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What is the Right Medical Management Model for Your ICU?

By Michelle Luffey

While hospitals may no longer be feeling the extreme clinical management challenges brought on by the COVID-19 Pandemic, countless organizations are still plagued by subsequent financial constraints. It was the perfect storm. The COVID virus profoundly affected the elderly population at a time when the 65+ population had grown from 41 million people in 2011 to over 71 million in 2019.[1] Year after year, CMS cut funding as hospitals experienced a progressively larger volume of Medicare patients which evidently led to hospitals decreasing staffing to a lean levels in an attempt to manage costs. At the same time, there are the challenges of an aging nursing workforce. The volume of nursing graduates was not able to keep pace with expected retirements, which was mainly due to an inability to increase enrollment within nursing programs due to a lack of instructors. This situation was not because of a lack of availability of highly educated or experienced nurses that could act as instructors. The nurse instructor supply shortage was exacerbated as nursing schools were unable to pay a higher rate than the nurse could achieve working in the hospital.

When the pandemic first struck, seasoned nurses held steady for a long time, but eventually those individuals were experiencing trauma and fatigue, and then retirements increased greatly. Hospitals that had already brought in "contract labor" were now in need of large numbers of workers to meet minimal staffing needs. According to the American Hospital Association (AHA) in the 2022 Cost of Caring Report, hospitals saw a median spend of 38.6% of their nurse labor costs on contract labor in January of 2022, which is a significant increase from the pre-pandemic [2019] rate of 4.7%. In addition to labor costs, supply and drug costs have also risen dramatically in the last 2 years resulting in over 33% of US hospitals operating on negative margins.[2]

Cutting labor costs can no longer be the "quick fix" for negative margins. This does not meanthat the healthcare industry should not seek ways to be more efficient with labor, but as movement into value-based care or pay-for-performance continues, having the correct resources in place to achieve the quality necessary to achieve best patient outcomes and subsequent full payment is required. So, where does one begin to assess the needs and seek opportunities to capture more patient revenue?

Assessing Needs and Capturing Additional Revenue in the ICU

One of the more costly areas within the hospital care setting is the Critical Care Unit. According to the Society for Critical Care Medicine (SCCM), Intensive Care Unit (ICU) costs per day in 2010 were estimated to be $4,300 per day and represented 13.2% of hospital costs.[1] While SCCM did not provide an update on this cost-per-day estimate in more recent years, it is likely to be significantly higher in 2023 since we know the cost rose 61% between 2000 and 2010.[1] Given this information, one might wonder, "**what are the keys to cost-effectively managing this intensive care?"**

While it may seem counter-intuitive due to the associated salary costs, Corazon has found that one of the top items to containing spend and increasing critical care outcomes is a 'closed' ICU with 24/7 Intensivist coverage. Both the Leapfrog Group and SCCM support the 24/7 use of intensivists, and it is recognized that a one-size-fits-all solution may not be logical in all situations. ICUs with a large size and higher acuity (e.g., large trauma centers) often require intensivist physicians on 24/7 basis. Alternately, those facilities that may not be handling that same volume of high acuity patients may successfully opt for a model using intensivists on the day shift with coverage by specially trained Advanced Practice Providers (APPs) on the off shift(s). For the hospitals that are struggling to make a solid decision that standardizes the ICU medical coverage, now is the time to undertake this evaluation and determine the model that provides the most consistent coverage.

What is the Best Medical Coverage Model for ICUs?

It is now accepted that critical care patient management that is led by an Intensivist team leads to reduced costs and improved quality outcomes. In hospitals without a readily available intensivist to assess a patient upon arrival to the ICU, the private practice physician or the hospitalist may not [have the ability to] prioritize this critical patient, thus leading to further deterioration and perhaps more medical resources.[4] Intensivists increase the use of evidence-based care protocols which help to optimize medical management and the judicious use of diagnostic testing and medications which improves resource utilization.[4] 24/7 intensivist team coverage also decreases ICU-related complications. This not only decreases the ICU length of stay (LOS), but also the overall hospital LOS, which presents significant resource / cost savings. These avoidable days in the ICU, and subsequently the overall hospital stay, can be put in perspective when you attach the cost. For example, assume that one patient per week who stays one additional day, the cumulative 52 extra days even at the 2010 estimated ICU cost per day of $4,300 ends up costing the facility $223,600 per year. In Corazon's experience in evaluating ICUs, unfortunately it is often many more than one patient per week that is experiencing one additional avoidable day in the ICU. A study published in JAMA Network Open in 2020,

found 69.1% of ICU patients had avoidable time during their ICU admission at a median rate of 7.2 hours.[5] And so this begs the question, **has there been an evaluation of the ICU avoidable days in recent history?**

Beyond simply providing the necessary ICU Intensivist coverage, it is also important to ensure billing and coding for the medical resources are accurate and timely. There are intricate rules related to billing for critical care services especially if using both physician and non-physician providers. During some of Corazon's recent Critical Care coding and billing assessments, there were findings that represented opportunities for additional payment that the hospital failed to capture. Furthermore, there were additional assessment findings, which in the event of an audit, would place the hospital at risk for potential payback to the insurance company. The table below presents some discrete examples from Corazon's ICU coding and billing assessments related to missed revenue and audit risk.

MISSED REVENUE	AUDIT RISK
Missed critical care visits where there was documentation in the chart supporting the billing of a critical care visit of 30 minutes, but no charge found on the corresponding hospital bill.	Critical care visits charged without the required time documentation or other required documentation within the patient's chart.
Missed add-on critical care visits where there was documentation in the chart to support billing of additional time for critical care beyond the initial 30 minutes for the day but no add-on critical care charge on the hospital billing.	Critical care visits are charged but the chart shows a lack of medical necessity for critical care visits where a basic E&M code should have been utilized.

Corazon has also found some hospitals have not implemented the necessary billing and coding algorithms when utilizing APPs as part of the Critical Care Intensivist Team Model to ensure all appropriate billing is captured. In 2022, there was a ruling change that allowed for split/shared billing in the critical care area with physicians and APPs – **Did your organization make changes in the coding and billing practices to capitalize on these changes?**

As we enter 2023, now is the time to evaluate your Critical Care provider coverage model and assess coding and billing practices to find opportunities for improvement in quality of care and revenue capture. Corazon's experienced team of experts "stand ready" to assist hospitals in this venture.

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