HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS
Formerly AHC Media

FEBRUARY 2018 Vol. 26, No. 2; p. 17-28

When Managing Denials, the Best Defense Is a Good Offense

Determine the causes and take steps to avoid those issues

In today's healthcare world, it's more important than ever to get a handle on denials and take steps to prevent them.

"Hospitals need every dollar. They've got to find a way to stop the bleeding in order to survive," says **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions in Tuscaloosa, AL.

He points out that some hospitals have a denial rate of 2% or less. "But since the average hospital's operating margin is 2%, those denials may put them in the red," he says.

"Managing denials is a challenge and there's no easy answer. However, it's important for hospitals to manage their denials well because they can represent a significant amount of revenue," adds **Yomi Ajao**, vice president of consulting for Cope Health Solutions.

"Even if hospitals get paid after they appeal the denials, it adversely affects the cash flow when payment is delayed," Ajao says. Appealing also ties up staff time, he says.

> "HOSPITALS NEED EVERY DOLLAR. THEY'VE GOT TO FIND A WAY TO STOP THE BLEEDING IN ORDER TO SURVIVE."

Avoiding denials is a tough job but it's an essential one, especially since managed Medicare and managed Medicaid payers are making every effort to decrease reimbursement, adds **Beverly Cunningham**, RN, MS, ACM, consultant and partner at Oklahoma-based Case Management Concepts.

"Case management has not always stepped up to the plate to manage

Financial Disclosure: Author **Mary Booth Thomas**, Editor **Jill Drachenberg**, Editor **Jesse Saffron**, Editorial Group Manager **Terrey L. Hatcher,** and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™,
ISSN 1087-0652, is published monthly by
AHC Media, LLC, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Cary, NC, and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Case Management
Relias Learning
111 Corning Road, Suite 250
Cary, NC 27518

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Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
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Outside U.S., add $30 per year, total prepaid in U.S. funds.

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GST Registration Number: R128870672.

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This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

The target audience for *Hospital Case Management*™ is hospital-based case managers. This activity is valid 36 months from the date of publication.

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denials. So now, in some hospitals, other departments are beginning to take over," Cunningham says.

There seems to be a growing trend for hospital finance departments to assume responsibility for utilization management because the hospital leadership believes that case managers can't handle it, Cunningham says. "What I've seen may be just the tip of the iceberg," she says.

The trend is problematic because hospital financial leadership does not always understand clinical denial management. Nor do they understand which department is responsible for what, she adds.

"Some case management leaders also have limited understanding of the denials management process. At many hospitals, no one does due diligence to find the root cause of the denials and take steps to correct any problems," she adds.

Denials management is a struggle for many case management departments, a problem compounded by the fact that there are many case management directorship jobs that are empty, Cunningham says.

Hospitals need strong and effective case management leaders who know and understand the denial process, the appeals process, and how case management and social work can contribute to a proactive approach to denials, she says.

"If you're not a strong leader, it's hard to integrate yourself and your department into the rest of the hospital," she says.

Case managers should be monitoring and managing payer reimbursement from preadmission until after the patient is discharged, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts. "Get involved from the minute the patient comes into the hospital," she says.

This means working with the precertification staff at the front end and the billing staff at the back end to avoid denials, Cesta says.

Case managers should conduct prospective, concurrent, and retrospective reviews to make sure all the payer's rules have been followed and that they have the information they need to prevent denials, Cesta says. *(For details on each type of review, see chart on page 19.)*

Ensure that the clinical information in the medical record is accurate and shows all of the care the patient received, Cesta says. Make sure that third-party payers receive patient information at the times

EXECUTIVE SUMMARY

Denials represent a significant amount of lost revenue. Case managers should take an active role in preventing and managing denials.

- Case managers should be monitoring all patients from preadmission until discharge, covering all points of access in the hospital.
- Leadership should be involved in the contracting process or, at the very least, review every contract with payers.
- Case managers should track denials and work with payers when there is a pattern of denials, and give feedback to hospital staff who may need education to prevent denials.
- Hospitals should create the position of appeals coordinator and develop a revenue cycle team to review, analyze, and manage denials.

they require. Then, facilitate a timely transition to make sure that patients go to the next level of care when they no longer meet clinical criteria.

Start managing patients up front and even before admission to make sure requirements are met so their cases won't be denied, Pisarsky says.

Ajao recommends that the registration staff gather the details of each patient's coverage, including eligibility, benefits, and the payer's requirements.

"Then the case managers have what they need to call the payer to get authorization," he says.

Case managers should be stationed at all access points to review admissions to ensure patients are in the right status and that the payers have authorized the treatment, says **Tina Davis**, RN, MS, CMAC, consultant for the Center for Case Management.

For instance, case managers should monitor surgical patients before and after surgery, Davis says. Make sure the surgery is authorized and the status is correct before the procedure. Then, make sure the surgeon has not changed the procedure in the middle of surgery and performed a procedure that has not been authorized. "This is an opportunity for a denial because the codes may be different before the surgery and after the surgery," she says.

A case manager also should be on hand to review the cases coming into the hospital through the bed management component, Davis says. This includes transfers from other hospitals and direct admissions from a physician office, she adds.

The way to improve your denials rate is to drill down and determine the reasons for denials, then change procedures to eliminate them, Pisarsky states. Make a list of every reason for denials — failure to obtain precertification, failure to meet medical necessity criteria, coding problems, the wrong insurance, missing the authorization deadline, and others.

When a claim is denied, the case management department should find the cause of the denial and track, trend, and develop action plans to mitigate future denial risks, Pisarsky says.

Develop a relationship with your counterparts at insurance companies that cover a substantial portion of patients so you can call them when an issue arises, Pisarsky suggests.

When there is a pattern in denials that points to the practices of one insurer, discuss it with the insurance company case manager. "When you have developed a relationship with that payer, you know who to call and can feel comfortable discussing the problem," Pisarsky says.

There may be occasions when one insurer continually issues denials for one type of patient and every other insurance company approves identical care, Pisarsky says. "Ask the insurance company case manager to help you understand the reasons for such denials since other payers that use

Types of Case Manager Reviews

1. Prospective review

Occurs before the services are rendered.

- If the payer requires preauthorization, the request would trigger a prospective utilization review.
- A preadmission case manager should review scheduled surgical cases to determine appropriate level of care and ensure that there are no pre-op days not meeting medical necessity.
- Review National Coverage Determination to assure that the documentation in the record demonstrates that specific procedures are appropriate.

2. Concurrent review

Occurs while services are being rendered.

- If a provider requests hospital days beyond those approved, a concurrent review would be triggered.
- Medicare expects that case managers manage the medical necessity of its beneficiaries.
- DRG reimbursed cases should be reviewed for medical necessity.
- Episodes of care covered under a bundled payment arrangement should be reviewed.
- Case managers should conduct a review of all concurrent denials.
- Cases of unfunded and underfunded patients should be reviewed concurrently.

3. Retrospective review

Occurs after services have been rendered.

- Case managers should review cases when a short stay patient is admitted and discharged before a medical necessity review has been conducted.
- A denial is issued after a patient has been discharged. ■

Source: Case Management Concepts

the same criteria are approving the services. Ask what other information you need to give them to avoid the denials occurring in the future," he says.

If that doesn't work, you may need to evaluate the contract with this particular payer to see if there is any language that could help you. Compile hard data on the denials and share the information with the contract management staff in your hospital. Ask them to address the issue when the contracts are up for renewal or file a complaint with the insurer, he suggests.

"When the chief financial officer of the hospital shows the data to their counterpart in the insurance company, it may result in positive future changes," he adds.

In addition, case managers should provide feedback to people in the area of the hospital where denials occur, Cunningham says.

"Everybody assumes that no news is good news, so if nobody gives the case managers or physicians feedback, they will assume they are doing the right thing," Cunningham says.

The best practice is for case management leadership to work with the medical director of the hospitalist team to develop a process to provide feedback to individual physicians when a denial occurs, Cunningham says.

"They may not like the information, but hospitalists are either employed by the hospital or are on contract, so they have a vested interest," she adds.

It is helpful if the case management team has one or more effective physician advisors who can work with the attending physicians on documentation and throughput issues, Cunningham says.

"It's ideal to have an internal physician advisor rather than relying on an external firm for denials management. The majority of physicians will not respond to an external physician advisor. A face-to-face discussion makes the difference in effective utilization management and denials management," she says.

Case management can't monitor and avoid denials alone, Pisarsky says.

"It takes a partnership between case management, the business office, and the contracting entities of the hospital system," he adds.

Ajao tells of working with hospitals where each department operates in its own silo and rarely communicates with the rest of the hospital. "This isn't productive. Everyone needs to work together and share information back and forth," he says.

For more information on denials management, the on-demand webinar "Case Management's Role in Managing and Preventing Third-Party Payer Denials," led by Toni Cesta and Beverly Cunningham, is available at: http://bit.ly/2CbZnyw. ■

How to Avoid Four Types of Denials

A proactive approach is best

Some payers deny reimbursement for cases just because they can, says **Tina Davis**, RN, MS, CMAC, consultant for the Center for Case Management.

That's why case managers must take a proactive approach to reducing the denial rate — and the best way to do it is to prevent the denial, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

The cause of denials varies across the country and depends on the patient population and, often, the size of the hospital, says **Beverly Cunningham**, RN, MS, ACM, consultant and partner at Oklahoma-based Case Management Concepts. "In urban areas, a significant portion of denials tend to be driven by contracts while in rural areas, they're more likely to be Medicare-based or Medicaid-based," she says.

The following are the most frequent types of denials:

• **Administrative denials.** These occur when the hospital's actions fall outside of the contract requirements. Case managers must be informed about the insurer's requirement for authorizing the care as well as the requirements for clinical reviews.

"If the notification falls outside the time frame specified in the insurance contract, the hospital will get an administrative denial," Cesta says.

Become familiar with payers' requirements for precertification and clinical review notifications and make sure the calls take place within the timeline the payer defines, says **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions.

"If a patient comes in on Friday afternoon and nobody calls the insurer until Monday, the hospital is three days behind and may get a denial or penalty based on not

notifying the insurer in a timely manner," Pisarsky says.

Make sure you have information about the patient's current insurer. If you don't have the correct information about the payer and their requirements, a denial may be unavoidable, Pisarsky says.

Pisarsky recommends working with the business office staff at all portals of entry to develop a series of questions about insurance coverage that the registration staff asks every patient, even if the patient has been treated at the hospital in the past.

"Even if patients have been to the emergency department multiple times in the last month, their insurance may have changed. If you just accept that they have the same payer and find out a couple of days later that it has changed and the insurer requires precertification, that's an administrative denial," he says.

Other denials may occur when a patient comes in unconscious or disoriented with no payer information, and by the time the family is located and provides the insurance information, the time frame required for authorization has passed, Pisarsky says.

• **Clinical denials.** When patients don't meet admission criteria or stay past the time their condition was acute, the hospital will receive a clinical denial.

Poor documentation is the most frequent cause for clinical denials, followed by lack of medical necessity, says **Yomi Ajao**, vice president at Cope Health Solutions. "When we work with a hospital and analyze denials, what we discover most is lack of documentation or incorrect information," Ajao says.

Case managers should work with the medical staff from the beginning to ensure that the patient status is correct and that the record contains clinical proof of the patient's condition and treatment, Davis says.

"Medicare has been very clear: The patient record has to contain a good history and physical, with a plan of care, along with information about why the patient needs to be hospitalized. If we can get the physician to document clearly what the illness is and the expectations for the patient, we are in a better place for preventing and fighting denials," she says.

"WHEN WE WORK WITH A HOSPITAL AND ANALYZE DENIALS, WHAT WE DISCOVER MOST IS LACK OF DOCUMENTATION OR INCORRECT INFORMATION."

Case managers should develop a good relationship with physicians and educate them about the need for documentation in the medical record to support the case for billing, Davis says.

"Documentation should include information on why the patients need to be in the hospital and why they can't be managed at another level of care," she says.

Some clinical denials may occur because of the hospital's internal processes, or by people outside the hospital, Cesta says.

Some insurers carve out the days when the patient was admitted but not being treated, Cesta says. For instance, a patient who comes in Friday night needs cardiac catheterization, but the lab is closed until Monday and the insurer denies the weekend stay.

Other denials may be caused by people or situations, Cesta adds. For instance, it's not unusual for a patient with a broken hip to be in a bed waiting for several days until the physician who is next on the list is free.

"This is not only a situation where the insurer may carve out those days before surgery and deny them, but it's also a quality of care issue. The longer the patient waits to go to surgery for a broken hip, the more adverse issues are likely to occur," she says. Patients who are lying in bed and sedated can lose cognitive function as well as muscle tone, both of which add to the recovery period, she adds.

This is where the case manager's role as a patient advocate should kick in. "Surgeons don't necessarily understand the need to get a broken hip replaced or repaired in a timely fashion. Case managers should work with the medical team to determine the maximum number of hours a patient should have to wait," she says.

Hospitals should have an orthopedic surgery on-call list so someone is available at all times.

"In one hospital, we worked with the medical leadership to develop a process so when one surgeon isn't available, the next one on the list is called until someone who is willing to come in is identified," Cesta says.

• **Out-of-network denials.** When non-emergent patients are transferred from another facility and carry insurance with a company that does not include the receiving hospital in its network, the care is likely to be denied unless a prior authorization is obtained, Davis says.

Davis reports that out-of-network denials occur in many hospitals

because the transfer department approves all patient transfers without identifying the payer and receiving authorization from the payer before the transfer. She recommends stationing a case manager in whatever department authorizes transfers to review the non-emergent cases and connect with the payers.

"If case managers review non-emergent patients before they are transferred, they can make sure that the hospital is part of the payer's network of providers and get authorization from the insurer before the patient is transferred. If a patient is admitted and the hospital is out of network, the whole stay may be denied," she says.

Hospitals may refuse to take an out-of-network patient as long as it's not an emergency and the care needed can be provided in a hospital that is in the payer's network, Davis points out. "Nurse case managers can manage this process," she adds.

• **Downgrades.** These occur when the insurer reviews the clinical information and changes the patient status from inpatient to observation.

"Downgrades can fly under the radar screen at hospitals and not trigger the appeals process," Davis says.

In a typical scenario, the staff in the business or case management office reviews the downgrade, accepts it, and moves on without any discussion with the physicians, Davis says.

"As a result, the hospital gets paid much less than if the hospital appealed and the payer agreed that inpatient status was correct," she says.

Patient downgrades are technically a denial but because they happen during the stay and sometimes shortly after the patient has gone home, many hospitals don't collect information on them or appeal them, Davis says.

"Certain payers do this more often than others. By collecting information, you can determine if the payer is using downgrading as a strategy to reduce their payment to you," Davis says. ■

Be Knowledgeable About Hospital's Payer Contracts

Make your voice heard about utilization management components

The best way to improve your hospital's denial rate is to prevent denials in the first place, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

To do so, case managers must know the requirements of each individual payer. But at some hospitals, the finance and/or managed care departments don't provide case management with the utilization review section of the contract where the rules are outlined, she adds.

"This creates a lot of problems and increases the potential denials. We have to comply with the rules and that's hard to do if we don't know what they are. A lot of contracts require hospitals to send in a review at a certain time. If it's late, the case gets an administrative denial," she adds.

All case management directors should make sure they have a current copy of the utilization review rules so they can make sure their staff complies, Cesta adds. "We don't need the whole contract, but we do need what the hospital has agreed to do in the utilization review section, as case management is responsible for most of that," she says.

Some of the bigger hospitals have the same utilization review section in all contracts. "This clearly helps the case managers make sure they are following payer requirements," Cesta says.

Case management leadership must be actively involved in managed care contracting, adds **Beverly Cunningham**, RN, MS, ACM, consultant and partner at Oklahoma-based Case Management Concepts. "Now, more than ever, case managers need to know what is in the utilization management portion of the contract. We need to understand it, how it works, and how and when we can appeal," she says.

At the very least, every contract should be reviewed by the director of case management prior to being signed, says **Brian Pisarsky**, RN, MHA, ACM, director at KPMG Healthcare Solutions.

Look for what criteria each payer uses, the requirements for notification on weekends and evenings, and how the hospital is notified if the insurer makes changes in the contract during the year. "Spell out what the case management department is required to do to be compliant. It's much better to have all the details spelled out in the

contract instead of leaving them vague," Pisarsky says.

Analyze the denials process and create a report that your contracting staff can use to talk to any payers that routinely issue inappropriate denials, says **Tina Davis**, RN, MS, CMAC, senior consultant for the Center for Case Management.

"When the hospital's contracting person sits down at the table with the payer representatives, they can talk through the issue and make changes in the process to reduce inappropriate denials," she says.

Pisarsky reports working at organizations where every contract's language is reviewed by the case management director, who could add specifically what was expected as far as authorization and medical necessity were concerned. "It was spelled out so there would be no question about the rules if they were changed in the middle of the contract," he says.

The contract should include who case management should contact and how concurrent appeals should be issued, Pisarsky says.

In addition to Medicare and Medicaid, hospitals treat patients who are insured by a number of commercial payers — many of which offer multiple insurance plans, all with different nuances, says **Yomi Ajao**, vice president, consulting for Cope Health Solutions.

Case managers must be familiar with the rules set out by each commercial payer, traditional Medicare, Medicare Advantage plans, Medicare HMOs, Medicaid, and Medicaid HMOs, all of which may have different requirements, he says.

Davis suggests creating a spreadsheet of all payers that shows whether they pay by diagnosis-related group or on a per diem basis, when they want reviews, the clinical criteria set they use, and other information the case manager can use to make sure the insurers have the information they need.

Keep track of each payer's "trim date," the day the payer expects the patient to be discharged.

"The requirements of the payers and the trim date should drive the work by the case manager," she says. For instance, if the payer wants a clinical review on day four and the case manager doesn't have additional information, the payer is likely to start denying days. "This should get the case manager talking to the clinical team for additional information or planning a discharge if it is appropriate," she adds.

In some hospitals, the requirements for authorization are in the hospital's computer system. At others, the case management department has prepared a handout for all case managers that spells out the requirements and contact numbers for all payers, Pisarsky says.

The most efficient way to ensure that case managers are following the payers' requirements is creating an IT platform that includes InterQual and Milliman Care Guidelines criteria as well as the various payer requirements and is available to everyone in the hospital, Ajao says.

"With that kind of system, the hospital can configure all of the benefits and requirements to make the process easier for the entire team," he says. ■

Large Caseloads Make Denial Prevention Difficult

Don't make utilization management separate from case management

Hospitals that pile task after task on case managers and assign them large caseloads are unlikely to effectively manage denials, says **Beverly Cunningham**, RN, MS, ACM, consultant and partner at Oklahoma-based Case Management Concepts.

"If a hospital doesn't have [an] appropriate patient-to-case-manager ratio, it will never have effective denial management," she says. There's no magic number for the caseload a case manager can handle, she adds.

But the type of payer and their requirements can be a guide in determining the caseloads, suggests **Tina Davis**, RN, MS, CMAC, senior consultant for the Center for Case Management. Compile a spreadsheet of all payers and include preauthorization and continuing stay requirements along with whether they pay on a per diem or diagnosis-related group (DRG) basis.

Case managers at a hospital that has a significant number of per diem payers that want a review on a daily basis should have a smaller caseload than a hospital with mostly DRG payers who don't require frequent reviews, she adds.

Cunningham recommends having one case manager responsible for care coordination, clinical discharge planning, and utilization management for one group of patients. But, often, it doesn't happen

because hospitals cannot attract enough case management staff to provide the appropriate ratio, she says.

"If there isn't a workable ratio of patients, there's no way the case manager can get everything done. They can perform only reactive case management," she says.

Separating the utilization management function from the case management function also can put a crimp in denials management efforts, she adds.

"When case managers and utilization management staff operate separately, it creates silos. If there are separate staff for each function, the case management leaders and the utilization management leaders must be aligned and the case managers, social workers, and utilization management staff must collaborate closely," she says.

Cunningham compares separating utilization management and case management functions to separate conductors leading the orchestra, with the result that the drums start beating before the violins begin playing.

When case management and utilization management are separate functions, it often creates delays, Cunningham points out. For instance, the utilization manager determines that a patient no longer meets medical necessity and sends a message to the case manager. But by the time the message is received, the physician already has made rounds, and the case manager must scramble to locate him or her. Then, the case manager must ask the physician to add to the documentation to support the medical reason the patient is in the hospital. By then, so much time has passed that the payer may deny the entire stay or pay only for observation — or, for a Medicare patient, he or she may already have been discharged from the hospital.

"Sometimes, even if you do the right thing it may be denied because it's late," she says.

In today's healthcare environment, the position of appeals coordinator is critical, Cunningham says. "How many appeals coordinators are needed depends on the size of the hospital, but there has to be someone on the staff who understands the denials process, how denials occur, why they occur, and how and why they occur from each individual payer," she says. He or she also must be familiar with the rules and regulations associated with self-denial, she adds.

The appeals coordinator should understand the nuances of traditional Medicare and Medicare Advantage plans, Medicaid and Medicaid HMOs, and be familiar with all of the commercial payers with which the hospital contracts, she says. ■

Revenue Cycle Team Optimizes Reimbursement

Team reviews contracts, analyzes denials

If a hospital doesn't have a revenue cycle management committee, case managers can approach leadership and suggest that they propose that the hospital administration create a committee to review all contracts and denials.

The revenue cycle committee should meet at least once a month to evaluate all new and renewing payer contracts and keep a handle on denials. It's essential for a case management representative to be an active participant, says **Brian Pisarsky**, RN, MHA, ACM, a director at KPMG Healthcare Solutions.

He recommends that the team include the director of the business office, the chief financial officer or his or her designee, the director of health information management, charge capture leadership, and the director of case management. Include corporate compliance as well as the individual who negotiates contracts with payers, along with ad hoc members who are invited to the meetings when there are areas of concern in their department.

For instance, if there is a significant number of physical therapy denials, invite the physical therapy director to review his or her processes and discuss potential process changes, Pisarsky says.

Start the revenue cycle committee by creating a charter to set up the team. Include the membership of the team, goals, and procedures, he suggests.

At each meeting, the case management director and other department leaders should present the denials that fall under the responsibility of their department, he says. Review your internal audits, which are either state or federal requirements.

Review denials from the various Medicare auditors and from commercial payers and look for patterns, he adds. Identify times when you didn't appeal a denial as

well as when you did appeal. Drill down and find out why you didn't appeal and come up with ways to avoid the issue in the future.

Many organizations develop monthly dashboards with 20 to 25 metrics they measure monthly, Pisarsky says.

Many of the metrics come from five areas: case management, health information management, charge capture, patient access/business office, and denials by payer, he says.

"These organizations also review the denials that were overturned on appeal and compile a spreadsheet that includes the total amount recouped," he says. ■

Patients Threatened by Gaps in Care When They Change Settings

Patient safety and quality of care are threatened when patients move from one setting to another, but there are strategies that can address those gaps in care. A recent report in the *The Joint Commission Journal on Quality and Patient Safety* addressed the risk, specifically in the transition of care from a hospital to a skilled nursing facility (SNF), noting that these transfers often are marked by delays in executing treatment plans and poor communication among providers. In addition, SNF clinicians often have the impression that hospital clinicians are unwilling to address errors or concerns after patients leave the hospital. The study notes that 23% of patients discharged from a hospital to a SNF will be readmitted to the hospital within 30 days. *(The full study is available online at http://bit.ly/2jvn75a.)*

The report supports the fact that many hospital readmissions are driven by the SNF's inability to properly care for the transferred patient, says **Larry Burnett**, RN, a principal with KPMG Consulting in Phoenix.

"If you have a patient who's been well cared for by a hospitalist and staff who are familiar with the condition and ready to answer questions, it's no surprise that when you transfer the patient to a facility without that physician support and knowledgeable staff, readmissions will occur," Burnett says. "We see that a lot. The solution is coordination between acute care and post-acute care, particularly with finding the appropriate place for the patient to be transferred."

The study notes that hospital clinicians often are challenged to find good discharge options.

"These providers often struggled to identify a safe, appropriate care setting for patients with complicated medical and psychosocial needs. They grappled with financial policies that limited the availability of services for patients, including payer sources and reimbursement rates," according to the report.

Collaboration Is Key

"Respondents emphasized the importance of communication but encountered significant barriers when exchanging information, including hospital providers' poor knowledge about SNFs, inaccurate and incomplete documentation, and work flow challenges," the report states.

Cases involving tracheostomy and ventilator patients show how quality of care suffers in transitions, Burnett says. "The average length of stay in a hospital for trach and vent patients is about 28 days, and getting them to a skilled nursing facility is actually better for them. Studies show that if you don't take the patient off the vent in about seven days, you're not likely to get them off the vent for quite a while," Burnett says.

"So, leaving them in a hospital in the ICU is not the best thing. You want to get them to a facility that can wean them off the vent, but if you don't find the right kind of facility with the right skills and resources, they will be right back at your hospital," he adds.

The study authors say hospitals, SNFs, and research programs must work across institutional silos to improve care and transitions.

"This could include establishing direct communication channels between sending and receiving providers, working collaboratively on care plans that follow the patient from hospitalization through community discharge, instituting tours or visiting rotations through healthcare institutions, and identifying opportunities for facilities to manage costs across the continuum of care," the authors wrote.

Hospital-to-SNF transfers can be improved with strategies such as hosting an interactive demonstration of the electronic referral system, convening a multidisciplinary team to conduct root cause analyses of 30-day unplanned readmissions, administering a survey assessing SNF

clinicians' experiences with hospital discharges, and implementing a telephone report between hospital and SNF clinicians before patient discharge, the study suggests.

Case Management Problems

One challenge for hospitals is how to get physicians involved in a patient's care after a transfer, Burnett says. The growing popularity of hospitalists complicates the issue, with up to 80% of patients in some acute care hospitals cared for by a hospitalist, Burnett says. "There's a huge break in the system when you try to get the patient back under the care of a physician in the community," he says.

"It's important that the case management system include components that get the patient appointments with a doctor who understands the care they've received so far and can take over in a seamless fashion. That's where people are getting tripped up on many occasions," he adds.

In many cases, hospital physicians are skeptical of the SNFs that are available for patient transfer and with good reason, Burnett says. That doesn't mean hospitals can absolve themselves of any responsibility for the quality of care after discharge, he says. Some hospitals are working with SNFs to improve their care, and Burnett says that, ultimately, is the best solution.

"It's a long, slow, painful process for most healthcare organizations. But until we get that care redesign built up more and better physician coverage in these skilled nursing facilities, hospitals are still going to suffer with readmissions and poor outcomes," Burnett says. "It is in their best interest to work with these downstream facilities to improve transitions and reduce these gaps in care." ■

Hospital Standardizes Debriefing After Critical Events

The maternal and fetal medicine team at Sharp Grossmont Women's Health Center, affiliated with Sharp Grossmont Hospital in La Mesa, CA, improved quality of care recently by implementing a standardized debriefing process for critical events.

Mia Taa-White, BSN, RN, and **Jennifer Turney**, MSN, RN, CNS, CPN, clinical leads in OB/GYN at the hospital, were part of a team that determined there was no standardized debriefing process that could help the clinical teams learn from patient experiences. They addressed the issue as part of their participation in the Clinical Scene Investigator (CSI) Academy sponsored by the American Association of Critical-Care Nurses.

The Women's Health Center has 24 labor suites and 24 single-occupancy rooms for couplets and women's surgical care. Physicians are in-house day and night, and there is an operating room and post-anesthesia care unit dedicated to women's services.

Hemorrhage Incidents Reduced

They theorized that improved debriefing could help lower the incidence of a serious complication of postpartum hemorrhage resulting in a massive transfusion, defined as more than four units of blood. They developed a program with the goal of reducing the incidence below a rate of 1.5/1,000 women.

From June 2015 to June 2016, there were four cases of postpartum hemorrhage resulting in massive transfusion. In the year since implementing debriefing education and standardizing the process, there have been no events of massive transfusion and the goal to decrease the rate below 1.5 has been achieved.

The incidents avoided in that period resulted in a cost savings of $101,212. *(More data and the standardized debriefing form are available online at: http://bit.ly/2AfCVDn.)*

"We standardized a debriefing form that evaluates our timeliness in recognition and timeliness in responding to a critical event," Taa-White says. "It also helps us evaluate our team dynamics. It aligned us with our journey to become a high reliability organization, heightened our awareness, and helped us create a mindset to think critically about work and performance."

Prior to the standardized form and process, critical events were loosely defined but included anything the nurse thought required a rapid response.

Debriefing after these events was

inconsistent, Turney says. "Nurses felt like they needed to weigh and discuss those events, but there was no process. Nurses would go home and think about what happened, recognize things that might have been done better or that suggested some potential for improvement, but they didn't have any formal way to pass that on to leadership," Turney says. "There might have been delays or supplies were missing, concrete things that could be addressed, but the information was not utilized."

An interdepartmental team addressed the issue, with representatives from labor and delivery, OB/GYN, the surgical post-anesthesia care unit, as well as frontline nurses.

"In addition to developing a way to send this information to leadership, we wanted to be able to communicate with staff also so that we all can learn from these experiences," Taa-White says. "We started with introducing the idea of debriefing itself — the importance of debriefing, what it means to debrief, and what would be done with the information."

Pushback on Time, Leadership

There was some skepticism and resistance, as can be expected with any initiative, Taa-White says. Time was the biggest concern, with clinicians pushing back on the idea of a new step they would have to work into their already busy schedules. The debriefing team emphasized that the process could be quite brief, as little as five minutes.

Leading the debriefing session was another source of concern. "Everyone was shy about leading the debrief, especially with doctors involved. After a critical event, everyone is still stressed out about the situation and catching up on charting, so debriefing was the last thing they wanted to do," Taa-White says. "The idea of leading it was even less popular, because nobody wanted to take that responsibility and be the one to criticize the team's work. We explained that leading doesn't mean criticizing or grading your co-workers on their performance, but rather it's about facilitating the discussion."

Turney notes that physician participation improved when Taa-White and another member of the debriefing team visited with OB and anesthesia leadership to explain the process and the benefits.

"It was a big step forward when we got physicians to stay after the event and discuss with the nurses what went well and what didn't," Turney says.

"It's not 100% participation, but it gets better and better with each event. The physicians are starting to see that this is an opportunity for them to educate others, and also to convey any concerns they had about the equipment they needed or changes that would have helped them do their jobs better."

Problems Revealed and Addressed

In addition to overall improvements in communication and teamwork, several specific improvements have come from the debriefings, Taa-White says. Comments from debriefings led to the refinement of the hemorrhage cart that is brought to a room during a bleeding emergency. Some necessary items were missing and new items were added.

The debriefings also revealed that the overhead speaker in a physicians' lounge was broken, so the doctors there could not hear OB stat calls.

However, addressing those issues was not enough. The changes were communicated to the clinicians with an emphasis on how they came about directly because of the debriefings, Turney says, to reinforce the importance of the process and to validate the input from caregivers.

The debriefings also provided a way to measure the quality of critical event responses, they note. "Previously we might have thought we did pretty well, but with this process we can put our team performance on a scale of one to four and categorize it over time, looking for patterns with particular types of emergencies and any consistency in what could be improved," Turney says.

One of the lessons from the project is that sometimes it is best to just get started rather than waiting for the perfect setup, Turney says. The debriefing team initially spent a great deal of time and effort trying to design the debriefing form, which delayed the implementation of the project, she says.

In retrospect, Turney says it might have been better to go ahead with an early version of the form and modify it as the project progressed. ■

COMING IN FUTURE MONTHS

- Is your hospital ready for a disaster?
- Pros and cons of offsite utilization management
- Recruiting case managers in today's world
- How to put technology to work for you

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

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CE QUESTIONS

1. **According to Brian Pisarsky, what should case managers do when one insurer continually issues denials for a particular type of patient and other payers approve it?**

   a. Call your counterpart at the insurer to discuss the problem and find out if additional information is needed.
   b. Compile hard data and give it to the people who negotiate the hospital's contracts.
   c. Ask the hospital's chief financial officer to share the data with his or her counterpart at the insurer.
   d. All of the above

2. **According to Yomi Ajao, vice president of consulting for Cope Health Solutions, what is the biggest cause of clinical denials?**

   a. Poor documentation
   b. Wrong coding
   c. Patient doesn't meet inpatient criteria
   d. Outpatient's procedure is on the Medicare Inpatient Only list

3. **Tina Davis, RN, MS, CMAC, recommends that case management departments create a spreadsheet that case managers can use to keep up with payer requirements. What should be included?**

   a. Whether they pay by diagnosis-related group or per diem
   b. When they want clinical reviews
   c. What criteria they use
   d. All of the above

4. **When case management and utilization management are separate functions, it does not create delays, according to Beverly Cunningham, RN, MS, ACM.**

   a. True
   b. False

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.