HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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INSIDE

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Inpatient vs. Observation: Will it ever be clear?

Patient status is biggest source of confusion

The Centers for Medicare & Medicaid Services (CMS) issued the two-midnight rule in 2013 in an effort to clarify the difference between inpatient stays and observation services, but even after three rounds of Probe and Educate audits by the Medicare Administrative Contractors (MACs), hospitals are still struggling to get it right.

In fact, 93% of members who responded to a Society of Hospital Medicine survey rated observation policy as a critical policy issue for them and their patients. Less than half of the respondents (40.4%) expressed confidence in determining patient status on their own and only 46.3% felt more confident in making these decisions with input from other people, including case managers, clinical decision support devices, coding and compliance

EXECUTIVE SUMMARY

Hospitals are still struggling with whether patients should be admitted or receive observation services despite efforts by the Centers for Medicare & Medicaid Services to clear up the confusion and conduct Probe and Educate audits.

- The two-midnight rule bases patient status on time in the hospital rather than clinical criteria, but case managers should still use decision-support software to determine if patients meet medical necessity criteria for an inpatient stay.
- Take a proactive approach and educate physicians up front about the level of detail the documentation should include to reflect the patient's conditions and intensity of service, and give them prompts in the medical record about what they should include.
- Notify patients that they are receiving observation services and that they may get a bill for their copay and pharmacy charges.

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administrators, and external review organizations.[1]

"Choosing between admitting patients or providing observation services was the biggest area of confusion I found at hospitals during my four years as a consultant for the Center for Case Management," says **Peggy Rossi**, BSN, MPA, CCM, now an auditor and trainer with California Health and Wellness.

Rossi adds that a check with her former clients reports that hospitals are still having difficulties with compliance, but that the problems have lessened as case managers continue to educate physicians when opportunities arise.

CMS announced the two-midnight rule to limit the use of observation status to reduce the financial burden on Medicare beneficiaries after fears of denials for short stay patients by the Recovery Auditors (RAs) prompted hospitals to significantly increase the use of observation, says **Jean Maslan**, BSN, MHA, CCM, ACM, managing consultant for Berkeley Research Group.

"Hospitals were concerned when they started getting denials from the Recovery Auditors and they started using observation status more aggressively," Maslan says.

The rule was intended to clear up confusion about patient status and to cut down on the number of patients with observation stays. But instead of reducing the instances of observation, the two-midnight rule has led to more confusion and hospitals are billing for observation services for all short stays, even when patients clearly require inpatient care, she adds.

The two-midnight rule has been a subject of controversy in the healthcare arena from the moment it was issued as part of the Inpatient Prospective Payment System (IPPS) final rule for fiscal 2014. CMS delayed post-payment audits of the rule before it went into effect on Oct. 1, 2013.

The IPPS proposed rule for 2016 delayed post-payment audits of the two-midnight rule for the third time, this time until Sept. 30, 2015. In the proposed rule, CMS also announced its intention to address the rule and "the broader set of issues related to short inpatient hospital stays, long outpatient stays with observation services" in the Outpatient Prospective Payment System final rule for 2016. The OPPS final rule is expected to be issued at the end of October and goes into effect Jan. 1, 2016.

CMs also says it is considering feedback it has received from healthcare stakeholders, including the recommendation from the Medicare Payment Advisory Commission (MedPAC) that it do away with the rule entirely.

Meanwhile, hospitals continue to be confused about how to comply with the rule, says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

"If CMS makes clarification in the OPPS, it won't go into effect until January," she points out.

Sallee's clients have told her that they have not found the Probe and Educate audits by the Medicare Administrative Contractors (MACs) to be as helpful as they expected.

"Hospitals get a report telling them what they did wrong, but it doesn't tell them what they should be doing to get it right," she says.

Physicians have been hesitant to declare how long they think patients will be in the hospital, adds **Bridget Gulotta**, RN, senior consultant for The Camden Group, a national

healthcare consulting firm with offices in Chicago. "Determining what a patient will look like in 24 or 48 hours is very subjective and physicians may default to observation or inpatient in some cases. This is why case management reviews are important," she adds.

"Many hospitals are fearful that any one-day stay they attempt to claim as inpatient status will be audited and the hospital will have to go through a time-consuming and expensive appeal process. Therefore, they make a claim only for observation services for one-day stays, even if the patient is in the intensive care unit. This may result in a huge loss of revenue for hospitals," says **Ann M. Sheehy**, MD, MS, a hospitalist at the University of Wisconsin Hospital and Clinics and a member of the Society of Hospital Medicine's Public Policy Committee.

Automatically putting short-stay patients in observation status rather than admitting them when they are high acuity is a disservice to the patients because they are vulnerable to higher out-of-pocket charges, including copays and hospital pharmacy charges, Sheehy says. It's a disservice to the hospital as well because reimbursement will be much lower. At the University of Wisconsin, for encounters between July 2010 and December 2011, observation care was delivered at nearly $240 loss per patient day, Sheehy says.

In addition, an observation stay does not count toward the three-day requirement for Medicare to pay for a nursing home stay, prompting some patients to choose to go home rather than pay out of pocket to go to a nursing home. As a result, these patients may experience problems such as dehydration, falls, and other avoidable complications, leading to preventable readmissions and increased costs, she adds.

Sheehy quotes the Medicare Benefits policy manual that defines observation as "a well-defined set of specific, clinically appropriate services" that are provided so "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."

The manual says that the decision should be made in less than 48 hours and usually less than 24 hours, and that outpatient observation services span more than 48 hours only in "rare and exceptional cases," she says.

> "ONE OF THE MAIN ISSUES WITH THE TWO-MIDNIGHT RULE IS THAT THE ACUITY OF ILLNESS DOESN'T HAVE ANYTHING TO DO WITH PATIENT STATUS."

"The two-midnight rule has attempted to address the issue of observation stays lasting longer than 48 hours, which is a positive aspect of the rule, assuming the Recovery Auditors respect our medical decision-making regarding the need for two midnights of care, which is still a big question mark. But the two-midnight rule has led to other problems, in part because the inpatient versus observation designation has been so problematic as observation care has expanded," Sheehy says.

"It is going to be hard for CMS to fix observation without a major overhaul, given that observation use has expanded so far beyond the original intent, combined with the reality that the Recovery Audit program charged with enforcement of observation is desperately in need of reform," Sheehy adds.

The difference with the two-midnight rule is that inpatient status is not based on any inpatient criteria. However, case managers still need to use guidelines to help them have an educated conversation about documentation with physicians, Maslan says.

Some hospitals follow one process for Medicare patients and another process for patients with commercial insurance, Maslan points out. "However, Medicare says to treat all patients the same regardless of insurance," she says.

"One of the main issues with the two-midnight rule is that the acuity of illness doesn't have anything to do with patient status. Whether a patient is an inpatient or receives observation services depends on the length of stay. Under the rule, patients in the intensive care unit can be classified as outpatients if their stay is less than two midnights," Sheehy says.

For instance, patients with diabetic ketoacidosis need intense medical care, a multitude of glucose checks and laboratory tests, an insulin infusion, and intravenous hydration, but often get better quickly and stay less than two midnights. "There's no way this intensity of care can be delivered in a clinic but, under the two-midnight rule, this stay is outpatient. It doesn't make sense," Sheehy says.

CMS has asked for input on exceptions to the two-midnight rule, Sheehy says. At present, mechanical ventilation is the only exception that was not in the original rule, she says.

To date, CMS has not made ICU care an exception to the rule, she adds.

Other exceptions to the rule are procedures on the Medicare Inpatient Only list, patient left against medical advice, unforeseen transfer, death, and patient chose to receive hospice care.

"There is a misconception that if a patient stays only one midnight he can't be an inpatient, but if the physician clearly documented the expectation that a patient would stay two midnights, the hospital can bill inpatient for those patients if the documentation supports an inpatient stay and notes that the patient improved more quickly than expected," Sallee says.

In cases when patients meet inpatient criteria when they present but stay only one day, case managers should make sure the physicians specify the intensity of services the patient needs within the medical documentation and the hospitals should fight it if they are denied, Maslan says.

However, even when hospitals take the time to appeal and are successful, the cost of the appeal could result in a net loss, she adds.

Some patients are being placed in the intensive care unit even though the physician has ordered observation services, Rossi point out.

When patients are placed in the ICU and receive observation services, their out-of-pocket costs can be substantial, Rossi points out. It's also a problem for the hospital, which receives minimal reimbursement for costly services such as telemetry, she adds.

"If a patient is sick enough to be in the intensive care unit, the severity of illness and intensity of services needed should meet inpatient criteria. But the documentation has to be detailed enough to reflect the need for an inpatient admission," Rossi says.

One of the biggest problems with the two-midnight rule is that it's based more on the time the patient is in the hospital than the risks of the patient, Maslan points out.

When researchers at the University of Wisconsin retrospectively applied the two-midnight rule to a group of patient records, it found that 46.9% of the cases would have been assigned observation status instead of being admitted as inpatients, based on the time of the day they presented to the hospital.

HOSPITALISTS SEE FIRSTHAND HOW THE CURRENT POLICIES NEGATIVELY IMPACT PATIENTS AND THE MEDICARE SYSTEM OVERALL...

"The results of this study are troublesome because the time of day the patient presented, and not different medical needs, would have dictated patient status under the two-midnight rule," Sheehy says.

She gives this example: If the patient comes in at 1 a.m. on a Tuesday and stays 40 hours until 5 p.m. on Wednesday, that's a one-midnight stay. But if the same patient comes in at 10 p.m. on Tuesday and has the same 40 hours of care, discharge would be at 2 p.m. on Thursday and would be a two-midnight stay.

"The time of day a patient gets sick, not different clinical needs, may determine a patient's hospital status and insurance benefits," she says.

Sheehy testified before the United States Senate Special Committee on Aging in the summer of 2014 and discussed the problems with the two-midnight rule and Medicare reimbursement for short-stay patients.

Hospitalists see firsthand how the current policies negatively impact patients and the Medicare system overall, Sheehy told the committee. "Observation care is provided physically within the hospital and the services provided are often indistinguishable from inpatient care, yet we are forced to label these hospitalized patients as outpatients," she says.

Sheehy told the committee that she has been asked what patients typically have to pay if they are receiving observation services.

"We still can't quantify what patients are likely to have to pay when they receive observation services because there is a copay for each service and there is no limit. Patients also are liable for certain pharmacy charges and their own skilled nursing facility care, should they need it. Cases range from simple to life-threatening. All we know is that the way Medicare Part A and Part B are set up, an observation patient has more potential liability than an inpatient," she says.

REFERENCE

1. The Society of Hospital Medicine Public Policy Committee white paper. *The Observation Status Problem: Impact and Recommendations for Change.* July 2014. http://bit.ly/1dglMd9. ■

Beef up your documentation reviews to ensure reimbursement is appropriate

Take a proactive approach to getting it right

Many of the problems the Medicare Administrative Contractors have cited during their Probe and Educate audits revolve around documentation, says **Bridget Gulotta**, RN, senior consultant for The Camden Group, a national healthcare consulting firm with offices in Chicago.

"In many cases, the documentation doesn't support that medical care would need to be provided over two midnights. Compliance primarily comes down to educating the physicians not only on what the rules and regulations are but on how to document appropriately," Gulotta says.

Instead of taking a reactive approach after the order is written, provide physicians with appropriate rules to follow so that when they write the inpatient order, they can use the right verbiage to pass muster if the chart is audited, Gulotta says.

"It's important for physicians to understand that they need detailed documentation to support patient status so the hospital can be reimbursed appropriately," adds **Jean Maslan**, BSN, MHA, CCM, ACM, managing consultant for Berkeley Research Group.

Have solid steps in place to make sure the documentation is comprehensive and supports a two-midnight stay, Maslan suggests. Educate the physicians about what documentation is needed. Even if you have forms with check boxes for the physicians to certify an admission, comprehensive documentation still needs to be in the medical record and progress notes, Maslan says.

The documentation should reflect patient complexities based on the diagnosis and prognosis, intensity of services, and details on treatment and tests, such as what type of blood work, Gulotta says. Make sure that any procedures or testing must be done in the hospital rather than on an outpatient basis and that the documentation supports it. "If there is anything that can be done on an outpatient basis, it generally will disqualify a patient from a longer-term stay," she says.

Linda Sallee, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago, recommends having the physician advisor review all observation patients to determine if inpatient care would be more appropriate. "Physicians are focusing on the care and not on getting the status right. Having the physician advisor work with case managers to educate physicians on patient status works very well," she says.

Gulotta suggests hiring an outside organization that uses nationally recognized care guidelines to review patient status.

"Sometimes peer relationships between the treating physician and those on the utilization management committee can affect what qualifies as inpatient versus observation," she says.

Case managers should assess patients for their status as close to admission as possible, Sallee says. "Even with the two-midnight rule, case managers still need to conduct medical necessity reviews and work with physicians to get the status right on the front end and make sure that the documentation supports the patient status," she adds.

Use medical necessity decision support criteria as a guide as to what you need to discuss with the admitting physician, Sallee says. "Case managers shouldn't ask physicians to document things that are not right, but if it appears that an observation patient meets inpatient criteria based on their assessment, they should use the information in the medical necessity criteria as a tool to point out that evidence-based criteria indicate that a patient with the medical issues could be an inpatient," she says.

Case managers are an invaluable resource in the emergency department, Gulotta says. "Coverage 24 hours a day may not be necessary, but there should be significant coverage seven days a week at times that are based on the volume of patients," she says.

She suggests creating a hybrid role that combines utilization review and case management and stationing these employees in the emergency department to assist physicians in determining patient status and ensure that patients who are admitted meet inpatient criteria.

"The people who fill this position should be well versed in the financial aspects and medical necessity and can be an excellent resource for the emergency department physicians and the admitting physicians. They should be familiar with resources in

the community that patients could be referred to, rather than receiving observation services," Gulotta says.

For instance, the case manager could obtain an appointment for appropriate patients at a heart failure clinic. "Sometimes a lack of information about resources may indicate whether a patient is kept in the hospital with observation services as opposed to being discharged," she says.

Case managers should tighten up on their observation management protocols and avoid unnecessarily long stays in observation, Maslan suggests.

She recommends reviewing observation cases every six hours, or a minimum of twice per shift, to make sure the hospital isn't losing any opportunity to convert the patient to inpatient status or to discharge the patient.

"Case managers should implement an effective trigger to review any change in a patient's condition that could result in a conversion to an inpatient stay. Hospitals shouldn't miss any opportunity to change patients' status to inpatient if appropriate," she says.

Follow observation patients closely to make sure they are in the hospital an appropriate amount of time, Maslan says. For example, if a discharge is dependent on lab results, be proactive and get the results to the physician and get a discharge order, she says.

If a patient receives observation services and a physician determines that the patient needs to be there another day or the patient meets inpatient criteria, the hospital is entitled to inpatient reimbursement, Maslan says. "It still shows up as a one-day inpatient stay when the bill drops but the auditors shouldn't deny it," she says.

Sallee recommends that hospitals set up an observation unit so the staff can easily distinguish the short-stay patients from those who have been admitted.

"If patients receiving observation services are on an inpatient unit, the staff treats them like the rest of the patients instead of assessing them at short intervals and getting them ready to be discharged or admitted as soon as possible in their stay. If they are in an observation unit, everybody will be focused on performing ongoing assessments and keeping the stay short," she says. ■

Educate observation patients on what "observation" means to them

Avoid the unpleasant surprise of a big bill for services

Many patients who are receiving observation services believe that they have been admitted to the hospital until weeks after discharge when they get a substantial bill for their share of the services they received.

Patients who are receiving observation services often aren't informed about their status and what it means, says **Peggy Rossi**, BSN, MPA, CCM, an auditor and trainer with California Health and Wellness.

"If a patient is in a hospital bed on the unit, they are likely to believe that they are inpatients and that bill they get for their copay is a shock," she says.

Observation can be a financial burden on Medicare fee-for-service beneficiaries, Rossi adds.

Patients who receive observation services are outpatients and have to pay their co-insurance, which can be higher than the deductible for inpatient care. In addition, patients in observation have to pay for "usually self-administered" drugs, even if a medical practitioner administers the drugs, Rossi says.

In addition, observation days do not count toward the three-day inpatient stay required for Medicare to cover a skilled nursing stay when patients need it.

As patient advocates, case managers have a responsibility to notify patients that they are receiving observation services and what their financial responsibilities may be so they won't be surprised when they get a bill, says **Jean Maslan**, BSN, MHA, CCM, ACM, managing consultant for Berkeley Research Group.

"It helps the patient and helps the hospital in the long run. If patients get an unexpected bill, it could affect their responses on patient satisfaction surveys. The Centers for Medicare & Medicaid Services includes patient satisfaction scores in its pay-for-performance measures. Not keeping patients informed about their status and their financial responsibilities could have an effect on hospital reimbursements," Maslan says.

It is particularly important to educate patients on their potential financial obligations if they are not enrolled in a managed care plan, have

only Medicare Part A coverage, or have Medicare Part B but do not have supplemental insurance to cover their copay, Rossi says.

Maslan suggests creating a short letter explaining observation and having patients sign the letter. "When patients are in the hospital, they don't comprehend everything people tell them. Medicare beneficiaries often are on fixed incomes and it's a big surprise when the bill comes," she says. *(For more on how one hospital notifies patients when they are receiving observation services, see related article below.)*

Another option is to use the CMS letter: "Are You an Inpatient or an Outpatient? If You have Medicare — Ask!," Rossi suggests.

"Whatever method hospitals use, it's critical for them to inform patients of their status and what their financial responsibilities will be, especially if patients will have a large copay. This eliminates surprises when the bill arrives," Rossi says. ■

Hospital revamped admission process to comply with two-midnight rule

CMs screen patients on arrival, EMR contains tips on determining status

When the Centers for Medicare & Medicaid Services (CMS) issued the two-midnight rule in 2013, the case management department at Northwestern Lake Forest (IL) Hospital began an initiative to change the admission process to comply with the new regulations, says **Jennifer Prescia**, MSN, RN, ACM, CCDS, director of case management.

"Instead of basing patient status on medical necessity criteria, we had to base it on a definition from CMS and the expected length of stay. Clearly, we had to step back and look at whether what we were doing was correct and educate ourselves on the new rule," Prescia says.

A multidisciplinary team began meeting to review the new CMS regulations and develop strategies for compliance. The team reviewed the hospital's Recovery Auditor experiences and identified diagnoses that were frequently denied and not overturned on appeal and drilled down to find the reason. They met with representatives from the vendor for the hospital's medical necessity criteria decision support software to learn about their upgraded admissions criteria guidelines.

The team collaborated with the hospital's utilization review committee on ways to help the case management staff understand the new rules and regulations on observation versus inpatient status and to determine the best way to help them explain the new requirements to physicians and Medicare beneficiaries, Prescia says.

"We identified that our physicians had a big educational deficit about what should be documented in the medical records and the level of detail the documentation must include. We did a lot of physician education, mostly one on one," Prescia says.

The team developed a minimum definition of what patient status should be based on expected length of stay, severity of illness, intensity of expected services, and risks for the patient. The definition was integrated into the electronic medical records as a reminder for physicians when they write an admission order, Prescia says.

Now when patients come into the hospital, emergency department case managers use revised inpatient criteria to screen them for medical necessity before the patient is registered. The case managers apply inpatient criteria to every patient at the time of registration, eliminating the need to

EXECUTIVE SUMMARY

A multidisciplinary team at Northwestern Lake Forest (IL) Hospital developed a way to change the admissions process to comply with the Centers for Medicare & Medicaid Services' (CMS') two-midnight rule.

- The team specified that patient status should be based on expected length of stay, severity of illness, intensity of expected services, and risks for the patient and had the information integrated into the medical record as a reminder for physicians.
- Case managers screen all patients for medical necessity before registration and recommend that patients who do not meet inpatient criteria receive observation services.
- The case management department gives patients receiving observation services a letter explaining their status, potential copays, and out-of-pocket expenses.

change patient status in the future. They recommend that those who do not meet inpatient medical necessity requirements receive observation services, Prescia says.

"This approach does work. It helps us avoid just automatically putting patients into observation and it takes the onus off the case managers to have to screen patients for inpatient and then make sure they meet requirements for observation. By attempting to make everyone meet inpatient criteria, we are giving all beneficiaries a fair chance at being admitted as inpatients," Prescia says.

The team created a form in the electronic medical record with a place for the case manager to write the recommended level of care. "The physicians have been educated that for every new admission, they have to write the level of care order stating their expectation that the patient will need inpatient services for two midnights or longer and to include the medical reasons for the admission, the services the patient is expected to receive, and the discharge planning expectations," she says.

When patients meet medical necessity criteria but stay over only one midnight, the case managers make sure that the physician documents the intensity of services the patient needs and the reasons they did not stay the expected two overnights, Prescia says.

For instance, patients with diabetic ketoacidosis require insulin drips, IV fluids, laboratory work every hour, and consume thousands of dollars of services, Prescia says. "They get better and go home the next day, but it still costs the hospital far more than reimbursement for observation services. We fight denials on these cases. It comes down to making sure the documentation reflects the intensity of services that indicate an inpatient stay," she says.

When the Medicare Administrative Contractor (MAC) conducted its initial Probe and Educate audits of the hospital's records, it denied about half of the audited cases. "We started digging deeper and found it was a billing error and the third audit came back with no problems," Prescia says.

The team continues to refine the process and analyze patient records to make sure they meet the CMS requirements.

"We do a lot of audits to make sure we are being fair to the beneficiaries and to make sure that patients who are admitted meet inpatient guidelines," Prescia says. ■

Letter explains observation services, financial obligations

Patients are notified that they may have copays

Several years ago, faced with increased complaints about out-of-pocket expenses from patients who received observation services rather than being admitted, the case management department at Northwestern Lake Forest Hospital began giving patients in observation a letter explaining the difference in inpatient and observation status.

"We felt like we were not serving our Medicare beneficiaries fairly by not notifying them of their status and the potential they would have out-of-pocket expenses," says **Jennifer Prescia**, MSN, RN, ACM, CCDS, director of case management at the Lake Forest, IL, hospital.

Observation letter

When the hospital's observation rate doubled after CMS issued the two-midnight rule, the hospital revised the letter and the way case managers explain observation services as part of an initiative to change the admissions process to comply with the new regulations.

"Patients are at their most vulnerable when they are in the hospital and they don't remember everything. We are not required by Medicare to give them a letter notifying them they are receiving observation services, but we do it as a service to them," Prescia says.

Since the hospital started giving patients letters telling them they are receiving observation services, patient complaints have decreased and patient satisfaction with the discharge process has improved each year, Prescia says. "But it's hard to tell if it's because of the observation letter or a variety of factors," she adds.

The observation letter explains the difference between inpatient and observation services and what observation means financially for patients. It does not include

specific out-of-pocket costs the patient may be responsible for because observation services are billed individually and the total cost isn't available until discharge, Prescia says.

"Many people seem to think that Medicare will pay for everything. The letter explains that patients may have a copay, that observation services do not count toward the three-day stay required for Medicare to cover a nursing home stay, and that Medicare won't pay for certain outpatient services, such as mammograms, when patients are in the hospital," she says.

Not only do the case mangers give patients the letter, they get them to sign it. "When patients get a bill for their share of observation services, they often call me saying they didn't know they were observation patients; I pull up the letter and mail them a copy and they always call me back and say 'yes, that is my signature,'" Prescia says.

When patients are receiving observation services the case manager explains it to them, then explains it again to their children, their spouse, sometimes their pastor or their neighbor, says **Karen Lutz**, RN, BSN, ACM, manager of case management. "The family and other caregivers want the patient to have a three-night qualifying stay for a skilled nursing admission. Often the patient is ready to go home, but their family isn't ready," she adds.

The case management team has created a patient pamphlet that explains observation vs. inpatient in more details. When patients ask questions about why they are receiving observation services instead of being an inpatient, the case managers use the pamphlet to help answer the questions.

"We also changed the way we talk to patients when Medicare doesn't cover something. Instead of saying that Medicare won't cover it, we say that their insurance doesn't cover it. It helps people realize that Medicare is insurance. It's a minor change but it's effective in helping people understand," Prescia says.

To educate people in the community who are Medicare beneficiaries on the difference in inpatient and observation and what it means to them, Prescia spoke at local senior centers, assisted living centers, and other community organizations to explain observation services, what it means to patients, and what rights they have.

> "WE FELT LIKE WE WERE NOT SERVING OUR MEDICARE BENEFICIARIES FAIRLY BY NOT NOTIFYING THEM OF THEIR STATUS AND THE POTENTIAL THEY WOULD HAVE OUT-OF-POCKET EXPENSES."

"I talked about the fact that Medicare has no appeals process for observation, that their out-of-pocket costs are likely to be greater than if they are inpatients, and why hospitals provide observation services instead of admitting people as inpatients," she says.

The input from these meetings was used to make the observation letter more detailed, Prescia says.

Issue an ABN

The hospital also gives observation patients an Advance Beneficiary Notice of Non-Coverage (ABN) when the patient will be financially liable for services or a stay that is not covered, Lutz says. For instance, a physician may order a mammogram or another test or procedure that isn't related to the hospital visit for an elderly patient who is receiving observation services after a fall.

In other instances, the staff and attending physician may feel a patient is ready for discharge, but the patient isn't ready to leave. "They don't want their husband to have to drive after dark or their daughter can't get off work to drive them home, and they want to stay overnight," Lutz says. In those cases, the hospital staff arranges for a second physician to review the medical record and issue the ABN.

"Since observation patients do not have appeal rights, we think it's fair to inform them of their financial risk if they choose to have the service or choose to stay," she says.

When patients find out that their cost for an additional overnight stay is around $1,800 they opt to go home, Prescia says.

The hospital can never bill a patient for a Medicare service unless patients receive an ABN, Prescia points out. "If we feel it's an avoidable delay and the patient had to stay overnight because of a problem on our end, we don't issue the ABN and we carve out those extra hours on the bill," Prescia says. ■

California staffing law reduces occ injuries; nurses in other states fighting for similar laws

NY nurses hit the streets demanding lower nurse-patient ratios

A 2004 California law mandating specific nurse-to-patient staffing standards in acute care hospitals has significantly lowered job-related injuries and illnesses for both registered nurses and licensed practical nurses, researchers report.

The need for higher nurse-to-patient ratios is typically invoked as a patient safety issue, and research supports that claim. Studies have found an increased risk of patient infections, mortality, and worker burnout as the number of patients assigned a given nurse increases. For example, a study that analyzed survey data from more than 7,000 registered nurses from 161 hospitals in Pennsylvania linked nurse understaffing to burnout and increased rates of catheter-associated urinary tract infections and surgical site infections.[1] Another study found that every additional patient assigned to a nurse over four resulted in a 7% increase in mortality for all patients under that nurse's care.[2]

That said, there is not a clear consensus that the California law has improved patient outcomes, which was its primary intent. However, the recently published study is believed to be the first to evaluate the effect of the California staffing law on healthcare workers.[3]

The researchers estimated that the California law has resulted in an average annual reduction from 176 injuries and illnesses per 10,000 registered nurses to 120 per 10,000 — a 32% cut. For licensed practical nurses, the average yearly change went from 244 injuries per 10,000 to 161 per 10,000 — a 34% reduction.

"We were surprised to discover such a large reduction in injuries — these findings should contribute to the national debate about enacting similar laws in other states," says lead author **J. Paul Leigh**, PhD, a professor of public health sciences at the Center for Healthcare Policy and Research at UC Davis in Sacramento.

California is the only state in the country with mandated minimum nurse-to-patient ratios, though other states have enacted requirements for staffing committees or public disclosure of staffing levels. California's mandated nurse-to-patient ratios include:

- intensive care units 1:2
- labor/delivery 1:3
- pediatrics 1:4
- medical–surgical 1:5
- psychiatric 1:6

According to Leigh, some hospitals have argued against extending the law to other states because of the increased costs of additional nursing staff.

"Our study links the ratios to something just as important — the lower workers' compensation costs, improved job satisfaction, and increased safety," he says.

Using data from the U.S. Bureau of Labor Statistics, Leigh and colleagues compared occupational illness and injury rates for nurses during several years before and after implementation of the new law. The change in injury rates among hospital nurses after implementation of the law in California was compared to the change in 49 other states and Washington, DC combined. This "difference-in-differences" methods separated the effects of California's staffing mandates, though only for a few years after it was enacted.

Leigh speculated that the lower rates of injuries and illnesses to nurses could come about in a number of ways as a result of improved staffing ratios. Back and shoulder injuries could be prevented, for instance, if more nurses are available to help with repositioning patients in bed. Likewise, fewer needlestick injuries may occur if nurses conduct blood draws and other procedures in a less time-pressured manner. The investigators recommended additional research using more recent data to see if the reductions in injury and illness rates held up over time.

"Even if the improvement was a temporary or 'halo' effect of the new law, it is important to consider our results in debates about enacting similar laws in other states," he says. "Nurses are the most recognizable faces of healthcare. Making their jobs safer should be a priority."

The research findings should embolden ongoing efforts to enact "safer" nurse-patient ratio laws in other states.

"The staffing problem in our hospitals has gotten worse lately," says **Kathy Santoiemma**, RN, a nurse at Montefiore Medical Center's New Rochelle (NY) Hospital. "The hospital practice of understaffing is almost a daily problem for us and it

must be addressed."

Santoiemma was one of some 1,000 members of the New York State Nurses Association (NYSNA), who recently rallied at the state capitol in Albany to support a proposed state law that would mandate "safe" nurse-patient ratios to protect patients from falls, healthcare-associated infections (HAIs) and other adverse events. Of course, protecting nurses is part of the equation, but the NYSNA has primarily seized on the political clout of patient safety in lobbying for the law.

"Staffing is an issue across the board, not just for our nurses but for our patients," says **Tara Martin**, senior communications manager for the NYSNA. "The primary function of a nurse is to be an advocate for the patients. When you're understaffed, you have a problem because you are not giving your full attention to every patient that needs it. So it creates an unsafe work environment for the nurses and also [endangers] patients. Our primary focus has always been to make sure our patients are safe. With the current staffing levels that are happening across the state, patients are definitely at risk."

The Safe Staffing for Quality Care Act would set enforceable nurse-to-patient ratios in New York health care facilities. The law would require minimum staffing levels ranging from one nurse per patient in trauma emergency, per two patients in ICUs, per three patients in the emergency department, per four patients on medical\surgical wards and per five patients in rehab\subacute. The bill has passed one committee, but must go through another committee to reach the floor for a full vote. "We actually have momentum on this bill and we hope to have a vote by the end of the session, which is in June," Martin says.

The nurses cite clinical studies that have consistently shown that safe staffing improves patient outcomes and even saves money.

"In study after study, unsafe staffing levels lead to worse health outcomes, including shock, cardiac arrest, and hospital-acquired pneumonia," says **Martha Wilcox**, an RN at Sullivan County (NY) Public Health. "We know that a safe and reliable healthcare system of the future cannot be created unless we empower our frontline providers of care, and give them what they need to get the job done. We need hospital management to take safe staffing seriously."

However, hospital associations and other groups are arguing against such laws, saying they need staffing flexibility and mandated nursing levels could undermine their economic stability and cause cuts in other areas. The Greater New York Hospital Association (GNYHA) warned that staffing mandates will force hospitals to lay off other members of the care team and close nursing units because of a shortage of appropriately trained nursing staff. The nurses risk making their situation worse by "draining the resources necessary to provide support staff, licensed practical nurses, nurse assistants, and other types of professional staff, including physical therapists, clinical pharmacists, and phlebotomists," the GNYHA said, adding that the extra work would then fall to nurses.

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2. Aiken, LH, Clark SP, Sloane DM, et al. Hospital Staffing and patient mortality, nurse burnout and job dissatisfaction. *JAMA* 2002; 288:16:1987-1993.
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CNE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- The lowdown on Bundled Payments
- Tips for transitioning patients safely
- How to use your PEPPER report
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HOSPITAL
CASE MANAGEMENT

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CNE QUESTIONS

1. In the Inpatient Prospective Payment System (IPPS) proposed rule for 2016, the Centers for Medicare & Medicaid Services (CMS) delayed post-payment audits of the two-midnight rule for the third time until what date?

A. Sept. 30, 2015
B. Oct. 30, 2015
C. Jan. 1, 2016
D. April 1, 2016

2. According to Ann M. Sheehy, MD, MS, under the two-midnight rule, patients in the intensive care unit can be classified as outpatients if their stay is less than two midnights.

A. True
B. False

3. Jean Maslan, BSN, MHA, CCM, ACM, recommends reviewing observation cases frequently to make sure the hospital isn't losing any opportunity to convert the patient to inpatient status or to discharge the patient. At what intervals does she recommend conducting the reviews?

A. Every four hours
B. Every six hours
C. Every eight hours
D. At the end of each shift

4. Emergency department case managers at Northwestern Lake Forest Hospital in Lake Forest, IL, apply inpatient criteria at the time of registration and recommend that patients who do not meet the criteria receive observation services.

A. True
B. False