HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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Case management's value is finally recognized. What happens now?

Caseload cuts haven't kept pace with added responsibilities

Case managers cheered when the Affordable Care Act and other initiatives by government and commercial insurers mentioned the need for care coordination over and over. But as more and more responsibilities are being heaped on case managers, all that recognition may have been a double-edge sword, experts say.

"We keep saying it is case management's day, and the increasing emphasis on care coordination and managing transitions means it truly is our day. But in many hospitals, the

EXECUTIVE SUMMARY

In recent years, case management has been recognized as a key in improving healthcare quality and reducing costs, but while hospitals are giving case managers more responsibilities, many administrators are not approving an increase in staff to handle the extra work.

- Case managers can help their hospital succeed with the Centers for Medicare & Medicaid Services' Value-based Purchasing program, the readmission reduction program, and bundled payments.
- Case management directors should make sure the hospital's senior leadership understands the roles and responsibilities of case managers and how their interventions can affect outcomes and the bottom line.
- The number of caseloads depends on the case management model, the responsibilities of case managers, and whether they have assistants or case management extenders who can take over some tasks and allow the licensed staff to work at the top of their licenses.
- Don't let technology replace communication and patient-centered interactions.

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EDITOR: Mary Booth Thomas, (marybootht@gmail.com).
MANAGING EDITOR: Jill Drachenberg
EDITORIAL & CONTINUING EDUCATION DIRECTOR: Lee Landenberger

EDITORIAL QUESTIONS
For questions or comments, call Jill Drachenberg at (404) 262-5508.

administration doesn't understand the case management department doesn't have enough staff, or the staff they have aren't doing the right things," says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts.

Hospital administrators have a concept of the value of case management based on the past, but many are not connecting the dots between the new initiatives from the Centers for Medicare & Medicaid Services (CMS) and other payers, what case managers can do to help their hospital comply and succeed, and the need for additional staff to handle the additional responsibilities, Cesta says.

Even with the pressure being put on case management, it's still an exciting time to be a case manager, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America (CMSA).

"As healthcare evolves, case management is playing a definite role. I believe that we will see significant changes in clinical outcomes and the ability to better coordinate care. We're getting there, but we still have a long way to go," Lattimer says.

As CMS and other payers move to new reimbursement models and requirements, hospitals are going to have to change in order to stay in business, and case managers are a key to their success, says **BK Kizziar**, RN-BC, CCM, owner of BK & Associates, a Southlake, TX, case management consulting firm.

CMS is quickly moving toward reimbursing hospitals for quality, not quantity, and testing initiatives that put hospitals at risk for patient outcomes, she adds. The most recent initiative, the Comprehensive Care for Joint Replacement bundled payment pilot project, announced in June, requires hospitals in 75 geographic areas to participate in the five-year project and bear risk for cost of patient care from the time of surgery until 90 days after discharge.

The voluntary Bundled Payment for Care Improvement pilot project has been underway since 2013. In addition, hospital reimbursement is affected by a variety of CMS programs, including the readmission reduction program and Value-Based Purchasing.

"Today's hospital case managers are under stress from increasing payer regulations and requirements, decreases in reimbursement, and the responsibility of ensuring that physicians document fully," says **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management.

Bundled payments are not yet having a big effect on case managers because only a minority of patients are part of a bundled payment initiative, but CMS has announced intentions to continue expanding the program, she adds.

"Healthcare systems and payer requirements are becoming increasingly complex and case managers are required to know more and manage more," says **Charlotte Sortedahl**, DNP, MPH, RN, CCM, assistant professor in the department of nursing, University of Wisconsin Eau Claire, and newly elected secretary of the Commission for Case Management Certification.

All of the changes in healthcare and reimbursement put case managers in an excellent position, she adds. "Case managers are well positioned to help hospitals comply with the new rules and regulations, as well as preventing readmissions and helping their hospitals succeed

under value-based payments and bundled payment arrangements," Sortedahl says.

With all the new initiatives, CMS and other payers are moving toward a goal of improving patient outcomes and patient satisfaction while lowering the cost of care, Lattimer points out.

"Patient models are focused on good outcomes and payers are no longer focused on payment for processes but are emphasizing value, improving outcomes and satisfaction, and lowering costs," she says.

Recently, CMS has accelerated the pace at which it implements new initiatives and requirements, Cesta says. "In the past, they went much more slowly in issuing new models of reimbursement and requirements for hospitals. They used to put out an idea and think about it and collect comments for years before they ever made a change. Now they announce potential changes and institute them quickly," she says.

When CMS required hospitals to track and report Core Measures, hospitals added staff to their quality departments, Cesta says. "The penalties that are instituted now are much bigger than penalties for not complying with the Core Measures requirements, and they're only going to increase," she says.

Case managers are the missing link for hospitals' success in the new world of reimbursement, Cesta says. "No other department focuses on patient transitions, but the resources are not behind it. Case managers don't have the resources to do their job effectively and they are burning out," she adds.

Caseloads have dropped in the last five years, but the powers that be in the hospital still don't understand how time consuming it is to do the job effectively, Cesta says.

"Discharge planning doesn't sound very complicated, but while creating a plan for one patient may take just five minutes, another may take five hours, and another five days. Hospital administrators don't understand how the work has accelerated and become more complex," Cesta says.

But things may be looking up, she adds.

"Since almost every major change that affects case management has been attached to some kind of reimbursement, it appears that things are starting to change for case managers because of the financial implications," Cesta says.

Most hospitals are looking at the possibility of following patients beyond the hospital walls and to do so in the most cost-effective way, Kizziar says.

"Everybody is scrambling to maximize reimbursement. Additional staff means added benefits for the hospital, but it's a real challenge to determine return on investment," Kizziar says.

Before asking for more staff, case management directors should ensure that their hospital's senior leadership understands the roles and functions of case management and how their interventions can impact outcomes. "Every hospital has to focus on performance measures, readmission penalties, patient satisfaction, and other measures as mandated by CMS," Lattimer says.

It requires data to make the case for additional staff, Lattimer says. If you don't have performance data from care coordination efforts from your own hospital, research the results from other hospitals and accountable care organizations, she says.

The National Transitions of Care Coalition (NTOCC) has an extensive compendium library that includes case management models and tangible savings data, she adds. *(For more information, see www.ntocc.org/Toolbox.)*

Chief financial officers often ask case managers for a return on investment report before they will talk about adding new staff, Zander says.

"They want to know what the costs for new staff compared to what will be saved or how much revenue will be increased by adding new staff. Before asking for new staff, case management directors need to determine a return on investment for every task the department undertakes," Zander says.

"It is going to have to get to the point where case management is recognized as being as necessary as other departments. The administration doesn't ask for return on investment for nursing or pharmacy," Cesta says.

Cesta recommends that case management directors start their requests for new staff by educating the administration on the Conditions of Participation. "Many administrators are not familiar with the Conditions of Participation and that's a good place to start. Point out that utilization management and discharge planning are CMS requirements," she says.

Then get into some of the other financial aspects and point out that nobody else is going to help the hospital meet the requirements from CMS and other payers, Cesta says.

"Aside from the fact that coordinating care for patients and ensuring a safe transition is the right thing to do, hospitals have to adhere to the law and comply with the Conditions of Participation," Cesta says. ■

There's no magic number for case management caseloads

CM model, patient acuity have an effect

When it comes to determining case management caseloads, there's no one-size-fits-all solution. But one thing is clear — if case managers have large caseloads, they can't perform all the duties their role requires and do them well, the experts say.

There's no simple way to come up with an exact caseload number for every situation, says **Charlotte Sortedahl**, DNP, MPH, RN, CCM, assistant professor in the department of nursing at the University of Wisconsin Eau Claire, and newly elected secretary of the Commission for Case Management Certification.

"Caseloads can be different depending on the setting and the acuity of patients, as well as the duties of the case manager," Sortedahl says.

"The days of case managers having caseloads of 20 to 30 patients are over from the perspective of being able to manage efficiently and effectively. Case managers have too many responsibilities to handle a big caseload," says BK Kizziar, RN-BC, CCM, owner of BK & Associates, a Southlake, TX, case management consulting firm.

How many patients case managers can manage and do their job well boils down to the responsibilities of the case manager in a particular environment, Kizziar says.

For instance, if case managers perform utilization review, care coordination, managing the cost of care and the progression of care during the hospital stay and through the post-acute transition period, caseloads have to be small. If they aren't responsible for utilization review and can concentrate on the hospital stay and post-acute transitions, their caseloads can be somewhat larger, she says.

Toni Cesta, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts, recommends a caseload of one RN case manager to 15 patients on a typical medical-surgical unit that has case management software and support staff who free case managers from clerical duties.

"When case management departments have information technology support and clerical staff, it frees up the professional staff to manage their patients at the top of their license," she says.

She recommends assigning different tasks to social workers and RN case managers. "The two disciplines have different areas of expertise and you're not optimizing the skill sets of each if they have the same job description," she says.

"Psychosocial issues often get lost for a patient in crisis. If we don't have social workers operating at the top of their licenses, we wind up getting patients with social problems who keep coming back to the hospital," she adds.

Hospitals should consider moving to a case management model that separates utilization management from discharge planning and care coordination, says **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management.

"Whether this is the right move depends on a lot of things and varies from hospital to hospital. It's important to look at payer mix before changing models," she adds.

The case management model of the future may merge the functions of utilization management and clinical documentation improvement, Zander says.

"We can see a time when those two functions are merged. At the very least, utilization review people need to know something about clinical documentation improvement and need to know some general rules about improving reimbursement," she says.

Case management models are likely to change when bundled payments become widespread, Zander says.

Case management in the future is going to require a combination of unit-based and service-based staff, Zander says. "Not every patient in the hospital is going to be covered by a bundled payment arrangement. Hospitals will need some case managers zeroing in on the bundled diagnoses to manage patients covered by the risk contracts. But others will have to coordinate care and plan the discharges for patients who are not part of a bundled payment arrangement," she says.

A new role is likely to be a transition case manager, who follows patients through the hospital stay and for all 90 days after discharge, Zander says.

"This makes the most sense. It would eliminate information getting

lost during handoffs and patients having to get used to a new case manager when they move to another level of care. Patients often keep the same doctor for the 90 days post-discharge, particularly if it's a specialist, so they might as well keep the same case manager," she says.

Having case managers who follow patients throughout the duration of the bundled payment period will reduce the caseload for the unit-based case managers who can coordinate care for patients for whom the hospital is not at risk, she adds.

Whatever model you choose, have a structure in place so you can evaluate what is working and what can be improved, Sortedahl suggests.

And whatever model you have, locate your case managers on the unit, not stuck away in a remote office, Kizziar says.

"How effective case managers are still comes down to communicating, not only with the patient but with the entire multidisciplinary team. Case managers need to make rounds with the doctors, talk to the family, and find out what is going on when patients are unable or unwilling to provide the information case managers need to develop a comprehensive transition plan," Kizziar says.

Once case management directors get approval to hire additional staff, it may be a challenge to find them and get them up to speed, according to Cesta.

"Case managers and case management directors are starting to retire and there's no one to fill their shoes. There is a huge need for case managers across the continuum, but it's the rare staff nurse who says they want to be a case manager without someone tapping them on the shoulder," she says.

And you can't just move nurses into a case management position and expect them to function effectively from Day 1, Cesta adds.

"Case management requires a whole new body of knowledge and an added set of skills for bedside nurses," she points out.

New staff need to have a clear understanding of what case management is, Lattimer says. "Case management is a professional delivery of services through standards of practice," she adds.

> "CASE MANAGERS COULDN'T DO THEIR JOB WITHOUT A NURSING BACKGROUND, BUT THEY HAVE TO LET GO OF THAT NURSING MENTALITY TO BE A SUCCESSFUL CASE MANAGER."

In some hospitals, utilization management nurses who are accustomed to dealing with length of stay and criteria are being moved into case management with little training, Lattimer says. "Utilization management is not a synonym for case management. They are two different protocols and hospitals need to provide training when nurses take on a new position," she adds.

Healthcare is getting more complicated by the day and case managers are being expected to understand all the changes, Kizziar says.

"Nursing school doesn't teach the business of healthcare. Most nurses and social workers in the hospital setting know nothing about the business part of the hospital. If they become case managers, nurses don't automatically know about the financial aspects of the job. This may limit the effectiveness of the treatment plan," she says.

Hospitals have orientation for new employees, but most of it tends to focus on policies and procedures and using the hospital's information system, Lattimer says.

Lattimer recommends that case management directors refer nurses who are thinking of becoming case managers or those who have just been added to the department to the CMSA Career and Knowledge Pathways online educational program. *(More information can be found at www.cmsa.org/ckp.)*

"Case managers couldn't do their job without a nursing background, but they have to let go of that nursing mentality to be a successful case manager. Healthcare providers never consider the financial side, but case managers have to learn it and embrace it," Kizziar says.

For instance, if a physician orders services for a patient, nurses never think about how the hospital is affected if the treatment costs the hospital $1,500 and the reimbursement is only $1,100, Kizziar says.

"This kind of awareness has to be in the forefront for case managers. They have to make sure that the patients get what they need when they need, but it can be difficult because a case manager may know that a patient would benefit from something they can't afford to pay for out of pocket and that their insurance doesn't cover," she says. ■

Case managers just can't do it all alone

It takes a team, and clerical help

Success in today's healthcare arena requires a collaborative effort from the entire clinical team, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America (CMSA).

"If a team approach isn't in place, we see issues with medication errors, lack of follow-up visits, poor adherence to the treatment plan, all of which contribute to some type of adverse incident," Lattimer says.

It's not just the responsibility of the case manager to support good transitions, reduce avoidable readmissions, and improve patient safety and quality care during and after the hospital stay, Lattimer points out.

"It's the responsibility of the entire interdisciplinary team: physicians, pharmacists, therapists, social workers, case managers, nurses, and allied health professionals. Hospital staff have got to stop functioning in silos and work together to ensure that patients get the care they need, improve patient safety and quality, support a good transition, and assist with reducing avoidable readmissions," Lattimer says.

One key to success is optimizing the healthcare team, says **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification.

Look at the roles and responsibilities of each team member and make sure each discipline is working at the top of its license, she adds.

"Care coordination takes a multidisciplinary approach involving an entire department — case managers, social workers, and with the addition of non-clinical extenders who can free up the licensed staff to do what they are trained to do," she says.

Case managers and social workers should be working at the top of their licenses and using their skills and education to do the jobs they were trained to do, Lattimer says. "They shouldn't be making sure patients have follow-up appointment and that durable medical equipment was delivered. Those tasks don't require the expertise of licensed staff," she adds.

When she works with hospitals across the country, **Toni Cesta**, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts, observes that case managers are spending a lot of time on jobs that don't require their expertise and training.

"It's not practical to pay a nurse to sit over a fax machine or stay on the phone to order a walker. We recommend that in addition to making sure caseloads are appropriate, case management departments provide clerical support for the case managers. Faxing, setting up equipment deliveries, and other clerical tasks are not a good use of a case manager's time," she says.

Case managers don't have the time to follow up with every patient after discharge, Lattimer points out. "This is where understanding patients' acuity and their needs is absolutely key. For most patients, follow-up phone calls can be assigned to an extender who can ask basic questions and refer the patients to a case manager if they need further follow up," she says.

Follow-up calls also can be done by volunteers if they have a specific set of questions and are trained to know when to refer the patient to a nurse or social worker, Kizziar says.

She suggests developing a set of 10 or so questions that can be answered "yes" or "no." Depending on the answer, the computer will direct the volunteer to the next question. ■

Technology is essential today, but there are pitfalls

Don't let it replace personal interactions

Technology, which was supposed to make case managers' jobs easier, save time, and reduce stress, can also create problems, limit communication, and increase the silos that healthcare professionals are trying to eliminate, says **Karen Zander**, RN, MS, CMAC, FAAN, president and co-owner of the Center for Case Management.

Technology is making clinicians more isolated and limiting communication, Zander adds.

"People in some organizations have told us that communication that used to happen verbally is now happening through email and text messages. It's not the same," she adds.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

The Top 10 Mistakes You May Be Making In Your Case Management Department! Part 4

By Toni Cesta, Ph.D., RN, FAAN

Introduction

Over the past several issues of *Hospital Case Management*, we have reviewed the top seven issues you may be facing in your case management department. This month, we are continuing with the final three issues related to opportunities for improvement in how you structure and organize your case management department, as well as how things are operationalized by the staff.

Case Management Department Mistake Number Eight: "Lack of Access Point Case Management"

Number eight on our list has to do with Access Point case management, which includes applying the roles and functions of case management in the most commonly used routes of entry to the hospital.

There are many reasons why you should have Access Point case management in your hospital. Below are the top 10 reasons:

1. Assign an appropriate level of care and/or appropriate placement from the point of entry.
2. Assure compliance with medical necessity.
3. Reduce Recovery Audit Contractor (RAC) activity.
4. Reduce readmissions.
5. Improve inpatient throughput.
6. Reduce the need to use Condition Code, provider liable billing, or self-denials for two-midnight rule.
7. Initiate timely utilization management and discharge planning.
8. Reduce admission and inpatient-only denials.
9. Manage observation service.
10. Increase patient satisfaction at access-covered entry points.

For most hospitals, at least 50% of admissions enter via the emergency department. For some, this percentage can be as high as 80%. However, consideration must be given for all hospital routes of entry. Routes of entry can include any, or all, of the following:

FOR MOST HOSPITALS, AT LEAST 50% OF ADMISSIONS ENTER VIA THE EMERGENCY DEPARTMENT. FOR SOME, THIS PERCENTAGE CAN BE AS HIGH AS 80%.

- ED
- Direct admission from physician office
- Outpatient sites in facility
- Cath Lab
- GI lab
- Clinics
- Therapies
- Special procedures
- Ambulatory surgery center
- Same day surgery
- Scheduled admission
- Transfer in from another facility
- Hospital
- Free-standing ED or clinic

Because of the wide array of ways in which patients can enter the hospital system, the following positions are recommended for any contemporary case management department:

- Admission Case Manager
- Emergency Department Case Manager
- Peri-Operative Case Manager

Depending on the size of your hospital, the roles listed above might become one, two, or three different positions. If your hospital is on the smaller side, the three could be combined into one as long as the roles are covered adequately.

The Admitting Department Case Manager's roles and functions should include the following:

- Screening of potential admissions (planned, urgent,

direct) and transfers.

• Use clinical indicators.

• Compare patient's severity of illness and intensity of service against established criteria and/or regulation, such as the two-midnight rule.

• When the patient's needs do not meet admission criteria and/or the two-midnight rule documentation is not met, a physician is contacted.

• Care alternatives are discussed.

• Review prior to day of admission to ensure that payer authorization has been obtained.

This position should be located in the admitting department and should work closely with the admitting staff while still reporting to the case management department.

If your hospital has an emergency department, then the ED case manager position should not be considered optional, but rather a necessary component of the department's infrastructure.

The Emergency Department Case Manager's roles and functions should include the following:

1. **Gatekeeper:** In the role of gatekeeper, the ED case manager screens all patients for appropriateness of admission. The ED CM also ensures that the appropriate documentation to support the admission is in the medical record. When the patient does not meet medical necessity, then the ED CM can offer alternatives to admission to the hospital. In the role of gatekeeper, the ED CM should also initiate contact with the admitting physician and the primary care physician, if they are different.

2. **Facilitator of care:** In the role of facilitator, the ED CM can expedite tests, treatments, and procedures on any patients presenting in the ED as time allows. This would include the treat and release, admitted, and observation patients.

3. **Intake/utilization management process for inpatients:** This is an important role for the ED CM, particularly for those patients being held in the ED, waiting for an inpatient bed. The ED CM can collect information from many sources as listed below:

• Assess current living situation

• Obtain info regarding informal and formal supports

• Review lab and ancillary test results

• Start discharge planning on admitted patients

• Review history

• Speak with ambulance staff

• Meet with family/friends

• Review patient's insurance benefits

• Introduce idea of home care or other alternative services

• Interface with inpatient case managers

• Check that patient has a primary care physician with whom they are comfortable

• Perform a readmission root cause analysis on any patients being readmitted within 30 days.

Based on the data collected, the CM can provide an initial assessment that can be passed to the inpatient case manager and can also provide any clinical reviews that are required by a third-party payer.

4. **Manage high-utilization patients:**

• Identify high-utilization patients

• In ED at least once every three months

• Patients discharged as inpatient in past 30 days

• Create care plan with ED staff and primary care physician (if patient has one)

• Refer to appropriate level of care: detox/rehab programs, SNF, group home

• Assist with medications, as appropriate

• No meals/showers/clothes/money

• Consistent approach.

The peri-operative case manager manages patients from the pre-admissions process through to the post-anesthesia recovery unit (PACU).

The peri-operative case manager roles and functions should include the following:

• Meet and "intake" triaged patient groups during pre-admission process

• Identify any pre-admission issues that might affect the in-hospital stay and/or discharge plan

• Explore discharge planning options with patient/family to set expectation for discharge disposition

• Review patient's payer benefits plan

• Discuss with attending physician when post-discharge needs cannot be clearly identified or do not meet patient's benefit plan

• Refer to inpatient social worker/case manager as appropriate

• Assure inpatient-only procedures have appropriate order

• Coordinate PACU patients

• Discharge planning needs for day surgery patients

• Appropriate order for patients needing observation service or extended recovery

• Provide education to physicians

• Role and functions

• IP-only procedures

• Two-midnight rule

• Levels of care and documentation

• Document all patient interaction, planning and coordination.

While your hospital may have other high-volume routes of entry, the three positions listed above should, in general, cover the majority of patients entering your system.

Case Management Department Mistake Number Nine: "No Control over External Auditors and Physician

Advisors"

The best way to deal with auditors is to do what you can to keep them from having to audit your department.

Strategies to keep auditors at bay include the following:

- Put patient in appropriate status
- Get admission order correct
- Follow the two-midnight rule guidelines
- First order: Expectation of patient to spend greater than one midnight or less than one midnight in the hospital
- IP order: Proceed with medical necessity evaluation, reviewing physician documentation for support of hospital services that require IP
- Observation order
- Discharge plan discussed
- All orders authenticated, dated, and timed before patient discharged (by physician).

It is important that you hardwire these processes so that they do not get overlooked or skipped. It is also important to self-audit on a regular basis to ensure that the processes are still in place. Monthly audits with a standard template are the best way to go.

The role of the physician advisor (PA), whether internal or external, needs to be managed as well. There are some standard elements that the PA can perform that will help the case management department operate more smoothly. The PA needs to be trained and educated in utilization management in order for the position to be utilized to its maximum. Once accomplished, the PA can become a valued resource for the case managers regarding specific or challenging utilization management situations. Having a PA in the department can help to increase the case managers' credibility with physician partners. The PA serves as a liaison with the medical staff, case management staff, hospital administration, and third-party payers. You should consider your PA as a collaborative and influential member of the medical staff and as such, they should participate in interdisciplinary team conferences and other committees as appropriate. It is sometimes helpful to have the PA chair the utilization management committee as well.

Whether you choose to have an internal or external physician advisor will depend on the needs and resources of your hospital. An external PA may be needed when you don't have a best-practice physician advisor on staff. Or you may have a physician advisor on staff who is a novice in the position and so you may need the support of an external PA. Finally, if you do not have coverage seven days a week, you might choose to supplement your internal PA with external resources to cover days off.

No matter what your structure is, you need to maintain control over the processes. Be sure that you have data that you collect, analyze, and report on. Reporting should be on a regular and scheduled basis. Audit regularly as well and you will maintain control of these important aspects of the department.

Case Management Department Mistake Number 10: "Lack of Compliance with the Conditions of Participation"

The Conditions of Participation, as outlined by the Centers for Medicare & Medicaid Services (CMS), have two sections that relate to the functions of case management. These include the conditions of participation for utilization review and for discharge planning. The hospital must comply with all the conditions in order to participate in the federal healthcare programs. Each department of case management needs to ensure compliance to these two conditions. The only way to know if you are compliant is to self-audit and be sure that all expected elements are present.

Listed below are the main areas for audit and compliance of the conditions of participation for utilization management:

- All hospitals must have a utilization review plan. The plan must provide for review of services furnished by your institution and members of medical staff to patients entitled to benefits under Medicare and Medicaid programs.
- All hospitals must have a utilization review committee.
- Hospitals must ensure that all utilization review activities, including review of medical necessity of hospital admissions and continued stays, are fulfilled as described in 42 CFR 482.30.

The conditions of participation for discharge planning are more complex than those for utilization review. They require the following:

- Discharge planning processes that apply to all patients.
- Policies and procedures in writing.
- Identification at an early point in the hospitalization of all patients likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.
- Discharge planning evaluation to patients identified as above, and to other patients upon patient's request, the request of a person acting on patient's behalf, or request of the physician.
- Supervision of plan development and plan evaluation by registered nurse, social worker, or other appropriately qualified personnel.
- Discharge planning evaluation.

• Evaluation of the likelihood of a patient needing post-hospital services and availability of the services.

• Evaluation must include evaluation of the likelihood of patient's capacity for self-care or possibility of patient being cared for in the environment from which he or she entered the hospital.

• Evaluation must be completed timely so appropriate arrangements for post-hospital care are made before discharge, to avoid unnecessary delays in discharge.

• Include discharge planning evaluation in medical record for use in establishing appropriate discharge plan and must discuss results of evaluation with patient or individual acting on his or her behalf.

• Reassess patient's discharge plan if there are factors that may affect continuing care needs or appropriateness of the discharge plan; reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

• As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

• Transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

Conditions of Participation and Patient Choice

Many hospitals still struggle with the best way to give patients choice and what to give choice for. According to CMS you should:

• Include in the discharge plan a list of home health agencies (HHAs) or skilled nursing facilities (SNFs) available to the patient that are participating in the Medicare program and the serve geographic area (as defined by the home health agency) in which patient resides, or in case of a SNF, in geographic area requested by the patient. HHAs must request to be listed by hospital.

• List must only be presented to patients for whom home healthcare or post-hospital extended care services are indicated and appropriate as determined by discharge planning evaluation.

• For patients enrolled in managed care organizations, the hospital must indicate availability of home health and post-hospital extended care services through individuals and entities that have contracts with managed care organizations.

• Must document in patient's medical record that the list was presented to the patient or individual acting on patient's behalf.

• Must inform patient or patient's family of freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when expressed; the hospital must not specify or otherwise limit qualified providers that are available to the patient.

• Discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has disclosable financial interest.

While you may want to discuss choice with your patients for other services such as acute rehabilitation or durable medical equipment, you are not required to give them a written list of hospitals or vendors. Patients may have particular preferences and you should always give them the option of choice when appropriate. However, for compliance with the conditions of participation, lists are only necessary for home health and skilled nursing facilities.

CMS recommends that the discharge planning process be performed at least 48 hours before discharge and requires surveyors to make sure that the discharge wasn't delayed because discharge planners didn't do a timely evaluation. If hospitals don't evaluate all patients for post-discharge needs, they should have a system to ensure there is a way for discharge planning staff to learn if a patient's condition changes to the point that he or she will need post-discharge services.

CMS wants discharge planners to assess that the patient's discharge needs can be met in their previous living environment. You should also be sure to document whether patients and/or family members have the ability to take care of the patient's needs after discharge. If not, discharge planners should make sure that there are community-based services that can provide care and needed services in place when the patient is discharged.

Auditing for Compliance

At a minimum, be sure to audit the following:

• All one- and two-day stays for traditional Medicare patients that have not been reviewed by a case manager.

• Utilization management documentation and accuracy.

• Patient choice documentation.

Summary

We have now completed our review of the top 10 mistakes you may be making in your case management department. I've included tips and strategies for correcting these mistakes if you are facing them in your organization. If you follow these suggestions, you will help to keep your case management practice and your department on track and moving forward!

For more information on the CMS Conditions of Participation, go to: http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr482.43.pdf. ■

Technology can be a wonderful tool, but it also brings challenges, says **Patrice Sminkey**, RN, chief executive officer for the Commission for Case Management Certification.

"Over-reliance on technology leads to case managers coming to the bedside and not actually talking with the patient," she adds.

Case managers have to step back and take the time to find out about the patients, their living situations, support systems, and post-acute needs, she adds. "We should never forget that one-on-one conversations ensure that an individual's needs are met. Technology is new and exciting, but it should never replace a patient-centered approach," she adds.

Because of the way the electronic medical records are designed, patient assessment has become a task-oriented function that often involves just checking off boxes, adds **BK Kizziar**, RN-BC, CCM, owner of BK & Associates, a Southlake, TX, case management consulting firm.

"When case managers complete an assessment using drop-down boxes, they are limited to a few options. Patients don't fit into boxes. That's not the way we are. The check-off boxes in the electronic medical record are supposed to make things easier, but case managers need to write down how each patient is different," Kizziar says.

When hospitals are financially at risk for what happens to the patients for 90 days after discharge, case managers need to spend a lot of time developing an effective discharge plan, Kizziar says.

"Case managers have to be able to understand their patients' support systems, and to assess their understanding of the disease process and their ability to follow their treatment plan. All of these can be tied to readmissions and it takes more than a three-minute visit, more than a checklist," she says.

"Instead of becoming more check-box oriented to get everything done, hospitals need to focus on patient-centered care and care coordination, and to be able to do that with the constraints of reimbursement changes. It's going to be a real challenge," Kizziar says.

Hospitals' information technology systems aren't always integrated, which produces more challenges, Zander points out.

"The electronic medical record doesn't always work with case management-specific software and case managers have to move from one software program to another in order to do their jobs. This is time consuming and burdensome," Zander adds.

Case management software producers have added functionality to their products, but case managers aren't usually at the top of the hospital information technology department's list in making changes to software, Zander says. ■

Care management assistants help improve patient flow, care transitions

They help licensed staff meet requirements from payers

The addition of care management assistants to the care management team at Spectrum Health Grand Rapids hospitals has contributed to work flow efficiencies, compliance, interdisciplinary teamwork, and smooth transitions of care, says **Britt Thompson**, MSN, RN, clinical manager of care management at Spectrum Health, a Grand Rapids, MI, health system.

Instead of asking for more licensed staff when new requirements from payers and an increase in the acuity of inpatients added more responsibilities for care managers, the care management department asked the health system's administration for care management assistants.

The administration appointed a person who was working as an insurance coordinator to the newly created position of care management assistant and asked her to try the job for six months as a pilot project. By the time the pilot project was drawing to a close, two more care management assistants were on staff, Thompson says.

The health system now has 10 care management assistants who work at three hospitals: Blodgett Hospital, Butterworth Hospital, and Helen DeVos Children's Hospital. The original staff member is still working as a care management assistant.

"With healthcare reform, we are experiencing a tsunami of new and changing regulations from the Centers for Medicare & Medicaid Services and changes in hospital reimbursement, along with an increase in our case mix index but we still are operating with the same caseloads as 10 to 15 years ago. Our care managers have a

caseload of about 22 patients. There is no way we could function without support from the care management assistants," adds **Tal Harris**, MSN, RN, ACM, supervisor of care management at Spectrum Health/ Blodgett Hospital.

In the beginning, the care management assistant went from unit to unit asking the care managers if they needed any help with faxing, copying, calling the insurance company, and other tasks that do not require a license.

Now care management assistants are assigned by unit and typically assist care managers and social workers on four or five units, depending on the unit size.

The care management assistant program is very structured, Harris says. Each morning, the care managers delegate tasks to the care management assistants through the department's software. All of the care management assistants meet every morning at 8 a.m. to discuss their caseloads and to make sure all of the units are covered.

"The care management assistants work as a highly functioning team and cover for each other when needed," she says.

The specific tasks vary according to the units on which the care management assistants work. They help identify primary care physicians for high-risk patients who don't have one, line up transportation, and help with ordering durable medical equipment.

The care management assistants verify with the courts that patients have guardianships within 24 hours of admission and enter the information in the electronic medical record to make the staff aware. They also facilitate the completion of Medicare's required Face-to-Face form that certifies a patient's need for home care and deliver the Important Message from Medicare to patients.

The care management assistant who works on the women's health floors (labor and delivery, obstetrics, post-partum) informs new mothers about community programs for mothers and babies, and facilitates referrals to the programs. In the pediatric hospital, they help parents fill out the paperwork for a State of Michigan program that supplies lodging and meals so parents of pediatric patients covered by Medicaid can stay nearby when their child is in the hospital.

Having care management assistants helps the department align with the healthcare organization's systemwide goals that include compliance with changing and new CMS regulations, efficient and lean work, role satisfaction, and tightening the budget, Thompson says.

"The addition of care management assistants have contributed to workflow efficiencies, to compliance, to interdisciplinary teamwork, and to smooth transitions. Our goals for the program are to allow licensed disciplines to practice patient-centered care and practice at the full scope of their professional licenses and to facilitate safe, smooth, and efficient transitions of care," Harris says.

Initially, some of the licensed staff were reluctant to turn some of the tasks over to the care management assistants, Harris says.

"We had a lot of conversations with them and are still prompting them occasionally to let the assistants do what they were hired to do. Some nurses and social workers still hesitate to turn over some tasks to other people but for the most part, the licensed staff has seen that the care management assistants are reliable and have learned to trust them," Harris says.

The care management assistants are required to have a two-year degree and experience in the healthcare arena, but the majority are college graduates.

"The position is a great entry level for college graduates who want to get into healthcare in a non-clinical way," Thompson says. One assistant worked through graduate school and has transferred into the health system's quality department. Another completed a graduate degree in social work and is working for the health system as a social worker.

New care management assistants go through an orientation process that varies depending on the unit to which they are assigned. Orientation includes completing a validation tool and partnering with a preceptor who helps them work toward competency in required skills. When they go out on their own, they have the support of a mentor who can answer any questions.

Accountability is built into the structure of the program. The design team developed well-defined role expectations and processes and provide constant feedback during the learning process, Harris says.

For instance, the team posts a weekly overall report of compliance with Medicare's requirement to give patients the Important Message from Medicare and measures individual performances to identify "star performers." More experienced assistants coach the new staff on what they should do, and the whole department celebrates improvements.

When Medicare began requiring the Important Message from Medicare, the hospitals' compliance levels were very low, Harris says. Today, better than 99% of the notices are successfully delivered.

Before the program started, representatives from the care management department approached the leadership team and talked about all the tasks they were doing that didn't require a license. "We talked

about how having care management assistants would maximize the skills and education of the nurses and social workers who could concentrate on the jobs that require their expertise and not be burdened with clerical tasks," Thompson says.

"It was easy to show the benefit to leadership. The assistants' salaries were much less than the nurses and social workers were getting. With assistants, the licensed staff could spend their time working on complex cases rather than being on hold with an HMO or doing other things that don't require a license," she says.

The care management team made the case for assistants by pointing out the similarities in a care management assistant and a nursing aide. "We told them that they don't want the bedside nurse bathing and toileting patients. At the same time, we don't want the care managers tied up on the phone with the insurance company or faxing documents to post-acute providers," Harris says.

Harris suggests that case management departments start small with one or two assistants and expand as they determine what works best in their hospital.

She cautions about letting care management assistants cross the line between their jobs and standard nurse case manager or social worker tasks.

For instance, care management assistants should not be asked to talk with families about choosing post-discharge destinations or to deal with difficult patients. "They never should be asked to perform an assessment of a patient or do anything else that requires a higher level of critical thinking," she says. ■

Community partnerships keep patients safe after discharge

Hospital teams with local fire departments

As part of its safe transitions program, Swedish Edmonds Hospital in Edmonds, WA, has partnered with two local fire departments to enhance follow-up care for patients being discharged to home from the emergency department.

"This is a collaborative approach to try to meet the needs of the patient. We want to reduce readmissions and we recognize that care doesn't stop when the patient leaves the hospital. We have a short period of time to educate patients about their disease and medication regimen, and often they need follow-up assistance," says **Deb Dukleth**, RN, director of case management for the 217-bed hospital.

Patients who are reluctant to accept home health services often are agreeable to have someone from the fire department come by the check on them, Dukleth says.

"Patients have a variety of reasons for refusing home health, but in many cases it's a concern about costs. Many times, they say yes to a visit from the fire department when they won't say yes to other things," she says.

When patients agree to visits from fire department personnel, the hospital faxes the fire department basic information about the patients including demographic and clinical information. Paramedics from either the Snohomish County Fire District or the Community Resource Specialists at Lynnwood Fire Department make the visits, depending on the location. The fire department representatives also visit patients who have frequent falls or other issues that land them in the emergency department.

During the visit the paramedics take the patient's vital signs, make sure patients understand their treatment plan, check the patients' homes for safety issues, and alert the hospital or the patient's primary care physician if there is an issue or if patients have questions about their treatment plan. They may make follow-up visits to patients to make sure they are doing well and have everything they need, she says.

The fire department partnership is part of Swedish Edmond's safe transition program, Dukleth says. As part of its efforts to cut down on readmission, a coalition of Snohomish County healthcare providers meets regularly to discuss ways to improve discharge transitions. The coalition includes representatives from community hospitals, skilled nursing facilities, assisted living centers, adult family homes association, home health, hospice and palliative care, specialty and primary care clinics, and representatives from two fire departments that serve the area.

"Our goal is to reduce readmissions, not just for the hospitals but also for the skilled nursing facilities, and to improve patient satisfaction at the same time. Our meetings are an open forum where participants identify reasons for readmissions and discuss barriers to discharge and potential communication issues," Dukleth says.

For instance, the group discusses ways the hospital can provide an accurate and complete handoff to the next level of care as well as how the skilled nursing facilities can improve their handoffs. Representatives from the other two hospitals share information about their readmission reduction programs, what has been successful, and what has not worked as well.

"The physicians who see patients after discharge have identified potential communications issues that we also are assisting with," Dukleth says.

Initially, the safe transitions program focused on reducing heart failure readmissions. The coalition has expanded the program to include any patients who are at high risk for readmission, Dukleth says.

At Swedish Edmonds, the case management staff assess all inpatients within 48 hours of admission using a high-risk screening tool to identify patients who may need assistance after discharge. In some cases, patients who are receiving observation services also are assessed for discharge planning needs and resources. Physicians and nurses also identify patients who may need follow-up after discharge.

"Swedish Edmonds staff members make follow-up calls to patients within three days of discharge. If they don't answer the phone, it might be another indication that they need additional support," she says.

When at-risk patients are identified, the case management team determines the patient's level of functionality before the hospital admission, his or her living situation, social support, and anticipated discharge needs. They work with the patient and family to identify needed resources and develop a discharge plan.

"Our healthcare team works with the patient and family to develop a safe discharge plan that may include medical equipment, home health, transportation and lower cost medication, if needed. Many people don't know what resources are available to them. They want to stay independent but need support to stay safe," Dukleth says.

Patients often need assistance with transportation or help with meals or housekeeping. Sometimes they can't afford their medication.

"It's sometimes a challenge to identify the issues in the home and the resources patients need. We try to cover all resources needed, but people in the hospital have an acute illness that affects them and their loved ones and they may not always provide accurate information," Dukleth says.

Having someone visit at-risk patients at home, whether it's a home health nurse or a paramedic, often alerts the treatment team to patient needs, she adds. "What they see in the home may be very different from what the patients and family members have told us. They identify problems and needs that we otherwise would never know about," she says.

The fire departments also work collaboratively with the emergency department and alert them when patients they transport to the hospital have issues in the home and additional needs, she says.

The case managers also refer patients to the Center for Healthy Living, which has a care transition coach who can follow patients after discharge, Dukleth says. The center is part of the county's senior services.

Sometimes a representative from the center visits the patients before discharge to explain the program and find out what the patient needs.

When patients are readmitted, the case managers work with the treatment team in the hospital to identify the reasons. "We try to identify the real issues in the home and what resources we can provide. We may reach out to family members, members of their church, and neighbors for help in developing a successful treatment plan," she says. ■

CMS continues its push for quality-based reimbursement

No surprises in the IPPS final rule

The final rule for the Inpatient Prospective Payment System (IPPS) for fiscal 2016 continues the CMS transition from Medicare fee-for-service to reimbursement that is based on quality.

"We are seeing an increase in value-based reimbursement as opposed to reimbursement for volume. This is still evolving and it remains to be seen how Medicare reimbursement will look in the future," says **John K. Hall**, MD, JD, MBA, chief clinical officer for Executive Health Resources, a Newtown Square, PA, consulting firm.

In the final rule, issued July 31, CMS announced that it was adding new metrics to Value-Based Purchasing,

the Hospital Readmission Reduction program, and the Hospital-Acquired Condition Reduction program, either effective Oct. 1, when the rule goes into effect, or in the future.

"There are no surprises in the final rule. CMS is continuing a steady movement toward a reimbursement system based on quality," says **Linda Sallee**, RN, MS, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

The final rule adds a care coordination measure to Value-Based Purchasing in fiscal 2018. The measure, which has been in the Hospital Inpatient Quality Reporting program, is a combination of metrics from three questions on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) that a focus on patients' understanding of their care when they left the hospital. CMS also will add a 30-day mortality for chronic obstructive pulmonary disease in 2021.

The rule expands the population of patients with pneumonia in the readmissions program to include patients with a principal discharge diagnosis of pneumonia, aspiration pneumonia, and sepsis with a secondary diagnosis of pneumonia present on admission.

CMS is expanding the Hospital-Acquired Condition program to include data for central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) from all medical/surgical locations.

CMS announced that is continuing to implement the Bundled Payments for Care initiative, which links payments for multiple services during an episode of care into a bundled payment and thanked commenters for their feedback on policy and operational issues surrounding the potential expansion of bundled payments.

"Case managers have a real opportunity to help their hospitals deliver top-quality care and to improve patient outcomes. Traditionally, case managers have focused on utilization review and discharge planning but now they need to add care coordination to their focus and ensure that patients get the care they need in a timely manner and in the right setting," Sallee says.

She suggests that case managers dig down to determine what is causing patients to come back to the hospital over and over, and work with the social workers to help ameliorate the social factors that keep patients from following their discharge plan.

"Case managers should look at the clinical care and make recommendations as necessary to help drive the progression of care," she adds.

The discharge plan that case managers develop can have a huge impact on the hospital's bottom line under a bundled payment initiative, Sallee points out. "With today's length of stay, case managers need to start talking to patients early and to take the time to find out everything they need to know to create a successful discharge plan," she says.

"Other than the doctor, the case manager is the one constant during the patient stay. They need to be someone who coordinates care and be the glue that pulls everything together," she says.

This year's IPPS postpones action on the two-midnight rule until CMS issues the Outpatient Prospective Payment System (OPPS) final rule in late October, Hall points out.

"The final rule didn't change anything that could affect what case managers do. Until the OPPS is issued and we see if there are changes in the two-midnight rule, case managers should maintain a compliant review process," he says.

In the OPPS proposed rule for 2016, issued July 1, CMS proposed allowing shorter stays to be reimbursed as inpatient stays if the documentation in the medical record supports it. The proposed changes left the policy unchanged for stays of two midnights or longer.

CMS has continued the moratorium on Recovery Auditor (RA) reviews on short inpatient stays until the end of the year, Hall says. RAs have been auditing for medical necessity but have been forbidden to audit for patient status, he adds.

In the OPPS proposed rule, CMS also proposed that the two Beneficiary and Family-Centered Care Quality Improvement Organizations (QIOs), Livanta and KEPRO, take over the responsibility of Probe and Educate and will review cases for medical necessity when patient stays are one midnight or less.

If hospitals have consistently high denial rates, the QIOs will refer them to the Recovery Auditors for patient status reviews, CMS said in the proposed rule.

"We don't know the details yet, but it appears that short inpatient stays may be eligible for RA review at the recommendation of the quality improvement organization," Hall says. ■

COMING IN FUTURE MONTHS

- Tips for decreasing readmissions
- Partnerships that improve transitions
- How to eliminate healthcare silos
- What's new on the two-midnight rule?

HOSPITAL
CASE MANAGEMENT

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CNE QUESTIONS

1. What caseload for RN case managers does Toni Cesta, RN, PhD, FAAN, partner and consultant in Dallas-based Case Management Concepts, recommend on a typical medical-surgical unit that has case management software and support staff who free case managers from clerical duties?

A. One RN case manager to 20 patients
B. One RN case manager to 25 patients
C. One RN case manager to 15 patients
D. Depends on the acuity of patients

2. At Spectrum Health in Grand Rapids, MI, RN care managers and social workers are supported by care management assistants. How many units do the care management assistants cover?

A. Four to five, depending on the size
B. Eight to 10, depending on the size
C. Three to four, depending on the size
D. Six to eight, depending on the size

3. How soon after discharge do Swedish Edmonds Hospital staff make follow-up calls to patients?

A. Within 24 hours
B. Within 48 hours
C. Within three days
D. Within a week

4. In the Inpatient Prospective Payment System final rule for fiscal 2016, the Centers for Medicare & Medicaid Services postponed action on the two-midnight rule until it issues the Outpatient Prospective Payment System (OPPS) final rule in late October.

A. True
B. False