HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

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American Hospital Association Sues CMS Over Final Rule Changes to OPPS Payments

New OPPS has some good things for case management

A recent lawsuit filed by medical associations seeks to stop the Centers for Medicare & Medicaid Services (CMS) from implementing a new payment rule. The change would shift funding away from hospital outpatient departments (HOPDs).

Plaintiffs claim CMS violated its statutory authority with changes that will reduce total hospital payments by $380 million in 2019 and $760 million in 2020, according to a civil complaint filed Dec. 4, 2018, in the United States District Court for the District of Columbia. *(The lawsuit can be viewed at: http://bit.ly/2AYwvHo.)*

> PLAINTIFFS CLAIM CMS VIOLATED ITS STATUTORY AUTHORITY WITH CHANGES THAT WILL REDUCE TOTAL HOSPITAL PAYMENTS BY $380 MILLION IN 2019 AND $760 MILLION IN 2020.

The American Hospital Association (AHA), the Association of American Medical Colleges (AAMC), and three hospitals filed the lawsuit against Health and Human Services (HHS) Secretary Alex M. Azar to stop HHS from implementing changes to the Medicare Hospital Outpatient Prospective Payment System (OPPS).

CMS revised OPPS to address longstanding concerns about growth in hospital outpatient expenditures,

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according to the final rule, "Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs," effective Jan. 1, 2019. *(The rule is available at: http://bit.ly/2S4A4CO.)*

The OPPS changes will affect hospitals' ability to care for patients with more severe conditions in their local communities, says **Lawrence Hughes**, assistant general counsel for AHA in Washington, DC.

"For example, some hospitals might need to limit the number of hours they operate these hospital-based clinics, so that would mean that patients would not be able to get services at particular times," Hughes says. "Some services might have to be consolidated into particular locations, so patients would have to travel longer distances to get some services. There might be a lack of ability to expand the capacity to serve more patients in those locations."

Medicare patients in HOPDs are more at risk due to poverty, frequent hospitalizations and ED visits, and multiple or severe chronic conditions, including end-stage renal disease, according to an AHA study. *(The study can be found at: http://bit.ly/2RJu8PP.)*

Currently, hospital outpatient clinics are reimbursed by Medicare at a higher rate than nonhospital outpatient clinics. The final rule offers an example of a physician visit in which a regular physician office would be paid $109.46 by Medicare, while the hospital outpatient clinic would be paid $184.55 — about 68% more.

"Taking into account that this payment discrepancy occurs across tens of millions of claims each year, this is a significant source of unnecessary spending by Medicare beneficiaries," the final rule states.

"We understand that many off-campus departments converted from physicians' offices to hospital outpatient departments without a change in either the physical location or a change in the acuity of the patients seen," the final rule says. "To the extent that similar services can be safely provided in more than one setting, we do not believe it is prudent for the Medicare program to pay more for these services in one setting than another."

In the lawsuit, AHA and AAMC

EXECUTIVE SUMMARY

The American Hospital Association (AHA) has sued the U.S. Department of Health and Human Services (HHS) to prevent changes to how Medicare reimburses care in hospital outpatient departments.

- The lawsuit claims the Centers for Medicare & Medicaid Services (CMS) violated its statutory authority and will reduce total hospital payments by $720 million in 2020.
- The final rule revises the Medicare Hospital Outpatient Prospective Payment System (OPPS) to address concerns about growth in hospital outpatient expenditures, with an effective date of Jan. 1, 2019.
- The AHA says that reducing payment to hospital outpatient facilities will harm a patient population that largely is poor, medically at-risk, and make frequent hospitalizations and ED visits.

claim that CMS is not authorized to enact cost-cutting strategies this way because it violates the Medicare statute's mandate of budget neutrality. At press time, CMS had not responded to *Hospital Case Management*'s requests for comment.

The lawsuit was a last resort.

"These changes were proposed as part of the OPPS proposed rule, and we commented very negatively on those proposed changes," Hughes says. "Unfortunately, CMS decided to go forward with them, and that's why we're bringing the lawsuit."

AHA filed other lawsuits against HHS over the past few years, including a lawsuit in September 2018 related to a delayed final regulation on the price ceiling and penalties for drug manufacturers that have provided discounts to participating hospitals, Hughes notes.

"We bring litigation only as a last resort," he explains. "We have filed lawsuits that were very successful, including one from 2014 related to a backlog in payment appeals at the administrative law judge level of appeals."

Individual hospital systems might also wish to address their concerns about the change to members of Congress. "Talking to your congressman and senator about the impact in your community is very important, and we encourage members to do that, as well," he says.

Other changes in OPPS include quality priorities that reinforce care coordination and case management, says **Ellen Fink-Samnick**, MSW, ACSW, LCSW, CCM, CRP, principal of EFS Supervision Strategies in Burke, VA.

"It has long been said that care is moving outside of the acute care hospital to ambulatory and community sites, and this is becoming a reality," Fink-Samnick says. "Disparity of reimbursements between IPPS [inpatient prospective payment system] and OPPS are being addressed, and that's the intent."

The OPPS final rule could affect patients' options, and case managers need to be aware of that possibility, suggests **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, a senior director of care management at Cleveland Clinic in Ohio. Davis also is the immediate past president of the Case Management Society of America (CMSA).

"IT'S REALLY ABOUT BRINGING THAT INTERDISCIPLINARY LEVEL OF CARE TO THE AMBULATORY SETTING, TOO, FOR LOWER COSTS AND HIGHER VALUE."

Hospitals in underserved communities have long been the safety net for patients.

"If a patient is from a rural area with one hospital, the patient's choices might not be as great as in other communities," she says. "Or if patients have few choices, it's important for them to understand what their choices are."

Helping patients make an informed decision takes more effort and time than just giving them a list of potential outpatient facilities, she adds.

Case managers also might see more of a push toward a care continuum focus under the final rule's quality priorities and The National Quality Initiatives for the U.S. Department of Health and Human Services, which include the following:

- making care safer by preventing errors in care delivery;
- strengthening person and family engagement in care aligned with patient goals;
- promoting effective communication and coordination of care, including medication management;
- promoting effective prevention and treatment of chronic disease, including mental health and substance use disorders;
- working with communities to promote best practices of healthy living;
- making care affordable, partly through appropriate use of healthcare resources. *(http://bit.ly/2S4A4CO)*

"They want patients to be informed and to have lower cost of care while still maintaining the quality," Davis says.

Interdisciplinary teamwork, improved patient education, case management, and value-based care are ways to accomplish that goal.

"Case managers will need to be more well-versed in a greater foundation of practice that includes models, which make use of interprofessional teams, including incorporating nurses, social workers, and pharmacists," Fink-Samnick says. "These models will need to be used in outpatient/ambulatory care, as readily as inpatient care."

Also, hospital case managers should partner with payer case managers and providers to assure smoother care transitions and handoffs, she adds.

"We understand how important it is that patients have a follow-up visit with their primary care provider when they're discharged," Davis says. "It's really about bringing that interdisciplinary level of care to the ambulatory setting, too, for lower costs and higher value." ■

Nursing Shortage or Not? It Depends on Location

Nurses are available — but will hospitals hire them?

Periodically, reports and surveys come out describing a nursing shortage in the United States. Nurses and RN case managers will confirm that they're working harder than ever to cover for unfilled staff positions.

But are there truly more nursing positions available than nurses to fill them, and will this trend worsen? Or is the reality something quite different?

The American Association of Colleges of Nursing (AACN) offers a mixed answer. The economy's downturn a decade ago led to more people entering the profession, but there still is a shortage in some areas, particularly in the South and West. *(More information is available at: http://bit.ly/2UAg5hh.)*

"There is no nurse shortage in the U.S., with the possible exception of some isolated rural areas," says **Linda H. Aiken**, PhD, FAAN, FRCN, professor of sociology, Claire M. Fagin leadership professor in nursing, and director for health outcomes and policy research at the University of Pennsylvania in Philadelphia.

"Graduations from nursing schools have more than doubled over the past 15 years, with as many as 150,000 or more nurses graduating each year," Aiken says. "This is far more than needed to replace retiring baby boomer nurses."

The American Nurses Association (ANA) estimates that the number of nurses leaving the field is about 75,000 per year, while the number of new nurses passing the certifying exam for registered nurses is approximately 140,000 per year. (*More information is available at: http://bit.ly/2ROwyNj.)*

Aiken points out that college students increasingly are drawn to BSN degrees because the opportunities for steady employment, good salaries and benefits, and professional advancement are better in nursing than in many other fields. It is one of the most popular career choices now, she says.

This trend has continued for more than a decade as people enter first careers that prove less rewarding and return to school to try nursing.

"About half of our undergraduate students who are in basic RN classes are students who had degrees in other fields, including law, engineering, and financial services," Aiken says. "We have had students who were trained to be attorneys and found the work very boring and wanted to do something more meaningful with their lives."

It helps that nursing salaries have risen over the past two decades and that nurses increasingly are seeking advanced practice degrees to become nurse practitioners, nurse midwives, and so forth. Nursing is seen as a pathway to clinical practice, more responsibility, and more autonomy.

"It's all market-driven," she adds. "Nursing schools have expanded as much as they possibly could have because they have so many great applicants and are turning away 50,000 qualified nursing students each year."

For case managers, the situation is different.

"We do have trouble filling case manager spots," says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, a senior director of care management at Cleveland Clinic in Ohio. Davis also is the immediate past president of the Case Management Society of America.

"Some hospitals have a lot of case management openings because it really is a special skill set," she says.

The average age of case managers is in the 50s, and it's not a role that RNs can learn in six weeks, she notes. "It takes time for a good case manager to move from novice to expert level."

EXECUTIVE SUMMARY

Although reports often emerge with predictions of a pending nursing shortage, some evidence also points to the opposite: plenty of new nursing graduates to meet the demand.

- Nursing schools are graduating more new nurses than ever, including people who enter the field as a second career.
- Nursing students increasingly are attracted to BSN degrees and advanced practice degrees, seeing these as a way to more meaningfully connect with patients and develop rewarding careers.
- Some hospitals and areas do have problems attracting or hiring as many nurses as are needed and could partner with nursing schools to create residency programs.

Transitioning patients safely and quickly is intense work that not everyone has the skills and interest to master, Davis adds.

Case management jobs are appealing to new nurses, but it takes time for new nursing graduates to gain the necessary experience for this role, Aiken notes.

"We have relatively more inexperienced nurses, and case management is looking for experienced nurses, so there might be a little, temporary experience gap," she explains. "Within five years, that will disappear. It's not too long of a wait for a really larger workforce."

Meantime, why will some nurses and patients say they are seeing the impact of a nursing shortage? One factor that adds to this perception is that some hospitals are not keeping their nursing departments fully staffed, so there can be bedside nursing shortages.

"People say there are not enough nurses in a hospital, and it's because the hospital doesn't have a large enough budget for nurses," Aiken says.

It's a mistake to take a shortcut on nursing care because that's the main reason patients are in a hospital, she notes.

"We've reduced hospital admissions by tens of millions of days for people who don't need continuous nursing care," she explains. "They can have same-day surgery and go home, so the only reason many patients need to be in the hospital is for nursing care."

When hospitals treat nursing as a service they want to minimize, they're forgetting that nursing is a major service and that having adequate staffing levels is what drives every positive outcome. "The more nurses employed at a hospital, the better patient satisfaction is," Aiken says.

Also, there are nursing shortages in some rural areas that are further from nursing schools. When hospitals are understaffed in nursing for a period of time, they can develop a reputation for having challenging working conditions. This can result in fewer nurses applying for jobs at those locations, she explains.

Another factor in the perception of a nursing shortage is that employers often do not want to give new nurses a chance.

"They're not willing to make that investment, and it's the same in every field," Aiken says.

One solution to this problem is for health systems and nursing schools to team up to develop residency programs for new-to-practice nurses, she suggests.

Case management directors also should consider hiring nurses with less that five years of experience for case management jobs, Aiken says.

"These nurses that are closer to their education could be very good," she says. "What they're learning is fresh in their minds." ■

Separating Utilization Review, Case Management Creates Transitional Care Coordinator Role

Some nurses prefer one role or the other

Utilization management is specialized work that has become more complex over the past decade. Working with patients at discharge and through care transitions also has become a greater priority for health systems due to the Affordable Care Act (ACA) and its focus on the continuum of care and population health.

Some health systems have decided to separate these tasks rather than have one person — usually a case manager — handle it all.

"Since utilization management has become very specialized work, in order to do it correctly and meet all compliance requirements our team decided to separate it," says **Mary McLaughlin Davis**, DNP, ACNS-BC, NEA-BC, CCM, a senior director of care management at Cleveland Clinic in Ohio. Davis also is the immediate past president of the Case Management Society of America (CMSA).

"The primary reason we separated utilization management and case management several years ago is for the benefit of our patients," Davis says. "The following are under the umbrella of care management: utilization management, social work, transitional care coordinators, and primary care coordinators."

Transitional care coordinators are nurse case managers. They provide care coordination to acute care patients, transitioning them to their homes, skilled or long-term nursing facilities, acute rehabilitation, long-term acute care, home care, and ambulatory care.

"We have a social worker and transitional care coordinator

partnering on one or several units," she says. "The social worker assists patients that are struggling with social determinants of health, such as food or housing."

The social worker also addresses other cognitive or behavioral needs, including guardianship and drug or alcohol addiction.

The transitional care coordinator manages the complex clinical transition, coordinating care for patients who are discharged with parenteral nutrition, IV antibiotics, or wound care, Davis says. "Often times, they have to work together to transition a patient."

For example, an elderly patient who lives with an adult child might be sent home from a hospital stay with IV antibiotics and additional complex care needs. The patient's child might not be able to handle the patient's medical needs. The social worker could contact home care and ask for a care assistant or ambulatory social worker to assist, she says.

The primary care coordinator is a nurse care manager who works in the primary care office. He or she receives the patient from the hospital transitional care coordinator and continues to follow the patient-centric plan with evaluation and revisions, as needed. "We also have social workers embedded in the primary care offices. They will assess the patient's community resources, social situation, and other issues," Davis explains.

"The point is that we transition the patient. We don't consider this a discharge — we consider it a transition through and beyond the healthcare system," she adds.

Transitional care coordinators consider patients' needs in any community, anywhere the patient might be transitioning.

"We have patients at our main campus from all over the world, but we're committed to carry out that same model for all patients," Davis says.

If a patient is from another state, the transitional care coordinator will call providers, such as skilled nursing facilities and primary care providers, in the patient's hometown. They also might help a patient gain support from family and neighbors.

"We arrange for those transfers to a skilled nursing facility or home care," she says. "We explain what happened to the patient when in the hospital, and what they'll need as the next step when they go home."

When Cleveland Clinic separated utilization management and case management, one key to a successful change was determining which role best suited which team members. For some case managers, working with insurance companies, ensuring cases meet criteria and getting denials overturned, is professionally rewarding. These nurse care managers now can focus solely on utilization management.

Other care managers wanted to spend more time on clinical work. "I was one of those people," Davis says. "I had worked in an insurance company years ago, but I knew I loved working with patients."

The utilization care managers can be instrumental in helping transitional and primary care coordinators connect with payers to advocate for patients and, sometimes, to negotiate benefits not expressly written in a health benefit plan.

Care managers across the continuum work with the interdisciplinary teams, which include the patient as the central member. The patient and/or the patient's caregiver work with the team at every setting to achieve the patient's goals, Davis says.

"The CMSA Case Management Standards of Practice have always informed my work, and I recommend them to all care managers," she adds. "Every day is different, but patient advocacy is a care manager's key standard."

There are many opportunities to use and enhance this competency across the care continuum.

"Transitional care coordinators huddle with social workers and look at their floor's census," Davis says. "Throughput is very important, so their goal is to make sure patients have the right care, at the right time, in the right place."

EXECUTIVE SUMMARY

Hospitals that still assign case managers to utilization review and care coordination at discharge might consider separating the duties to improve care quality.

- Utilization management is very specialized work and requires someone to focus on compliance requirements and other details.
- Case managers could be transitional care coordinators that care for acute care patients, transitioning them to skilled nursing facilities, acute rehabilitation, long-term acute care, home care, and ambulatory care.
- One key to successfully dividing these roles is to determine which role works best for each person. Some people are more suited to working with insurance companies to reverse denials, while others thrive in working directly with patients.

They also are involved in interdisciplinary rounds, accompanying the team to patients' rooms. They ensure patients are part of the care team and goal-making.

"The patient has a critical input into what's going to happen to him or her," Davis says.

"When the team visits a patient, the physical therapist might recommend acute rehab to help the patient reach his or her highest functional level. The pharmacist might talk about new medications, and the transitional care coordinator will say, 'I'll tell you your choices for acute rehab care,'" she explains. "If the patient's ultimate goal is to go home, then the transitional care coordinator will say, 'I'll do my absolute best to make this happen.' There may be some steps needed prior to meeting the patient's goal, but the goal is central through the transitions." ■

Case Managers Should Beware of Medicare Fraud, Waste, and Abuse Issues

Learn about compliance to prevent big fines

All hospital employees, including case managers, should receive frequent compliance training that includes information about how to prevent problems with fraud, waste, and abuse.

"Receiving training is one of the most effective ways to prevent fraud, waste, or abuse issues," says **Chris Ambrose**, MBA, CHC, CHPC, healthcare compliance officer at Service Access and Management Inc. of Reading, PA.

"Without effective training, case managers are put in a position to break policies, rules, or laws they don't even know about," Ambrose says.

The government recoups about $4-$6 for every $1 spent on preventing and detecting issues related to compliance, according to the Office of Inspector General (OIG).

According to the 2018 report, the Health Care Fraud and Abuse Control (HCFAC) Program's investigations recovered four times the amount spent. *(The report is available at: http://bit.ly/2UOnDxb.)*

Earlier OIG reports showed an even bigger return on investment, with a five-to-one return on fraud and abuse investigations investment in the 2017 report, and $6.10 collected for every $1 invested, according to data from Fiscal Year 2015. *(The reports can be viewed, respectively, at: http://bit.ly/2LkCdIj and http://bit.ly/2QX4JFc.)*

This shows how government healthcare funders scrutinize case management and the healthcare industry as a whole, Ambrose says.

"It, therefore, is imperative — through effective training — that case managers have an absolute understanding of their respective program's payment standards," he says.

The federal government incentivizes anyone who is concerned with potential violations of fraud, waste, and abuse laws by awarding whistleblowers who report suspected false claims information with up to 30% of what is recouped in a substantiated allegation. *(More information can be found at: http://bit.ly/2GmZ1bP.)*

In the fee-for-service reimbursement environment of case management, the government and funding organizations rigorously monitor and pursue cases of billing for services that are inconsistent with program requirements.

Overbilling, overlapping services, padded billing, and documentation that does not meet the funder's

EXECUTIVE SUMMARY

Frequent and thorough compliance training is necessary for hospital case managers, as well as other healthcare professionals and staff. The goal is to prevent healthcare fraud, waste, and abuse.

- The U.S. Health Care Fraud and Abuse Control Program investigates allegations of abuse and often reaches costly settlements with healthcare organizations.
- The government's return on investment for fraud and abuse investigations is from four to six times the money spent on the investigations.
- Overbilling, overlapping services, padded billing, and documentation that does not meet the funder's payment standards are some of the red flags of fraud, waste, and abuse.

payment standards are just a few of what case management funders in the fee-for-service environment consider red flags of noncompliance, Ambrose says.

For example, there are several recent cases that illustrate how costly false claims can be — even if the problem was a documentation or other mistake that was later reported by the clinician to the government:

• **December 2018:** A hospice care provider agreed to pay $5.86 million to the federal government to settle False Claims Act allegations. The provider submitted Medicare claims for hospice care that was medically unnecessary or lacked documentation. *(https://bit.ly/2R0OtTJ)*

• **May 2018:** A hospital in Coudersport, PA, paid the United States $373,547.54 to settle allegations from two self-disclosures to OIG. The hospital billed incorrectly for services and failed to see some Medicare hospice patients in person, although they were billed for this service.

According to OIG, the hospital took corrective action and voluntarily disclosed the problem, so it was settled without litigation. *(http://bit.ly/2EnLJt0)*

• **April 2018:** A physician and owner of a pain clinic in Scranton, PA, had submitted numerous improper claims for payment by upcoding care to receive a higher reimbursement amount, between 2003 and 2014, which is when the physician died. The settlement resulted in the physician's estate agreeing to pay the United States $625,000 to settle the False Claims Act allegations. *(http://bit.ly/2EnLJt0)*

• **November 2014:** HHS investigated a healthcare fraud case involving a psychiatrist in Mt. Carmel, PA. The psychiatrist was charged with false billings for psychotherapy services, including for face-to-face therapy sessions when he actually was out of the country. The total amount of his fraudulent billing was $322.75.

In a plea agreement, the psychiatrist acknowledged guilt to six misdemeanor charges and agreed to pay a total of $95,000 to the government. *(http://bit.ly/2QVjCb0)*

> "AN EFFECTIVE COMPLIANCE PROGRAM IS ONE THAT WILL ENABLE ALL STAFF TO BECOME THE EYES AND EARS OF THE COMPANY."

"This underscores the importance of having an effective compliance program — inclusive of effective training, which encourages staff to come forward, internally, if they suspect problems," Ambrose says. "Organizations should have a non-retaliation policy that ensures staff will not be disciplined for reporting."

Health systems and other healthcare organizations operate multiple types of case management programs, and these often feature their own unique funding standards.

This is why it's crucial that case management directors and supervisors, who have direct responsibility for the case management program, remain on the front lines to ensure adequate training, Ambrose says.

Training should address the distinct payment standards for each program, he explains.

"Inadequate training often is the catalyst for case managers to cause unnecessary costs to funders, which leads to fraud, waste, or abuse issues," Ambrose says.

In addition to compliance training, effective compliance programs require a robust monitoring and auditing effort.

"An effective compliance program is one that will enable all staff to become the eyes and ears of the company," Ambrose says.

"Ideally, monitoring and auditing efforts will take place prior to claims reaching the funder," he adds.

Proactive measures, like monitoring/auditing, enable the case management organization to resolve issues before claims are submitted.

"In my experience, fraud, waste, and abuse training that simplifies the legalese for staff is engaging," Ambrose says.

Training can be provided in a way that is exactly relevant to how an organization does business, he says.

Fee-for-service payment case management programs typically are more vulnerable to compliance concerns than other payment models, such as grants, capitated care, population health, and bundled payments.

These other funding models generally involve a set payment that covers all the work they do in caring for patients versus the fee-for-service model, which results in multiple claims per day, per case manager.

While accurate billing is vital, accurate documentation is equally important to prevent False Claims violations, Ambrose says.

Documentation of case management services must demonstrate that the claims meet the funder's payment standards. If they don't, they can lead to an overpayment and cause a fraud, waste, or abuse concern. ■

Dedicated Case Managers Can Improve ED Efficiency

There are more than 136 million ED visits in the United States each year, and about 12 million of these result in a hospital admission. The average is 43.3 visits per 100 persons, according to data from the CDC's FastStats. *(Data can be viewed at: http://bit.ly/2Ce3rgK.)*

Research suggests that as many as one in four ED visits were unnecessary. Those patients could have been treated at a doctor's office or some other site. These unnecessary visits cost the U.S. healthcare system about $4.4 billion each year, according to 2010 data from the Department of Health and Human Services. *(Read more at: http://bit.ly/2QWMOyy.)*

Hospitals can help eliminate ED inefficiency with targeted case management programs that have the goal of getting people into the right level of care at the right location, says **Diana Cokingtin**, MD, medical director, customer service, in Change Healthcare in Nashville, TN.

"Case managers need to be in the emergency department," Cokingtin says. "They don't need to be down the hall or two floors up."

ED case managers can ensure there are nursing homes and behavioral health facilities that will accept patients around the clock for smooth patient transitions.

"We think putting case managers in the emergency department assists hospitals in multiple ways," she says. "It's difficult to have case managers in the ED 24/7, but it's ideal."

If a hospital cannot staff around-the-clock case management in the ED, another strategy is to create an on-call system so ED staff can contact a case manager at midnight or early in the morning as needed, she adds.

Change Healthcare conducted a study of 1,300 hospitals and found that 65% use case managers in their EDs. *(http://bit.ly/2CdSCv9)*

"Almost 60% said it ensured they would get the right level of care for patients, and one-third said it ensured the right admissions," Cokingtin says.

"Another 11% reported it improved documentation," she adds. "All of these things tell us that having case managers in the emergency department helps reduce denials from insurance companies."

For instance, the ED case manager can ask physicians questions as they write out orders.

"They can say, 'You said he failed physical therapy. How did he fail physical therapy? Did he take his meds? Is he getting worse?'" she explains. "Case managers can make sure physicians fill out all of the information that meets the criteria and can teach them proper documentation."

"Upstreamists" in healthcare are the people who look for the root causes of problems and seek to achieve the triple aim of better care, lower total medical costs, and increased patient satisfaction.

"I heard a talk from someone who said he was an upstreamist, and he felt it was important to learn why patients show up in the emergency department," Cokingtin says.

In some EDs, the solution is to place a case management team in the ED that includes social workers, pharmacists, and even legal help. Even if the team consists solely of case managers, it can be helpful, she says.

"When you have case managers in the ED, they can help you develop relationships and contracts with other facilities — rehab, substance use, etc.," she explains. "Then patients can go right there once the contracts are in place."

For example, an ED patient might be ready for discharge home but need durable medical equipment (DME). If case managers are working in the ED, they could have established a DME contract, making care transition easier, Cokingtin says.

Case managers can facilitate better transfers and transitions by working with a physician advocate in the ED.

"The other big thing is documentation, which is the number one reason why claims are denied by insurance companies," she says. "If it's not written down, then the insurance company cannot see that it meets medical criteria."

EXECUTIVE SUMMARY

EDs in the United States handle 136 million visits each year, and as many as one in four of these visits are unnecessary, according to U.S. Department of Health and Human Services (HHS) data.

- About 12 million ED visits result in hospitalization.
- Hospitals can reduce unnecessary visits by placing case managers in the ED.
- The goal is to eliminate ED inefficiency through targeted case management programs that are designed to get patients into the right level of care at the right location.

ED case managers help doctors learn to improve documentation, she adds.

Best practices strategies can improve efficiency in the ED and throughout the care transitions. Here are several best practice solutions:

• **Build relationships.** There's a tendency for hospital staff and payer staff to blame each other for payment problems. Collaboration is a solution, Cokingtin says.

"Collaboration and having a relationship solves problems," she says.

Case managers can start the collaboration by listing patients who are ED frequent fliers, who usually are admitted, and who will likely see their claims denied, she explains.

The next step is to determine the payers for each person on the list. Then they contact those insurance companies' case managers, Cokingtin says.

"They say, 'These patients are a problem for insurance companies and hospitals and emergency departments, so let's solve it together,'" she says. "Insurance company case managers know these patients, and they can help them meet their needs from a health side so that, hopefully, they won't come in as often."

Cokingtin describes an example of the collaboration in action: "We had a case of a patient who came in every Sunday, usually late at night," she says. "The patient was admitted for heart failure that was getting worse. I told our case manager that we needed to figure out this problem and talk with the patient."

The case manager sat down with the patient and reviewed everything the patient had done that week. The patient talked about buying pig's feet and slow-cooking them from Friday to Sunday. On Sunday, the patient would eat the pig's feet — causing a flare-up of the patient's heart disease because pig's feet are so salty, Cokingtin explains.

To find a solution to this pattern, the hospital's case manager contacted the insurance company's case manager. Together they came up with a simple remedy: Instruct the patient to take an extra dose of medication and bring the IV meds home, she says.

"Then we contacted another hospital the patient often goes to and spoke with people in their emergency department, telling them the whole story and asking them to give the patient an IV medication if the patient shows up," Cokingtin says.

"We went upstream to find out what was making the patient's heart failure worse. We were being detectives, and it's important that we do this," she adds. "That's what you can do with frequent flier patients."

• **Assess denials.** Identify physicians who receive the most denials and find out why, Cokingtin suggests.

Often, there is one physician who receives the most denials. The likely causes are documentation or not managing patients' expectations, she says.

For example, one physician's practice had a high number of patients sent to the hospital without proper documentation of the reasons. Insurance companies were denying the claims because they didn't meet criteria, Cokingtin says.

The solution was to have the hospital's physician advisor review the medical notes, speak with insurers, provide more information, and serve as a liaison about the cases where patients were admitted without adequate documentation, she says.

It was a shared problem, and the insurer and hospital worked together to solve it. "Relationships are so important," she adds.

• **Prevent denials.** It can be difficult and frustrating, but hospital staff — including case managers — should discuss cases in which episodes of care might be denied and call payers about them, Cokingtin says.

"It's nerve-wracking at first when you're going in there but haven't talked with those people before," she says. "But before the denials come in, call some medical director and payer and say, 'Here's a unique situation with this patient.' You can work it out before the denial occurs."

Putting case managers in the ED also helps with preventing denials because case managers can develop relationships within their facility and with other service providers.

"Having case managers in the ED will make everyone's life a little easier," Cokingtin says. "Relationships will be much better for those cases." ■

Plan Ahead to Integrate Technology for Efficient Workflow

By Andrew Robinson, Relias

Not 20 years ago, industries shuddered at the threat of Jan. 1, 2000, because of a fear that computers would not be able to process the change from 1999 to 2000. Today, patients get text reminders on their mobile smartphones that they have an upcoming appointment with a provider or use telehealth apps to see and talk with their care teams without ever leaving their homes. Technology has dramatically shaped the way we live, including the delivery and provision of healthcare.

Technological innovations have brought significant gains to healthcare — and few patients or providers would roll the scroll back to 1999. However, healthcare organizations and case managers have room for improvement in how they integrate technology into their workflows.

From electronic medical records (EMRs) to electronic medical devices and clinical decision support tools, healthcare workers and providers are engaging in an increasing number of activities to deliver care.

Besides new tools, recent research indicates the amount of medical knowledge available continues to increase dramatically and is projected to double every 73 days by 2020.[1]

The increasing level of burnout for providers is cause for concern, and one factor many healthcare providers cite is the rise of mandatory EMR systems. However, EMRs are powerful tools that can yield the following benefits:

- improve patient safety through clinical decision support;
- provide easier access to clinical data;
- allow providers to easily interact with other hospitals, clinics, labs, and pharmacies;
- promote complete documentation and accurate coding.

Providers' complaints around EMR use often center around difficulty of use and their ability to distract from the patient-provider interaction.

There are ways to mitigate these drawbacks, including using a virtual assistant or a scribe to transpose the provider's comments from an appointment or building time into the workday for providers to enter data into the EMR.

Considering how the new technology will affect existing workflows is important, as noted in a Relias whitepaper.[2] When making a change in a healthcare facility's technology, leaders need to ensure ease of use and plan the adoption strategy carefully. Weighing the impact on case managers, providers, and the rest of the care team should be part of the initial discussion.

Because the goal of technology is to improve outcomes for all, an optimal solution requires minimal learning and offers efficiencies over existing workflows to reduce cognitive load. ■

REFERENCE

1. Densen, P. Challenges and opportunities facing medical education. *Trans Am Clin Climatol Assoc* 2011; 122:48–58.
2. Relias. *Overworking Your Working Memory: The Effect of Cognitive Load on Patient Care*. Available at: https://bit.ly/2QGvBKo.

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.

COMING IN FUTURE MONTHS

- Hospital discharge process helps prevent rehospitalization
- What's going on with Two-Midnight Rule?
- Best practices in bringing case managers into ED
- What do case managers need to know about new OPPS rules?

HOSPITAL
CASE MANAGEMENT

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CE QUESTIONS

1. **Which of the following is not a quality priority listed in the 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule?**
   a. Making care safer by reducing harm caused in the delivery of care
   b. Ensuring reimbursement of hospital services includes every code at the greatest allowable reimbursement rate
   c. Strengthening person and family engagement in care, such as personalized care, aligned with patient goals
   d. Promoting effective communication and coordination of care, including medication management

2. **Some hospitals are separating case management into different jobs and responsibilities. Which of the following is a role that might be part of case management but can be separated from other current tasks?**
   a. Utilization management
   b. Transitional care coordination
   c. Primary care coordinator
   d. All of the above

3. **Whistleblowers can report to the federal government suspected false claim information. If the government launches an investigation and succeeds in recouping Medicare funds, the whistleblower could be awarded up to what percent of the money collected by the government?**
   a. 10%
   b. 15%
   c. 25%
   d. 30%

4. **What is an upstreamist in healthcare?**
   a. A person who looks for the root causes of problems and seeks to achieve the triple aim.
   b. A decision-maker at the top level of the healthcare organization
   c. A liaison between a hospital and pharmacy who makes sure medication reconciliation takes place
   d. None of the above