HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Inpatient or observation: Will the difference ever be clear?

Clarifications by CMS just created more confusion

The Centers for Medicare & Medicaid Services (CMS) has been trying for several years to clear up the confusion about which patients should be admitted as inpatients and which should receive observation services as outpatients, but the new rules seem to make it more difficult to understand.

Hospitals have long struggled with patient status, and CMS tried to make it easier by issuing the Two-Midnight rule, which states that stays spanning two midnights or longer are presumed to be inpatient stays. Then the agency modified the rule in the Outpatient Prospective Payment System (OPPS) final rule for 2016, which went into effect Jan. 1 and said that shorter stays could qualify for inpatient reimbursement based on physician judgment.

EXECUTIVE SUMMARY

It's been more than two years since the Two-Midnight rule went into effect, but the Centers for Medicare & Medicaid Services' attempt to clear up confusion about patient status just has people more uncertain.

- Case managers should monitor patients at every access point in the hospital and work with the admitting physicians to ensure that patients are in the proper status.
- Observation patients should be easily identified, preferably in a dedicated observation unit, so clinicians know to give them priority and either admit or discharge them.
- Now that CMS has agreed that some short stays may qualify as inpatient admissions based on physician judgment, case managers should make sure the documentation supports the admission.

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"There has been a lot of discussion and a lot of written material about inpatient versus observation since the Two-Midnight rule went into effect on Oct. 1, 2013. But there is still a lot of confusion and misunderstanding about what constitutes an inpatient admission," says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

"In the OPPS final rule, CMS gave a nod to physicians and said that they will consider physician judgment in addition to their previous directions on how to determine inpatient status. This doesn't mean much because they did not give any examples of how it would work," Hale says. *(For information on the need for good documentation, see story on page 50.)*

When CMS "clarified" the Two-Midnight rule, it made choosing between inpatient and observation more complicated, says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, headquartered in Chicago. "CMS said that hospitals could bill some one-night stays as inpatient stays based on physician judgment, but gave absolutely no guidance and no examples of what kind of stays would qualify," she says.

But CMS has made one thing abundantly clear, says **Beverly Cunningham**, RN, MS, consultant and partner at Oklahoma-based Case Management Concepts.

"CMS has said over and over that it is not their intent for hospitals to put everyone in observation," Cunningham says.

As she consults with organizations around the country, Cunningham finds that hospital clinicians still aren't clear about when to admit some patients or when to provide observation services.

The problem often is compounded by inadequate staffing in the case management department, she adds.

"Staffing is a challenge in many case management departments. We see people staying in observation for extended periods because the case managers don't have time to focus on patient status and the Two-Midnight rule. Many times, the case managers know what they are supposed to do, but at some hospitals they cannot get it done because of staffing levels," Cunningham says.

More and more healthcare professionals are realizing how important the role of case managers are in helping hospitals stay compliant and solvent, but they often overload case managers with tasks "because they're already in the chart," Sallee says.

"This puts a lot of pressure on case managers and dilutes the focus on the primary responsibilities. When you have a lot of responsibilities, it's hard to do all of them well. It's very important for case management directors to protect the ability for case managers to do the work they do and not to give them other tasks that bog them down. This requires the director to be able to present a return on investment report to ensure that there is sufficient staff to do the tasks required," Sallee says.

The bottom line is that case managers need to monitor patients to ensure that they are discharged or admitted as an inpatient in a timely manner, she adds. *(For information on identifying and monitoring observation patients, see story on page 49.)*

When patients receive observation services, there are financial and other consequences for patients as well as for the hospital, Cunningham points out.

On the hospital side, CMS made a significant change in hospital reimbursement for observation services in the OPPS final rule, shifting reimbursement to a single, comprehensive payment that covers the emergency department visit, the observation hours, and most billable services provided during observation, Hale reports. CMS raised reimbursement for hospital-based observation services by almost $1,000 but stated that the additional reimbursement will cover all tests and procedures, which in the past have been paid separately. *(For details on the changes, see story on page 55.)*

"The issue of the financial implications of physician decisions is going to be extremely important. The need for case managers to closely monitor observation patients and the services they receive is much stronger than it's been in the past," she says.

Patients receiving observation services are outpatients and if they are covered by Medicare Part B, they are responsible for up to 20% of the bill if they don't have secondary insurance. In addition, the time that patients are in observation does not count toward the minimum three-day inpatient stay CMS requires in order to cover the cost of a skilled nursing facility.

Case managers should make sure that physicians understand the financial effect a stay in observation can have on patients, Cunningham says.

If patients are admitted to the hospital when they don't meet the requirements for an inpatient stay, the level of care can be changed using Condition Code 44 as long as the conversion is made before the patient is discharged and the additional requirements are met, Sallee points out.

When case managers believe an admitted patient may not meet inpatient criteria, they should refer the case to a utilization management committee physician member, or the physician advisor for case management.

"The physician advisor has to agree with the case manager that the patient doesn't require an inpatient admission. Then the physician advisor should discuss with the admitting physician who has to write an order for the conversion," Sallee says.

When patients are placed in observation status after being admitted as inpatients, the hospital must give them a written notice of their change in status and alert them that they may be responsible for their Medicare Part B deductible and copay for outpatient services. If patients insist on continuing as an inpatient, the hospital must give them a Hospital-Issued Notice of Noncoverage (HINN) notifying them that Medicare does not cover their care, Sallee says.

"It's better to get it right in the beginning and let the patients know up front about their financial responsibilities. If patients who don't meet criteria are admitted and their status is changed to observation, they are going to be highly dissatisfied when they learn what they will have to pay," Cunningham says. *(For information on the importance of reviewing cases for status up front, see story on page 48.)*

Patients who spent the night in the hospital are not likely to be happy if they find out that being in observation means being an outpatient, Sallee adds.

"I've had a number of patients tell me that if they had known they were outpatients, they would have chosen to go home," Sallee says.

To educate your patients on their status, Sallee recommends the booklet, "Am I an Inpatient or an Outpatient?," published by Medicare. The booklet explains the difference in observation and admissions in easy-to-understand language, Sallee says.

Beginning August 1 under a law passed by Congress, hospitals will be required to give patients receiving observation services a written notice of their financial responsibility. Some states already require notification of observation services, but CMS is requiring it nationwide, Cunningham says.

The new law requires hospitals to give them oral notice of observation status within 24 hours and written notice within 36 hours.

The notice must include the reason the patient is an outpatient and not an inpatient, the cost-sharing requirements, and the effect on eligibility on a skilled nursing stay. The law requires the document be written in plain language that is understood by the recipient and that it be signed by the patient or his or her representative.

To be effective in today's healthcare environment, case managers need to be well-versed and up to date on rules and regulations issued by CMS and other payers, as well as have the clinical knowledge that allows them to ask questions of physicians, Sallee says.

"Physicians are not likely to learn all the rules because they need to spend so much time keeping up with the clinical side. As case managers talk with the physicians, they should let them know what the rules are," Sallee says.

Case management directors should educate the case managers and the emergency department physicians and hospitalists on the Two-Midnight rule and whatever criteria set the hospital uses to establish

medical necessity, she says.

Cunningham suggests that case management directors make sure their staff receives education about the rules and regulations they should follow at least once a year. "Education should include the CMS requirements, but also cover the hospital's contracts with other payers. Commercial payers and state Medicaid organizations also have rules governing observation, and the case management staff needs to understand their requirements as well," she says.

While it is good for case managers to educate physicians one on one as they review cases, Cunningham also recommends that case management directors or the case management educator provide education to as many physicians as possible at one time. "This helps provide consistent education. If a case manager is interpreting the rules the wrong way, they'll pass it on to the physician. This way, everybody gets the same message," she says.

Emergency department physicians and hospitalists should be top priority for education, and surgeons and other high volume hospital admitters should be included in the education as well, she adds.

The CMS requirement that hospitals perform self-audits on the Two-Midnight rule falls through the cracks at some hospitals, Cunningham says. She urges case management directors to comply with this requirement.

"It is important for case management directors to review what the staff is doing right and what they are doing wrong. Then they need to educate the case management staff and the physicians about what needs to be changed to be in compliance," she says.

The self-audits provide a good opportunity to zero in on common mistakes, Cunningham says.

She suggests going over some of the hospital's self-denials as examples during education for both the case management department staff and physicians. "When you can go back and use the same verbiage that was in the chart, it's really helpful," she says. ■

Review patients at every entry point to ensure patient status

Get it right up front to avoid problems later on

The solution to getting patient status right is to have case managers in the right places to review the cases of patients who are coming into the hospital, says **Beverly Cunningham**, RN, MS, consultant and partner at Oklahoma-based Case Management Concepts.

She recommends that hospitals place case managers in the emergency department seven days a week, at times when the volume is high. There also should be a case manager reviewing the cases of patients who come through other points of entry — patients who have had surgery and those who are admitted directly from a physician office or who are transferred from other hospitals.

Establishing the position of perioperative case manager to review surgical orders ahead of time and work with the physicians to get the patients' status and orders right is one solution to ensuring that surgical patients who are admitted meet inpatient criteria, Cunningham says.

In smaller hospitals, the emergency department case manager could also review patients who are being directly admitted, she says. In a few large hospital systems, case managers work in the transfer center, she says.

When CMS issued the Two-Midnight rule, some people interpreted it to mean that medical necessity reviews no longer were needed and some hospitals eliminated the position of emergency department case manager or had them focus on discharge planning, says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, with headquarters in Chicago.

That was a big mistake, she adds.

"Hospitals have to have a case manager in the emergency department working with physicians to get patient status right on the front end so they don't end up using Condition Code 44 frequently to correct patient status," she says.

Sallee also recommends having case managers in the transfer center and other areas, such as the cardiac catheterization lab. "So many cardiac patients should be receiving observation services rather than being admitted. With cardiac catheterization patients, there is a fine line between when they meet criteria

for an inpatient admission and when they should be receiving observation services," she says.

In some cases, the decision to place patients in observation or to keep them there for an extended period depends on how difficult it is to get services scheduled, **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

For instance, many hospitals don't have the ability to perform cardiac stress tests on weekends and some cardiologists will not send a chest patient home until they have the results of a stress test, so the patient stays until Monday. Others are willing to consider scheduling the test for Monday and sending patients home if they are low risk.

"Stress tests and other services that aren't available on weekends are problematic when it comes to justifying inpatient stays. The real answer is having the services available every day of the week, but that's not practical for some hospitals," Hale says. ■

Who's in observation? The treatment team needs to know instantly

Observation patients should be No. 1 priority for case managers

Patients receiving observation services can fall through the cracks and stay in the hospital longer than necessary if there's not a way for the treatment team to easily distinguish between them and admitted patients.

"Hospitals need to have a good process in place so everyone on the healthcare team knows which patients are receiving observation services so they can ensure that they get the tests and procedures they need done in a timely manner with the physician to decide whether to admit them or discharge them," says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

The best solution is to place observation patients in a dedicated unit, but when that's not possible and observation patients are scattered all over the hospital, Sallee suggests developing some kind of process so the staff can quickly identify them, such as a sticker on the chart, a sticky note or notice in the electronic medical record, or a note on the white board in the patient's room.

Make sure that the case managers understand the difference between observation and an inpatient admission and that they stay on top of it, says **Beverly Cunningham**, RN, MS, consultant and partner at Oklahoma-based Case Management Concepts.

She recommends that case managers make observation patients their top priority every day and collaborate with the admitting physicians to determine if the patient should be admitted or should be discharged as early in the shift as possible.

If your hospital has daily rounds, point out the observation patients, how long they have been in the hospital, and the fact that a decision has to be made to discharge them or admit them as inpatients, she says.

"Case managers need to be focused on observation patients to make sure that decisions are being made so they can move along," she says. Sallee recommends that case managers see observation patients at least twice a day to see if they are progressing and help get them either admitted or discharged.

"If observation patients meet inpatient criteria and their status isn't changed to inpatient in a timely manner, there is the potential for patients not to qualify for the three-day inpatient stay necessary for Medicare to cover a nursing home stay. The three-day period doesn't begin until the inpatient order is written," Sallee says.

The best solution is to have a dedicated observation unit or clinical decision unit and put all observation patients in one place where the staff can focus on them, Cunningham says. "When observation patients are placed on a busy unit, their status sometimes gets overlooked by nurses, doctors, and case managers. When they're all in one place, everyone has the same focus to move them along," Cunningham says.

Sallee recommends that hospitals reserve their observation units strictly for patients receiving observation services. Some hospitals use their observation units for admitted patients when beds on the medical/surgical floors are not available. This defeats the purpose of the observation unit, Sallee points out.

"Observation units are very effective if they are kept as closed units and staffed with nurses who are experienced in monitoring patients and getting them in and out. Case managers and everybody else on the team knows which patients are observation patients and can give them priority," she adds.

In addition to observation units, some hospitals have instituted clinical decision units for patients who are not being actively treated but who need to stay in the hospital until their physician has the information needed to make a decision on discharging or admitting them, Sallee says. For instance, physicians may be waiting for test results or to see if the antibiotic or pain medicine they prescribed for the patient is effective.

"Clinical decision units are particularly useful when the emergency department is busy because they avoid tying up beds with patients who no longer need emergency treatment but who need to stay in the hospital for a short time," she says. In some hospitals, units dedicated to observation patients are also called clinical decision units, she adds. ■

Ensure that patients meet criteria, documentation supports it

Call on your physician advisor when there's a question

If you've got a system for getting patient status right up front and it works, don't change anything but make sure that the documentation is detailed and complete, advises **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

"Hospitals should have solid steps in place to make sure the documentation is comprehensive and supports an inpatient stay. Even if the record includes check boxes for the physicians to certify an admission, comprehensive documentation still needs to be in the medical record and progress notes," Sallee adds.

When CMS changed the Two-Midnight rule to allow physician judgment in determining patient status for short-stay patients, it became more important than ever for the medical record to contain explicit documentation as to why patients need an inpatient stay rather than observation services, adds **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

Hale cautions case managers to be especially vigilant when to admit or not to admit is a borderline call. Make sure that the clinical rationale for admitting a patient is carefully documented in the medical record and that the documentation includes an explanation of the risk of sending the patient home and providing services later in a different setting, she says.

"There may be cases where patients don't stay past the second midnight or there is a weak case for medical necessity to begin with and the patient stays less than two midnights. In these cases, there has to be strong clinical support for an inpatient stay in the medical record or the case is likely to be denied," Hale says.

It's important for case managers to ensure that physicians clearly document what is going on with patients that makes an inpatient admission medically necessary, says **Beverly Cunningham**, RN, MS, consultant and partner at Oklahoma-based Case Management Concepts.

Work with the physicians to determine if patients meet inpatient criteria and call on your physician advisor for assistance if necessary, she adds.

"An effective physician advisor is a critical asset to case management departments when it comes to determining whether patients should be admitted. Case managers can advise the admitting physician, but CMS says that a non-physician should never be the person to make the final determination of whether a patients meets medical necessity criteria. This is where the physician advisor comes into play," she says.

Hospitals need to make sure that everyone on the team works together, rather than operating in silos, Cunningham says. Some hospitals are separating the function of utilization review from the RN case manager role. In that case, it's particularly important for case management and the utilization review staff to work closely together to make sure that patient status is correct, even if they are in different departments, Cunningham says.

Without good communication,

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Case management's role in the new proposed bundled payment program

By Toni Cesta, PhD, RN, FAAN

Introduction

As we have discussed in prior editions of *Case Management Insider*, the 2010 Affordable Care Act (ACA) was a game changer for the healthcare system. The payment reforms it introduced began the process of requiring health systems to communicate across the continuum of care and to reduce and/or eliminate existing silos. This across-the-continuum integration required sharing of accountability for cost and quality of care among providers.

On July 9, 2015, as one of several follow-ups to the ACA, the Centers for Medicare & Medicaid Services (CMS) announced a new program that would mandate a 90-day bundled payment model for patients undergoing lower extremity joint replacement. The program is based on the Comprehensive Care for Joint Replacement (CCJR) initiative that began in 2011 and the Acute Care Episode (ACE) demonstration project that ran from 2008 through 2010. The program's goals are to improve cost efficiencies, patient outcomes, and enhance collaboration among providers for an episode of care. These goals are not foreign to case managers as they have been part of our lexicon for decades. The biggest change in this program is that the bundle will require the entire acute care team to think beyond the walls of the hospital in ways that have been quite limited up until now.

THIS ACROSS-THE-CONTINUUM INTEGRATION REQUIRED SHARING OF ACCOUNTABILITY FOR COST AND QUALITY OF CARE AMONG PROVIDERS.

The BPCI Program

Titled the Bundled Payments for Care Improvement initiative (BPCI), this program introduced four payment models. It was CMS' first attempt at understanding how bundled payments might work and was initiated as a voluntary program. Hospitals volunteering to participate could choose one of four payment models, each with different levels of financial risk. The following are the four payment models:

Model 1: Retrospective Acute Care Hospital Stay Only

- Episode of care defined as acute hospital inpatient.
- Medicare paid hospital a discounted amount based on payment rates established under the Inpatient Prospective Payment System (IPPS) in the original Medicare program.
- Medicare continued to pay physicians separately for services under Medicare Physician Fee Schedule.
- Under certain circumstances, hospitals and physicians were permitted to share gains arising from providers' care redesign efforts.
- Participation extended no later than January 2014 and included most Medicare fee-for-service discharges for the participating hospitals.

Model 2: Retrospective Acute Care Hospital Stay Plus Post-Acute Care

- Episode of care included hospital inpatient stay and all related services during the episode.
- Episode ended 30, 60, or 90 days after hospital discharge.
- Participants selected up to 48 different clinical condition episodes.

Model 3: Retrospective Post-Acute Care Only

- Episode of care was triggered by an acute care hospital stay.
- Began with initiation of post-acute care services with participating skilled nursing facility (SNF), inpatient rehabilitation facility, long-term care hospital or home health agency.
- Post-acute care services included in the episode had to begin within 30 days of discharge from the inpatient stay and

ended with a minimum of 30, 60, or 90 days after initiation of episode.

• Participants could select up to 48 different clinical condition episodes.

Model 4: Acute Care Hospital Stay Only

• Encompassed all services furnished during the inpatient stay by the hospital, physicians, and other practitioners.

• Physicians and other practitioners submit "no-pay" claims to Medicare are paid by the hospital out of bundled payment.

• Related readmissions for 30 days after hospital discharge included in bundled payment amount.

• Participants selected up to 48 different clinical condition episodes.

The Comprehensive Care for Joint Replacement (CCJR) model

Each of the BPCI models was tested in order to determine which might be the better arrangement for providers as well as CMS. However, CMS did not wait until the results were in and released the new rules for the bundled payment program on July 9, 2015. The CCJR was proposed to be mandatory for 75 geographic metropolitan service areas. It included approximately 800 hospitals in the 75 geographic areas with some exclusions, including hospitals with low volume for these procedures. In its final rules, CMS reduced the number of geographic areas to 67, excluding eight areas with low volume. Excluded hospitals include non-IPPS hospitals (critical access and Maryland hospitals), and hospitals actively participating in BPCI. Colorado Springs, Richmond, VA and Las Vegas are also excluded. Those participating in models 1 and 3 went active as of July 1, 2015. Those in models 2 and 4 went into risk-bearing phase as of July 1, 2015.

The Elements of the Mandatory Bundled Payments

The program applies to traditional Medicare patients only. An "episode" begins with admission to the hospital for surgery and ends 90 days later. Patients must be enrolled in Medicare Part A and Part B throughout the duration of the episode and Medicare must be the primary payer.

Certain patients are also excluded from the program. If the patient is on Medicare due to end-stage renal disease (ESRD) or if they are in a Medicare Advantage Plan, they are excluded. Patients are also excluded if they are covered under a United Mine Workers of America health plan.

The payment timeline is as follows:

There is a five-year testing period from January 1, 2016 to December 31, 2021. The only applicable DRGs are 469 and 470. The episode starts with admission to the hospital and ends 90 days after discharge.

Once the episode begins, it continues until the patient no longer meets inclusion criteria, and then it is cancelled. For example, the patient is readmitted to the hospital after a discharge from one of the eligible DRGs, MS-DRG 469 or 470. The readmission cancels the episode and a new one begins.

Another example would be death during the initial hospitalization. The anchoring hospitalization is the one that triggered the procedure. It is also known as the index hospitalization for the readmission program. Charges incurred for up to three days prior to the hospitalization are still included in the DRG charges only for services performed by the hospital or an entity wholly owned and operated by the hospital where the anchoring hospitalization occurred.

Payments are retrospective each year and are based on claims submitted by March 1, following the end of a performance year. Retrospective calculation of the hospital's actual performance compared to the target price results in the raw net payment reconciliation amount (NPRA).The target price is calculated based on three years of historical Medicare payment data grouped into episodes of care. The data are updated every other performance year.

Major joint replacement or reattachment of lower extremity (DRG 470) currently ranks No. 1 in Medicare patient discharges. It replaced health failure and shock several years ago, which ranked No. 1 for at least 20 years. For this DRG, the greatest number of resources is consumed during the hospital portion of the episode. The next greatest amount of resources is consumed during the post-acute period and the least amount applies to the physician and other outpatient services. The procedure is also more clearly and easily defined and is relatively routine and predictable. It typically has a clear beginning, middle, and end point.

Services included in the CCJR bundle include:

• physician,
• outpatient,
• inpatient,
• inpatient rehab,
• home health,
• skilled nursing facility, and
• readmission.

The following are services excluded from the bundle:

• unrelated services,
• unrelated hospital admissions, as identified by MS-DRG,
• unrelated Part B services based on ICD-9-CM/ICD-10-CM code,
• drugs paid outside MS-DRG (such as hemophilia clotting factors), and
• IPPS new technology payments.

Medicare is projecting the following results for the CCJR program:

• Decreased used of inpatient rehab and SNFs.

• Increased use of low-cost options, such as home care.

• Reduction in referrals to one-star and two-star SNFs.

• Closure of 25% of SNFs.

• One- and two-star facilities.

• No IT integration with hospitals.

• Suboptimal physical therapy programs.

• No clinical protocols.

• Poor physician collaboration and alignment.

• No effective medical director (rounding on patients daily).

• SNFs with strong medical direction and processes will flourish.

• Hospitals will de-emphasize the poorly performing SNFs when choice is provided.

The Five-Star Nursing Facility Rating System

As discharge planners, case managers are required to give our patients a "choice list" of facilities that meet their clinical needs, are within their geographically desired area, and are covered by their insurance. The notion of including quality or rating information was not part of this process. With this new approach, the skilled nursing facility's star rating becomes part of the equation. Patients are informed of the star rating of the facilities they are choosing from, and while in the CCJR program they must pick a facility with a three- or four-star rating. The ratings are based on the following factors:

• **Health inspections:** Three most recent comprehensive annual inspections, and inspections due to complaints in the last three years.

• **Staffing:** Registered nurse (RN) hours per resident per day; and total staffing hours per resident per day.

• **Quality measures:** Values on 11 quality measures (QMs — a subset of the 18 QMs listed on Nursing Home Compare) to create the QM rating.

All skilled nursing facility ratings can be found at: https://www.medicare.gov/nursinghomecompare/search.html.

Be sure to include this information on your hospital's choice lists.

The post-acute providers must comply with the following requirements:

• achieve quality and efficiency improvements,

• furnish services in the CCJR beneficiary episodes,

• payment must be proportionally related to CCJR beneficiary care,

• follow BPCI Model 2,

• audit,

• document retention requirement, and

• maintain all books and records for 10 years.

There are a number of risks associated with the bundled payment models that, if not well managed, can have a negative financial effect on your hospital. These include the following:

• excess cost for poor management of episodes,

• hospital-acquired infections,

• readmissions,

• paying others out of the bundle, as many billing systems are not set up to administer bundled payment contracts,

• physician,

• medical device,

• hospital, and

• quality metrics accompanying payment are not met.

The CCJRs must maintain quality metrics to be eligible for reconciliation payments in the following ways. They must meet or exceed the following payment thresholds for all three measures:

• at or above 30th percentile each year for years 1-3, and

• at or above 40th percentile each year for years 4-5.

The three quality metrics are:

1. Thirty-day readmission rate.

2. Complications: infections and PE within 90 days of hospitalization.

a. Already decrease in complications from 3.4% to 3.1% in two years.

3. HCAHPS survey: Sampling of all patients; already a decrease in readmission from 5.4% to 4.8% in two years.

The Role of Case Management

The first step in managing the CCJR program is for your hospital to develop a steering or oversight committee. Many hospitals have already done this. Ensure that the appropriate key stakeholders are present, committed, and engaged in the process. Collect data and identify savings opportunities. Based on these identified opportunities, plan to make improvements in those that will provide the largest return on investment. Develop a dashboard or report card so that you can track and trend the data. Review the results monthly and modify your plan accordingly. It is critical that you implement your strategies quickly as the clock has already started ticking.

If you are a case management leader, you must realize that you are now part of the value-revenue cycle. Know whether you are in one of the geographic areas under the program. Take the time to evaluate your case management model, your staff's roles, and their functions. In addition, you need to know and understand your cost-per-case for the DRGs that are included in the CCJR program. Determine your case management opportunities for cost per case, LOS, resource management (things ordered that have nothing to do with the procedure), and physician effect regarding practice patterns and resource utilization.

The effective and responsive case management department needs to

ensure that they are performing the functions listed below. If not, incorporate these things as soon as possible:

Provide optimal care coordination, including the following:

• know the star ratings of all SNFs in your service area,

• know outcomes of SNFs, including readmissions and reasons for readmissions,

• plan for a barrage of home health agencies wanting to partner,

• know the outcomes of home health agencies, including readmissions and reasons for readmissions, and

• be prepared for next level of care providers to be confused about this initiative.

Manage your patient choice lists:

• ensure choice for SNF is a part of the discharge planning process,

• evaluate choice list to determine how to highlight SNFs based on star rating,

• consider limiting your choice list, and

• develop scripting for discharge discussions with patients.

Discharge planning requirements include the following:

• Provide beneficiary with complete list of available post-acute care options in service area consistent with need.

• The list should include beneficiary cost sharing and quality information where available and applicable.

• These requirements supplement discharge planning requirements under Conditions of Participation.

Other factors to consider include:

• Understand total joint certification by accrediting bodies.

• Partner with the person responsible for total joint accreditation in your hospital.

• Understand the total joint dashboard.

• Educate your staff.

• Review the "back to the basics" case management processes.

• Learn the bundled payment process.

• Plan to mentor your novice case management staff.

• Be aware that staff who work in other hospitals who may not be under this rule will need more focused oversight.

• Ensure adequate staffing to respond to this change.

• Review your readmissions for these DRGs and the source of the readmission.

• Understand root causes of previous readmissions.

• Collaborate with a hospitalwide plan to address LEJR readmissions.

• Look for patterns and trends associated with physicians and post-acute providers.

The depth of the changes you may have to make will depend on the volume of cases you discharge with the two DRGs included. If your hospital is a small player, you may not need to consider huge changes to staffing or processes. However, if your hospital is a larger player concerning joint replacements, it is prudent to enact as many corrective actions as are necessary.

Case Management Team Leads for CCJR Episodes

As your patients transition to other levels of care, it is important to be sure the team transitions as well. Each level of care should identify the lead team member who will ensure that cost and quality indicators are being met for these patients. Below are suggested team leads for each level of care listed:

• **Inpatient hospital:** RN case manager supported by social worker.

• **Outpatient:** RN case manager or physical therapist.

• **Physician office:** RN case manager, physician assistant or nurse practitioner.

• **Inpatient Rehab:** Physical therapist supported by social worker or RN case manager.

• **Skilled nursing facility:** Physical therapist supported by social worker.

• **Home health:** Physical therapist supported by RN case manager.

As a case manager caring for patients in the CCJR program, there are many things you can do to assist the patient and the hospital in performing well under this program. Optimize your role in the categories listed here:

• **Utilization management:** You are now your own UM case manager.

• **Discharge planning:** Involve the social worker early, if needed; provide preoperative discharge planning; collaborate with perioperative case manager.

• **Care coordination:** Decrease all avoidable/delay days.

• **Resource management:** No procedures/treatments unrelated to reason for admission.

As a social worker in the CCJR program, you can optimize your role in the following ways:

• **Discharge planning:** Timely response to all referrals; timely self-referrals when appropriate; participate in preoperative discharge planning as needed; collaborate with perioperative case manager.

• **Care coordination:** Decrease all avoidable/delay days.

Summary

The CCJR program is a complex one. It is important that case managers, social workers, and case management leaders educate themselves on the program and what they can do to be successful partners in this process. Use total joints as a pilot to prepare for future bundles. They are on the way! ■

this situation is rife for glitches and, ultimately, denials, Cunningham says. For instance, each morning, the utilization review nurses are reviewing what happened overnight while, at the same time, case managers are making rounds with the physicians. "Neither is aware of what the other is doing because it's happening simultaneously. Ensuring the status is correct becomes a real challenge," she says.

"In the situation when utilization management is removed from the case management role, case managers on the unit don't always have the same medical necessity knowledge level that utilization review nurses have. If utilization review is a separate function, case management directors should make sure that there is communication between the utilization review nurse and the case managers on the unit," she says. ■

Ensure that services observation patients receive are necessary and timely

CMS shifts to paying a flat fee for entire observation stay

The move by CMS to change the payment methodology for patients receiving observation services means it's more important than ever for case managers to ensure that patients receive the services they need in a timely manner and that they receive only the care they need while they are in an acute care setting, says **Amy M. Smith**, RN, MSN, CCM, director of case management at Dartmouth-Hitchcock Medical Center, a 421-bed academic medical center in Lebanon, NH.

On Jan. 1, 2016, CMS raised the rate hospitals receive for observation patients from $1,234 to $2,174, but eliminated payment for individual services such as injections, infusions, MRIs, stress tests, and other services. CMS issued the new rule in the Outpatient Prospective Payment System (OPPS) final rule for 2016.

"At first, it looks like CMS is paying more for observation services but in reality, the new payment is like a mini DRG. It is going to incentivize smart hospitals to carefully manage the services they provide to observation patients," says **Deborah K. Hale**, CCS, CCDS, president of Administrative Consultant Services, a Shawnee, OK, healthcare consulting firm.

The $2,174 payment covers the ED visit, the observation hours, and most billable services, Smith adds. "The observation payment is going up, but it most likely won't cover the cost of care. This makes it more important for patients in observation to receive services as efficiently as possible and receive only necessary testing and procedures," Smith says.

Historically, hospitals have been paid a flat rate for observation services and additional payment for each service provided to the patient, Hale points out. "The more you provided, the more you got paid," she adds.

Then in fiscal year 2015, CMS began bundling some observation services. "If a hospital qualified for an observation payment, they still got paid for big-ticket items, but services such as laboratory were bundled into the observation payment," Hale says.

"CMS is slowly transitioning the multiple payment for services in the outpatient setting to a comprehensive payment for certain

EXECUTIVE SUMMARY

CMS changed the payment methodology for observation services to a flat rate that covers most major services patients receive during the observation period.

- Hospitals can no longer bill for individual services such as injections, infusions, MRIs, and other services, but will receive a flat fee for the entire stay, which in some cases may not cover the observation stay.
- Case managers should monitor observation patients closely and ensure that the services they receive are necessary for the physician to make a decision on whether to admit or discharge the patient.
- Collect data on avoidable delays in observation that are due to inappropriate tests and procedures and how the cost of the procedures affect the hospital's bottom line.

major services," she says. Right now, the new rule applies only to patients receiving outpatient services in the acute care hospital, and not patients being treated and released from the ED or treated in outpatient clinics, Hale says.

The new rule may give seasoned case managers a sense of déjà vu, Hale says. "When CMS began the prospective payment system and began paying hospitals a flat fee based on DRGs, the average length of stay was about 10 days. If hospitals wanted to stay afloat, they had to find a way to reduce the length of stay. Now, the average length of stay is about four days," Hale says.

The new rule by CMS puts hospitals in the same position when it comes to outpatient services. "Case managers and utilization reviewers are going to have to help hospitals become efficient in delivery of observation services," Hale says.

Emergency department case managers tend to focus on utilization review and discharge planning rather than care progression, but that's got to change, says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, headquartered in Chicago.

"Case managers need to be asking questions and pushing back when physicians order a lot of services for observation patients. In our litigious society, physicians may order tests and procedures to protect themselves. Case managers should try to distinguish between these and procedures that are necessary," Sallee says.

Case managers need to work with physicians to determine what patients need in the observation setting in order to be discharged in stable condition, Hale adds. "This means no more annual colonoscopies or mammograms while the patients are receiving observation services. Instead, case managers should schedule the patients to receive the tests as outpatient services," Hale suggests. For instance, if patients come in with stomach pain, case managers should work with the physician to decide if they can be scheduled for an endoscopy later, as an outpatient, she adds.

"CASE MANAGERS NEED TO BE ASKING QUESTIONS AND PUSHING BACK WHEN PHYSICIANS ORDER A LOT OF SERVICES FOR OBSERVATION PATIENTS."

When a physician orders tests and procedures that could be performed in an outpatient setting, Sallee suggests asking, "Will the results of this test help you make a decision about what to do with the patient in the hospital?" If the answer is "no," ask if it can't be scheduled at another time, when the patient is not in the hospital.

Under the old system, tests and procedures ordered during the observation period added more money to the hospital's bottom line, Hale says. "The Medicare Administrative Contractors [MACs] have put out local coverage determinations that hospitals wouldn't be paid for a CT scan just for a headache, but CMS hasn't done a lot to limit services. Until now, there haven't been any penalties or incentives to stop hospitals from packing in services to the observation payments," Hale says.

Hale predicts that it will take a while for the reality of the new payment methodology to set in and hospitals may lose money the first year.

Case managers should make everyone in the hospital aware of the changes in observation payment methodology and the financial implications for the hospital, Smith says.

"We are implementing Milliman Care Guidelines and hope that we will able to use them to prevent wasteful and unnecessary testing, particularly with observation patients since we will no longer be reimbursed in the same way for them under the new observation payment structure," Smith says.

Sallee advises case management directors to collect data that can demonstrate efficiency or lack of it when observation services are provided. Look for patterns of avoidable delays for observation patients that are related to inappropriate tests and procedures in the hospital. Collect data on high-cost procedures that are typically performed in an outpatient setting, but that physicians order for observation patients.

Analyze the cases of patients who spend more than 18 to 20 hours in observation to determine the reasons for longer stays, and look for ways to decrease the amount of time patients spend in observation, she says. ■

Hospitals push back against reimbursement cuts due to Two-Midnight rule

Lawsuits challenge CMS claim that admissions will increase

Hospitals across the country have filed lawsuits challenging the decision by CMS to reduce Medicare reimbursement by 0.2% to compensate for the financial effect of the Two-Midnight rule.

CMS claims that under the rule, the number of patients who are admitted as inpatients will increase, resulting in $220 million in additional reimbursement each year. Their calculations are disputed by several studies, including one commissioned by the American Hospital Association (AHA).

A coalition of hospitals and hospital associations led by the AHA filed a lawsuit in April 2014 challenging the 0.2% reduction, and a separate suit challenging the Two-Midnight rule itself. The suit challenging the 0.2% reduction was consolidated with several other similar lawsuits by the federal court.

"The hospitals argued that CMS did not follow proper procedure and did not provide sufficient information about how the analysis was derived. Therefore, the lawsuits say, the 0.2% reduction is arbitrary and capricious," says **Lawrence Hughes**, JD, assistant general counsel for the AHA.

"We are asking CMS to rescind the cut in its entirety, to restore the base rate for Medicare payments to where it was before the cuts, and to pay hospitals back for the reductions they have received since the 0.2% cut when into effect," Hughes adds.

AHA is also challenging the entire Two-Midnight rule, saying that it does not meet the Medicare statute requirements.

After hearing oral arguments, the federal court agreed that CMS had not followed the proper procedures or provided sufficient rationale for the cuts and ordered CMS to provide additional information and offer the healthcare field and the public a chance to comment on the proposal. The comment period ended Feb. 2.

Since then, other hospitals and hospital groups have filed other lawsuits challenging the reduction.

CMS released additional information on how they determined the effect the Two-Midnight rule would have on reimbursement, but the AHA feels the data do not support the 0.2% cuts, Hughes says. In a Feb. 2 letter to Acting CMS Administrator Andrew Slavitt, Thomas P. Nickels, executive vice president of AHA wrote, "Despite offering some additional details, CMS' explanation still fails to establish a rational and lawful basis for the imposition of the 0.2% reduction."

Nickels told CMS that an analysis of actual inpatient claims since the Two-Midnight rule was implemented has not resulted in the increase of inpatient cases. Instead, there has been a net decrease in inpatient stays, he adds.

An analysis by Watson Policy Analysis, commissioned by the AHA, contradicted the CMS assumption that that reimbursement would increase by $220 million a year under the Two-Midnight rule due to more patients being admitted as inpatients. The Watson report pointed out that the CMS actuaries used data that was not available to the public and assumed mistakenly that data from the Medicare Provider and Analysis Review (MedPAR) would yield similar results.

The Watson report's analysis using the MedPAR data concluded that "the CMS published figure of $220 million as the financial impact of the Two-Midnight rule is questionable.

EXECUTIVE SUMMARY

The American Hospital Association (AHA) and other hospitals are suing CMS, challenging the 0.2% cut in Medicare reimbursement that CMS instituted to compensate for the financial effect of the Two-Midnight rule.

- CMS' actuaries reported that inpatient claims are likely to increase under the rule, resulting in $220 million additional reimbursement for hospitals.
- Hospitals disagree and a study commissioned by the AHA concluded that the CMS study was based on data not available to the public and that data from the Medicare Provider and Analysis Review (MedPAR) would lead to a different conclusion.
- The AHA suit asks CMS to rescind the cut, restore the base rate for Medicare payments to its previous level, and reimburse hospitals retroactively for the reductions.

A more likely figure is 0 net change or a change in the other direction, resulting in a positive, rather than a negative, adjustment."

The hospital industry is pleased with the changes to the Two-Midnight rule that CMS announced in the Outpatient Prospective Payment System final rule in October 2015, says **Priya Bathija**, JD, MHSA, senior associate director for policy for the AHA. In the final rule, CMS modified the controversial Two-Midnight rule to allow shorter stays to be billed as inpatient stays based on physician judgment, and shifted enforcement of the rule to two Beneficiary and Family-Centered Care Quality Improvement Organizations (QIOs), Livanta and KEPRO.

"The hospitals feel the changes are a good first step to address a critical problem," Bathija says. "We believe that the decision of whether a patient is an inpatient or an outpatient should be based on the judgment of the physician and the patient's medical condition," she adds.

Hospitals also are pleased that CMS is shifting patient status reviews away from the Recovery Auditors and to the QIOs, Bathija says.

"We think this is a good step toward instituting a thorough review and educational process rather than arbitrary denials. We are cautiously optimistic, but only time will tell if CMS has made the situation better," she says. ■

Utilization review process calls for assessing patients at every point of entry

Team works together to get status right up front

Dartmouth-Hitchcock Medical Center in Lebanon, NH, reviews every patient at every point of access to make sure that they are placed in the correct status.

"Having a strong utilization review process at the portals of entry is key for any organization," says **Amy M. Smith**, RN, MSN, CCM, director of case management at the 421-bed academic medical center and Level I trauma center. The hospital is 92% occupied on average.

"We believe that having the right patient in the right place at the right time, from the front door, decreases work on the back end," Smith adds.

The case management department uses a triad model that includes utilization management nurses, case managers, and social workers. The licensed staff is supported by a resource specialist who manages referrals, sends clinical information to payers, distributed the Important Message from Medicare letters, and performs other clerical tasks.

The department divides the responsibilities to cover all points of entry where patients are admitted by doing the following:

- RN case managers staff the emergency department 12 hours a day, seven days a week, and work with the physicians to identify patients who meet admission criteria or who will require observation services and plan a safe discharge for patients who can be treated and released.
- The hospital's team of eight physician advisors rotate being on call as medical director for the transfer center and assist in determining the status of patients being transferred from other hospitals and direct admissions from physician offices. They cover the transfer center 24 hours a day. "The physician advisors act as a gatekeeper and ensure that the status is correct for incoming patients," Smith says
- The utilization management nurses review the operating room schedule every morning and make

EXECUTIVE SUMMARY

Dartmouth-Hitchcock Medical Center in Lebanon, NH, reviews patients at every point of access to get their status right up front.

- Case managers cover the emergency department, utilization review nurses review surgical patients, and physician advisors are on call to the transfer center.
- Observation patients are placed in a clinical decision unit next to the emergency department; surgical patients who need a longer-than-normal recovery period are monitored in a short-stay unit.
- The electronic medical record allows clinicians to see what the other disciplines are doing in real time.

sure that each patient has an appropriate order. The utilization management nurses also review patient charts after surgery to identify any patients who may meet inpatient criteria.

The hospital has a five-bed clinical decision unit adjacent to the emergency department for patients who are receiving observation services. Among the diagnoses or complaints of patients placed in the clinical decision unit are chest pain, transient ischemic attack, strokes, syncope or near syncope, minor intracranial hemorrhage, asthma, chronic obstructive pulmonary disease, dehydration, cellulitis, and heart failure.

Surgical patients who do not need an inpatient stay but cannot be safely discharged are transferred from the recovery room to the 12-bed short-stay unit when the normal recovery period has passed.

When the hospital's capacity is high and all the beds in the clinical decision unit are filled, the hospital places observation patients on the inpatient units. "This isn't ideal but the utilization review nurses review the charts frequently to ensure that we are actively managing the patients and that they are not staying in observation longer than necessary," Smith says.

The hospital has documentation specialists who review the medical record to ensure that the documentation is detailed and complete and works with the physician advisor to give real-time feedback to the physicians, she says.

At Dartmouth-Hitchcock, the records of Medicare patients are triaged to be reviewed first over those of patients with commercial insurance, Smith says. The utilization management nurses review observation cases daily, starting with the day of admission, and work closely with the RN case managers to make sure that patients are getting the services and tests they need in order for the physician to determine if patients can be converted to inpatient or be discharged to home.

A key to managing observation patients has been an electronic medical record system that allows all members of the treatment team to see what other team members are doing in real time, she says. The hospital added a case management module to the electronic medical record system last fall.

"Before we started using the new case management software, several different systems were being used in the hospital, making communication difficult. Now, the utilization management nurses can easily identify the observation patients when they log into the software system. It helps them set their priorities for the day," Smith says.

Each unit has multidisciplinary rounds each day, during which the team reviews the record of each patient, his or her status, and what needs to happen that day to move the patient toward discharge. In the case of observation patients, the team makes sure that whatever orders are needed for test or procedures are issued in a timely manner. The rounds are attended by the case manager and the charge nurse on the unit, along with a representative from the physician team, usually a resident.

Case managers document on the computer during rounds and during patient encounters. The utilization management nurses document their reviews. "Even though the utilization management team is in the office and the case managers are on the floor, they see the same thing on the screen and each knows what the other is doing in real time," Smith says.

The utilization management nurses give priority to observation in an attempt to catch patients who are being discharged and meet the criteria for Condition Code 44 so their status can be changed while they are still in the hospital.

"We review patients rigorously to determine if we should change the status using Condition Code 44. The utilization management nurses notify the patients during the day. After hours, it's the responsibility of the emergency department case manager. We also conduct self-denial reviews after patients are discharged to make sure we didn't miss anything," she says.

Smith's goal is for members of her staff to become experts on the various rules and regulations that affect the hospital and case management. For instance, she occasionally assigns one case manager to shift his or her workload to another case manager and spend the work day studying new Medicare regulations, then report back to the team.

"Things are changing so fast that it's impossible for everyone to know it all," she says. ■

COMING IN FUTURE MONTHS

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HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. A new law requires hospitals to give patients written notice that they are receiving observation services within what time frame after the services are ordered?

A. 24 hours
B. 36 hours
C. 48 hours
D. Any time before discharge.

2. According to Beverly Cunningham, RN, MS, consultant and partner at Case Management Concepts, where should hospitals have case managers review cases for patient status?

A. The emergency department.
B. The surgical area.
C. The transfer center.
D. All access points where patients enter the hospital.

3. According to Linda Sallee, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare, hospitals should reserve their observation units strictly for patients receiving observation services.

A. True
B. False

4. How many hours a day do case managers at Dartmouth-Hitchcock Medical Center cover the ED?

A. 12 hours a day, seven days a week.
B. 12 hours a day Monday through Friday and 8 hours on weekend days.
C. 24 hours a day, 7 days a week.
D. 9 hours a day.

CE 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.