basic Hospital Functions

Sec. 482.30 Condition of participation: Utilization review.

****A MUST to know and understand**

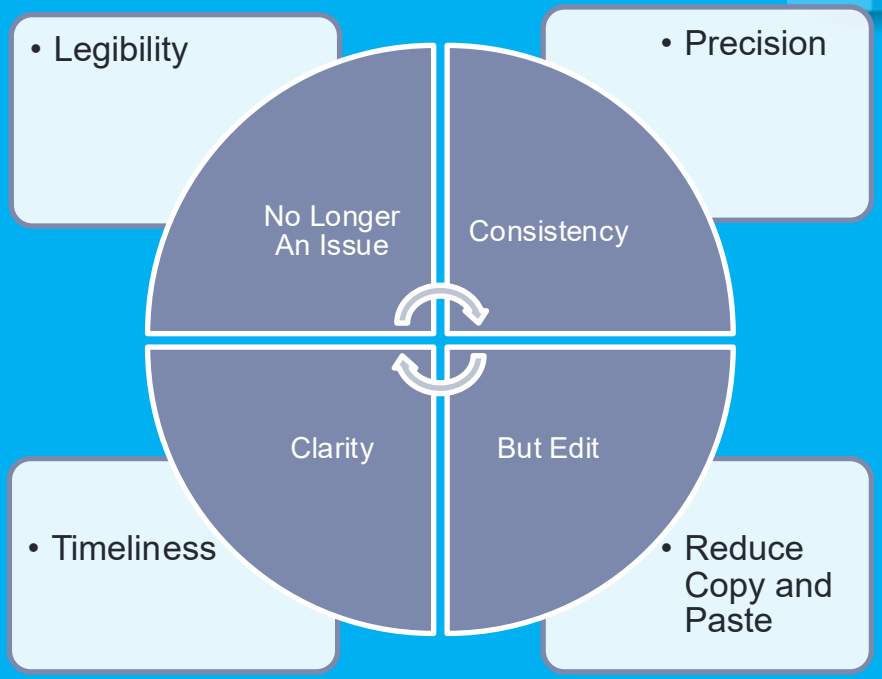
Copyright 2026 - All Rights Reserved

How Does Documentation Play A Role?

Since the role of a physician advisor is commonly documentation improvement, these are some key factors to be aware of:

Copyright 2026 - All Rights Reserved

Requirements for High-Quality Documentation



Copyright 2026 - All Rights Reserved

What to Document

- The primary diagnosis
- All diagnoses that impact the patient's care, evaluation, and treatment
- Co-existing acute conditions
  - Do not use "H/O, History of" if actively being treated
- Chronic conditions
- Treatment – must be monitored, evaluated, or treated
- Conclusions and diagnosis
  - In DCS – probable, possible, suspected, likely
  - The DCS is the "rescue" document and can be updated
  - Don't wait until the last day to do your DCS
- RULE of 3: Document it 3 times

Copyright 2026 - All Rights Reserved

General Documentation Takeaways

5 key pieces of documentation for Medicare cases and determining medical necessity of Inpatient:

- Medical history
- Current medical needs
- Severity of signs and symptoms
- Facilities available for adequate care
- **Predictability of an adverse outcome**

Copyright 2026 - All Rights Reserved

Areas for High-Quality Clinical Documentation

- Earlier than Expected DC
- 1 Day Stays
- Status Order Changes
- Patient Acuity
- CC44 Bullet Point #4
- Need for IP Level of Care

Copyright 2026 - All Rights Reserved

What You Need to Remember?

Let's make it simple

- Documenting Acuity – 4 guidelines
  - Suspects
  - Concerns
  - Predictable risk
  - Intent for treatment



Easy to remember

- Why does or doesn't this patient need an IP level of care
- What's the plan?

- **Document initially and every time there is a status order change**

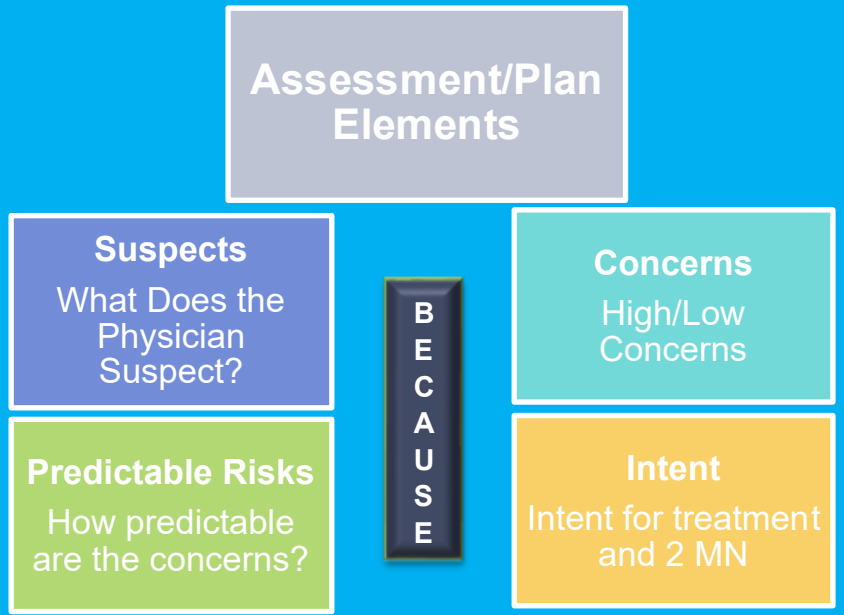
Copyright 2026 - All Rights Reserved

Discharge Summary is the “rescue” document!



Copyright 2026 - All Rights Reserved

A/P – The True Opening Statement



Copyright 2026 - All Rights Reserved

Documentation Examples

Copyright 2026 - All Rights Reserved

A/P Template

IP/OP/OBS level of care is warranted for this patient…

Because…

He/she presents with…

Suspicions…

And I have a high/low level of concern for… (Diagnosis, not symptom)

Concerns…

He/she is at high/low risk for…

Predictable Risks…

Plan of care/treatment includes…
Must also include intent for 2-midnight stay

Intent…

Adding the phrase “I expect this patient to cross 2 MN and require medically necessary hospital care.

Copyright 2026 - All Rights Reserved

Documentation Example HPI

Chief Complaint
Fall at home, hip and rib pain

History of Present Illness
Patient is a 90 yo female with c/o fall at home and rib pain. According to the family pt fell in bathtub and hit her left side. Unable to ambulate after fall. Has been on oral levaquin for tx of UTI per PCP. Gets unsteady and weak when has UTI per family. In the ER the **x-rays showed left-sided rib fxs (7-11).** No hip fx noted. Patient has uncontrolled pain so needs IV pain medication for pain control. PMHx significant for A fib, CHF, COPD, CVA, and hypothyroidism. At the time of the exam the pt is resting comfortably. Mostly nonverbal at baseline due to dementia. Most of this gathered from daughter. Would like NH placement.

Copyright 2026 - All Rights Reserved

Documentation Example A/P

Assessment
Principal Problem
Multiple fractures of ribs, left side

Active Problems
COPD, dementia, hypothyroidism, UTI, generalized weakness, frequent falls, fall at home

Plan
90 yo female with left side rib fx's, SP fall at home. Has been recently tx UTI OP. gets weak and unsteady with UTI
Fall at home with left sided rib fracture: admit for pain control, IV and oral analgesics, lidocaine patch for topical use, supplemental O2, fall precaution, PT consult, case management for possible placement, will continue to monitor

UTI: continue oral levaquin, IVF, repeat UA with urine Cx

Copyright 2026 - All Rights Reserved

Documentation Suggested A/P

Assessment/Plan
Inpatient is appropriate for this 90 yo female who fell in a bathtub sustaining multiple left rib fractures (7-11). **Risk** factors include failure of out-patient management of UTI with oral antibiotics, dementia, unsteadiness and weakness which typically occurs with UTI and leads to a fall risk, and I have a high level of **concern** for this UTI resulting in a significant injury, as this patient is at risk for sepsis due to a UTI. **Additional risk factors** include elevated WBC, elevated temp, advanced age, pulmonary complications due to lack of pain control, and COPD. **Plan of care** includes pain control, IV and oral analgesics, lidocaine patch for topical use, supplemental O2, fall precaution, PT consult, case management for possible placement, monitor, continue oral levaquin, IVF, and repeat UA with urine Cx. I anticipate a **2 midnight stay** and these services could not have been provided in a lesser setting.

Copyright 2026 - All Rights Reserved

Documentation Example 2 - A/P

IMPRESSION Osteoarthritis of the left hip

PLAN: Left total hip replacement.



TOTALLY INADEQUATE
For Justification of Acuity

Copyright 2026 - All Rights Reserved



STREAMLINE SOLUTIONS
CONSULTING, INC

© 2026 Streamline Solutions Consulting, Inc. All rights reserved. Licensed for individual use only. Redistribution prohibited.