

Observation Status: A 360° Perspective

By Catherine M. Mullahy, RN, BS, CRRN, CCM

Even before the passage of the Patient Protection and Affordable Care Act (PPACA), a controversy loomed relating to case managers and their role in the area of Observation Status services. Now, with increasing financial pressures on hospitals, there has been an increased in the number of patients being placed under Observation Status rather than admitted as inpatients. Data from the Medicare Payment Advisory Commission (MedPac) indicated that the number of “Observation” services it administered from 2004 to 2011 rose by almost 34%. Centers for Medicare & Medicaid Services’ (CMS) figures revealed that in 2011, there was an increase of 230,000 Observation claims filed. One Albany, New York, hospital, St. Peter’s Hospital, reported that its “Observation” cases had risen from 2,560 in 2009 to 5,000 in 2012; an over 50% increase.

Some within the health care industry believe case managers have a clear and definitive role in determining a patient’s Observation Status. Others hold that their involvement in Observation Status creates an untenable conflict of interest specifically relating to case manager’s primary role as patient advocates. In the interest of full disclosure, I am in the second

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camp. I believe that Observation Status belongs in the area of Utilization Review (UR), not case management. And, while hospital case managers perform UR functions, case management is not UR. Unfortunately, though, the lines between case management and UR have been blurring for some time now. The difference today is that, since health care reform, the financial stakes have become much higher. It is imperative that health care institutions, those supervising case management, and case managers themselves clearly understand the Observation Status dilemma. For case managers, it is particularly important that Observation Status services be considered within the context of the Case Management Standards put forth by the Commission for Case Manager Certification (CCMC, ccmcertification.org, Mt. Laurel, NJ) and the Case Management Society of America (CMSA, www.cmsa.org).

Understanding the Impacts of Observation Status

On the face of it, there would seem to be no negative impact on patient care stemming from Observation Status. Patients placed in the category of “Observation” care are being tested and evaluated within a hospital setting for a 48-hour period. After the first 48 hours, a physician determines whether or not the patient requires an inpatient stay or can be discharged home or to another setting for care, such as a rehabilitation facility. The types of conditions under which a patient is given

Observation Status typically are those that can possibly be treated within the 48-hour window, for example, stomach pain, certain breathing problems, kidney stones, nausea and/or vomiting, or unexplained weakness. The case manager’s role in determining whether the patient should be discharged or admitted is where a conflict arises. Keep in mind the following:

- A physician decides if a patient needs to be admitted as Inpatient or should be placed in “Observation Status” in the hospital. A physician must issue an order to convert a patient from the Observation Status to full Inpatient Status or for discharge to another setting such as home care, a rehab facility, or a nursing home.
- Medicare and Medicaid patients under Observation Status receive coverage up to the 48 hours only. After that, as “outpatients,” their visits aren’t covered under Medicare Part A, which pays for hospital charges above the \$1,184 deductible, and instead are billed under Medicare Part B, requiring patients to assume 20% of their costs with no cap on their total expenses. In addition, these Observation Status patients are responsible to pay for the medication they receive while in the hospital, although those with Part D prescription plans can file a claim for reimbursement, assuming their plan covers the medications they were prescribed while in the hospital and that the hospital is within their network.
- Patients with private insurance ►

typically are covered for only 23 hours while under the 48-hour Observation Status.

- Observation Status patients who are discharged to a rehab or nursing facility can also be denied Medicare coverage and/or be subject to a big bill based on the fact that Medicare pays for up to 20 days of rehabilitation at a skilled nursing facility *only* after a patient has spent 3 consecutive nights with Inpatient Status in a hospital.

As you can see, the effects of having been placed under Observation Status can have significant financial consequences on unsuspecting patients and their families, most of whom have never heard of the term.

There are financial consequences for hospitals as well. They are being scrutinized by CMS to determine whether or not a patient's level of care (ie, outpatient or inpatient) is proper. Under CMS' Recovery Audit Contractor (RAC) program, hospitals' records and related documentation are being audited. If the auditors find improper determinations, documentation, or processes, the hospital is denied payment. Further, the payment a hospital receives for a patient is based on how a patient is admitted (ie, Inpatient or Observation Status). For example, an Observation Status patient with congestive heart failure would provide the hospital with a payment of less than \$1,000 versus more than \$5,500 for an Inpatient congestive heart failure case.

An 18-month study of Observation Status patients conducted by the University of Wisconsin Hospital and published in *JAMA Internal Medicine*, reported that 25% of all adult general medicine stays at the hospital were classified with Observation Status. The study noted that owing to their Observation Status, the hospital received an estimated \$500 less per patient compared with if they had been classified as Inpatients.

If it is not apparent already,

Observation Status is as much about financial impacts as anything else; something that should not sit well with dedicated health care professionals. Given that our health care system is overwhelmingly economically driven, there needs to be some clear-cut controls on the use of Observation Status. This is something our legislators have also been considering.

Pending Legislation to Address Observation Status

To address the rise of Observation Status patients and the negative consequences on patients (ie, failure to qualify for Medicare payment of follow-up care after their 48-hour observation care), three different bills have been presented in Congress and are currently pending Senate vote. They include:

- H.R. 1179 ("Improving Access to Medicare Coverage Act of 2013"), introduced on March 14, 2013, by Representative Joe Courtney (D-CT), which would count all of the time a patient stays in the hospital to meet the 3-day inpatient requirement. (S.569 is the companion Senate bill.)
- H.R. 3144 ("Fairness for Beneficiaries Act"), introduced on September 19, 2013, by Representative Jim McDermott (D-WA), which would eliminate the 3-day inpatient requirement for Medicare coverage of a skilled nursing facility stay.
- H.R. 3534 ("Creating Access to Rehabilitation for Every Senior [CARES] Act of 2013"), introduced on November 19, 2013, by Representative Jim Renacci (R-OH), would eliminate the 3-day inpatient requirement if a patient goes to a skilled nursing facility that has an overall rating of 3 or a rating of 4 stars or higher on either the Quality Measures or Staffing on CMS' Nursing Home Compare website.

Based on feedback from various national organizations, H.R. 1179 is believed to be the best crafted bill,

which has bipartisan support and no opposition. Still, while change in the current Medicare 3-day requirement would be advantageous, it alone is not the solution. Hospital case management must be defined separately and distinctively apart from Utilization Review for a change to occur wherein we prevent the problems associated with Observation Status that go beyond the negative financial impacts and into patient care.

Also bringing attention to the problems associated with "Observation Status" was a lawsuit filed on November 3, 2011. At issue in the case of "Bagnall v. Sebelius" was whether or not the policy of the US Health and Human Services Secretary Kathleen Sebelius allowing hospitalized Medicare beneficiaries to be placed under "Observation Status" as opposed to being admitted with inpatient status is depriving them of the Part A coverage and is therefore in violation of the Medicare statute, the Administrative Procedures Act, the Freedom of Information Act, and the Due Process Clause. The lawsuit sought relief to end and correct the depriving of Part A coverage stemming from the use of "Observation Status" and to provide notice and appeal rights to those patients placed in "Observation Status." Seven Medicare beneficiaries and their estates filed the complaints and a Motion for Certification of a nationwide class. In January 2013, the district judge on the case transferred the case to a new district judge. On May 3, 2013, an oral argument on the government's Motion to Dismiss was heard and on September 23, the Motion was dismissed on jurisdictional grounds, but granted on the basis of failure to state a claim, resulting in the case's dismissal.

Discharging Patients Sicker and Quicker

In 1990, with the passage of the HMO Act, we saw the start of transitions in models of case management used by

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hospitals. One model, the consolidated model, had nurses and social workers serving in separate departments performing their individual roles, but both reporting to one supervisor. In the *integrated model*, one individual—a case manager—had responsibility for both the former separate roles of the nurse and social worker. Typically, it was a nurse performing these duties, which were coming under the new heading of Utilization Review and Discharge Planning. The outcome of this change in how hospital case management is performed has led to a disturbing trend of the so-called, “sicker, quicker” patient discharge and subsequent same-patient readmission. What was and is still happening is a greater focus by hospital case managers on UR and discharge planning than on ensuring that patients are being discharged to the right situation (ie, the right home care equipment and therapy services, as appropriate; the right medical treatment plan and scheduled follow-up appointments; etc.). Case managers, now performing two roles instead of one, were and are often overloaded with cases and therefore unable to devote as much attention as needed to their patients. Further, many were and are more concerned with the financial condition of the hospital that employed them and consciously made patient decisions based on their concern for the hospital finances and/or their concern about keeping their jobs. Observation Status protocols only intensify these problems and interfere with hospital case managers’ ability to fully focus on upholding the standards

of their profession.

Among the “Certification Principles” presented by the CCMC are such tenets as:

- Place the public interest above their own at all times.
- Respect the rights and inherent dignity of all their clients.
- Always maintain objectivity in their relationships with clients.

Help maintain the integrity of the Code of Professional Conduct for Case Managers.

The CMSA, which has organized a petition for Medicare to waive the 3-day hospital stay requirement, includes among its “Guiding Principles” the following:

- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision making, and education.
- Promote optimal client safety.
- Promote the use of evidence-based care, as available.

As you can see, hospital case managers wearing one hat covering UR and discharge planning are too often overwhelmed with these responsibilities, which are in direct conflict with the Standards and Principles of their profession and what should be their primary role—to advocate for their patients, coordinate patient care, increase patient adherence to their treatment plans, and ultimately, improve patient outcomes.

Case Management and Observation Status Patients

So what exactly is and should be the case manager’s role with respect to

“Observation Status?” Currently, the role of the case manager relating to “Observation Status” varies from hospital to hospital. Many hospitals have physician-led teams, which include members of their hospitals’ case management departments and nursing departments. It is the case managers, who are executing hospital protocols for various diagnoses typically falling under observation care, and assisting with the related documentation and delivery of care. Many hospitals will state that it is their case managers who are the real experts in patient status determination based on their ongoing contact with the patients and observation of the nuances in their patients’ condition. I would add that case managers involved in the care of Observation Status patients need to also be patient advocates relating to this designation. They should consider it an obligation to inform their patients and their families what this represents regarding their Medicare coverage if they are discharged to a skilled nursing facility (ie, the financial ramifications).

A point that should be noted is that even if a physician directs that a patient be admitted for inpatient care, the current CMS system authorizes a hospital’s UR committee to change that physician directive from a patient having Inpatient status to having outpatient Observation Status. This is vivid example of how case managers wearing two hats are forced in a most difficult situation. Do they step up and advocate for their patient being admitted per the physician’s order? Or fall in line based on their UR responsibility? ►

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They should not be put in this no-win situation.

I am not alone in this position. Hospital leaders across the country echo this point of view. In the article titled, "Observation Status: How Medicare's Solution Could Make Things Worse," author Bob Wachter, MD, quoted Richard Rohr, a hospitalist leader and consultant as saying:

"The basic problem with observation stays is the disconnect between functional status and medical necessity. Many elderly patients who are not able to care for themselves and need more help than a family can perform come to the hospital because it is the social service agency that is open at night and on weekends and does not turn anyone away. These patients often do not have medical needs as defined [by Medicare]. Having stepped away from clinical hospital medicine to focus on medical necessity work, I talk regularly with hospitalists and other physicians, who struggle with the distinction between functional needs and medical needs in caring for patients."

The conflict between "functional needs and medical needs in caring for patients" is at the core of the problem of Observation Status and the precarious position in which it places case managers performing UR functions.

Closing Remarks

In hospitals across the country, Medicare's aggressive call for more Observation Status is reportedly being credited with a decline in preventable

readmissions. Not everyone is convinced, though, that the correlation is well-founded. American Hospital Association Vice President for Quality and Safety Nancy Foster was quoted as saying, "It would be unfortunate if Medicare readmissions penalties for hospitals were causing some clinicians to use observation status more. And you may be invoking penalties and pressuring hospitals and clinicians to make changes that the science shows are not in the patients' best interest."

What we do know is that Observation Status is creating financial difficulties for many already struggling healthcare institutions; it is causing both financial and emotional stress on patients and their families; and it has placed hospital case managers between the rock and hard place where they clearly should not be. **CE**