HOSPITAL CASE MANAGEMENT™

The monthly update on hospital-based care planning

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Taking care of hospitalized patients also means taking care of business

Be aware of financial implications for patients, facility

As a case manager, your job involves being an advocate for your patients as well as keeping your hospital's best interest in mind. That means you need to be informed about the financial aspects of patient care.

"The things we do, the decisions we make, and how we interact with patients all are tied to the financial health of the patients as well as to the hospital's bottom line," says **Charleeda Redman**, RN, MSN, ACM, executive director of corporate care management for the University of Pittsburgh Medical Center. "Doing what is right for the patient is the most important reason why care managers need to understand the business side of healthcare."

Clinical decisions are what drive patient care, but case managers need a basic knowledge of the contracts the hospital has with payers, the services that each will and will not pay for, each payer's requirements for ensuring medical necessity, and the financial impact of additional time

Understand the balance between business and healthcare

Clinical decisions should always guide patient care, but case managers also should keep payer requirements, coverage limits, and patient co-pays in mind as they coordinate care and develop a treatment plan. In this issue, we'll look at why case managers need to be informed about the how the hospital is paid and the implications their care plan might have for patients. We'll show you how one hospital's care management team collaborates with the contracting and business office. We'll give you tips for creative discharge planning when patients have coverage limits. We'll describe how one case management department's revenue integrity team includes nurses and follows the patient throughout the stay to ensure that the hospital will be paid appropriately. It's all in this issue of *Hospital Case Management*.

in the hospital for the patient and facility, adds **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, and partner and consultant in Case Management Concepts, a case management consulting firm based in Dallas.

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Editorial Questions

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When the Centers for Medicare and Medicaid Services (CMS) rolls out value-based purchasing, case managers also will need to understand how the hospital will be impacted financially by readmissions, by mortality, and by all the quality measures on which the hospital's payment will be based, Cunningham adds. (*For more information on the proposed value-based purchasing initiative, see* Hospital Case Management*, March, 2011, p. 33.*) **Brian Pisarsky**, RN, MHA, ACM, CPUR, corporate director of case management at DCH Medical Center and DCH Northport Medical Center, both in Tuscaloosa, AL, says, "Case management is where the clinical and the financial aspects of healthcare meet. Case managers need to have a clinical understanding of why patients are in the hospital and what care is appropriate, but they also have to make their decisions on financial as well as clinical issues." (*For details on the case management department's revenue integrity team, see story on p. 70.*)

Case managers need to know how the hospital is paid so they can follow all the payer requirements and ensure that the hospital gets paid appropriately, Pisarsky says. "I want everyone who comes into the department to know that we talk about finances in this department. Medicare pays one way, Medicaid a different way, and commercial insurance companies pay in multiple ways," he says. "Case managers need to know the difference in order to do their work effectively and efficiently."

Case managers can't develop an appropriate plan for patient care without taking the insurance benefits into consideration, Redman points out.

EXECUTIVE SUMMARY

To be an advocate for their patients and keep their hospital's best interest in mind, case managers should be informed about the financial aspects of patient care. Clinical decisions should always guide patient care, but payer requirements and coverage limits are also important.

- Know how the hospital is paid, and understand payer requirements for reimbursement.
- Keep patients' benefits and lifetime limits in mind when developing a discharge plan.
- Ensure that patients get the care they need to avoid unnecessary time in the hospital.
- Keep up with Medicare's and other payers' changes in terms of what they will and won't approve.

For example, Medicare patients don't have the same co-pays for observation services as they do for an inpatient admission. The same situation is true of many patients with commercial insurance, Redman points out. "We no longer can take it for granted that patients have certain benefits," she says. "Companies are changing their employee benefits every year. Patients who had a skilled nursing benefit may no longer have it, or they may have a limited benefit. Care managers need to know what each individual patient's benefits are."

Don't make any assumptions that because patients are employed by the same company and have the same insurance, they have the same benefits, Redman says. "During open enrollment, companies offer employees a variety of packages," she says. "The benefit structure is different depending on what the employee selects." (*For tips on tailoring a discharge plan around a patient's benefits, see story on p. 68.*)

At the University of Pittsburgh Medical Center, care managers work closely with the patient access department to find out the specifics of the benefits for their patients as they develop the patient's discharge plan. "One person can't know everything about every patient's benefits, but we have the resources available so the care managers can get the knowledge they need and plan appropriately," Redman says. (*For details on how care management and finance collaborate, see story on p. 69.*)

At Medical City Dallas, a multidisciplinary team meets twice a week and reviews the cases of high dollar patients and those who are unfunded or underfunded. The team has noticed an increasing number of patients whose insurance has an unlimited lifetime maximum but an annual maximum of $100,000 for inpatient care. Cunningham tells of one patient who needs a transplant, but her insurance policy has a $100,000 limit on transplants, which is a figure that won't cover the cost of the transplant or the cost of the post-transplant care. "It's very important for case managers to understand all the aspects of their patients' benefit plans," she says. "We need to look beyond what their patients need during the current episode of care and be a good steward of their benefits to ensure that they will have coverage for post-acute care. This is very important for patients with complex disease processes or procedures, such as transplants or ventricular assist devices."

Case managers need to understand the implications for the patient and the hospital if patients experience delays in service that result in a longer length of stay, Cunningham adds. Delays in service not only may affect the hospital's reimbursement, but they also could create a financial burden for patients. Most patients, whether they have commercial insurance or are covered by a government plan, have a financial limit or a benefit allowance, and many will have to pay a percentage of the hospital charges, Cunningham points out. For example, consider the example of a patient who is supposed to fast before a procedure, but he receives his lunch tray and eats the meal. He has to stay in the hospital another day. Also, if members of the radiology staff are so busy that they bump a patient and nobody intercedes, it increases the length of stay and has the potential to impact the patient and the hospital financially, Cunningham adds. Another example is when family members delay the discharge because plans haven't been made for a post-acute facility. They need to understand that they are using up the patient's benefits, Cunningham says.

"If patients don't progress through the continuum in a timely manner, we're not being good stewards of their resources," Cunningham says. "There is a responsibility to be a good steward of patients' resources among the entire treatment team, but the coordination falls back on the case manager."

When patients stay in the hospital longer than necessary, there's no added value, she says. In addition to being a financial issue for the patient and the hospital, the longer stay becomes a patient safety issue as well, Cunningham says. Patients have an increased chance of experiencing a fall or getting sick from a hospital-acquired disease, she explains.

Case managers also need know the hospital's cost-per-case and be aware of the overall cost of care. This information enables them, for example, to work with physicians in choosing less expensive but still appropriate medications for the patients. Cunningham and a hospital pharmacist meet with the hospitalist team every month and talk about the cost of various medications. "We ask them to consider other more cost-effective medicines if they will work as well as the more expensive medications," she says.

As CMS and commercial payers make changes in documentation requirements and medical necessity criteria for procedures, case managers need to stay up to date, Cunningham says. For example, Medicare has made the medical necessity criteria more stringent for four procedures: carotid stents, implanted defibrillators, bariatric surgery, and certain types of pacemakers. "Patients

having these procedures have to meet certain criteria or Medicare will deny payment for them," Cunningham says. "This means the documentation has to be in place before the procedure is performed and it has to translate into an ICD-9 code. In the past, patients never had to meet criteria for these procedures. They had them and CMS paid for them. Now case managers need to have a good relationship with the physicians and work with them when they order these procedures."

As she consults with hospitals, Cunningham has observed that case managers don't always give out the Hospital Issued Notice of Non-Coverage (HINN) when a patient is receiving a test or procedure that is unrelated to the reason for which he or she was hospitalized. For example, a patient is admitted with pneumonia, and the family requests a CT scan of the abdomen to determine whether his cancer is progressing. If a procedure for a Medicare patient isn't related to the reason for admission, it rolls into the Medicare Severity-Diagnosis Related Group (MS-DRG) and the hospital's costs for the patient stay go up. If a procedure requested by the family isn't related to the hospitalization, case managers should inform the family that they are responsible for paying for it and should offer them the option of having the procedure as an outpatient, she says. ■

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Ensure patients' needs are met after discharge

Look for affordable alternatives

When case managers develop a discharge plan, they should take the financial implications for the patients into consideration and look for options that the patients can afford, says **Brian Pisarsky**, RN, MHA, ACM, CPUR, corporate director of case management DCH Medical Center and DCH Northport Medical Center, both in Tuscaloosa, AL.

Case managers need to understand what every patient's plan covers and doesn't cover and what co-payments or deductibles the patient might have to make. If the patients don't have coverage for the post-acute care or can't afford the co-pay, they are at risk for emergency department visits and readmissions, Pisarsky adds.

At his hospitals, case managers work with the insurance companies, community agencies, and other organizations to come up with alternatives when patients can't afford what they need after discharge. For example, if patients need medication after discharge and don't have coverage or they are in the Medicare Part D donut hole, the case manager might be able to set them up for medication assistance through a pharmaceutical company. If the patient's insurer won't pay for a certain medication or it is not on their formulary, the case manager works with the physician to determine if a different medication or generic brand that is covered by insurance would be as effective.

Sometimes patients don't have home health or nursing home coverage and they are too sick to go home, but they don't qualify for inpatient rehabilitation. In those cases, the case manager can contact the insurance company and ask if there is a way to flex benefits so the patient can receive rehabilitation services in a skilled nursing facility. "It costs less to send a patient to a nursing home than to keep them in the hospital, or pay for multiple hospitalizations or emergency room visits," Pisarsky points out.

Sometimes, if all else fails, the case managers can arrange for the patient to receive additional physical therapy and other services while they are in the hospital. Their family members can attend

EXECUTIVE SUMMARY

Understand patients' benefits, and create a discharge plan based on co-pays they can afford.
- Consider medication assistance or asking for cheaper alternatives if their prescriptions aren't covered.
- Look for alternatives to home health if patients don't have that benefit.
- Work with insurance companies to flex benefits.

the sessions so they can continue them at home. "Most of the time when they encounter difficult discharges, case managers talk to the insurance company case manager to work out arrangements," he says. "There's no cookie-cutter process for this because patients don't have the same benefit or needs after discharge, but there are creative ways to get patients what they need after discharge. We need to think outside the box." ■

Work closely with the business office

Frontline CMs see issues that affect bottom line

As executive director of corporate care management for the University of Pittsburgh Medical Center, **Charleeda Redman**, RN, MSN, ACM, takes an active role in contracting and business issues. Redman is the liaison between care management and the integrated health system's contracting department and represents care management at the biweekly meetings of the chief financial officers of the system's 20 acute care hospitals.

"What care managers encounter in our day-to-day duties drives what our hospitals need to do to stay competitive," she says. "We track payer issues on a day-to-day basis and report any trends to the contracting department."

Redman meets regularly with the contracting department to report any issues with payers that arise in the care management department. She works with the department to ensure that the hospital is being paid in the way the contract is written and to point out any problems that could be avoided when the contract is renegotiated. For example, the team analyzes day-to-day concurrent denials and how they are tied to the way payer contracts are structured, then uses that information when contracts are renegotiated.

"In our health system, care management collaborates with the contracting department to ensure that contracts with payers are managed appropriately. As care managers, we see the payer issues first-hand, and I relay the information to the contracting department," she says. "Our goal is to ensure that we are paid appropriately and to avoid any issues in which payers do not act in accordance with their contract." For example, some payers tend to micromanage patient care on a day-by-day basis when their contract is structured a different way. Redman relays the information to the members of the contracting department, who discuss the situation with the payer and use the information when renegotiating a contract.

Some payers have contracts to pay on a per diem basis and spend a significant amount of time on day-to-day management and micromanagement of the patient care. "This is overwhelming to the care managers who work with the payers," Redman says. "Our contracting department will approach the payer and suggest that a case rate might be a more appropriate type of payment."

When contracts are being negotiated or renegotiated, members of the contracting department rely on input from the care management department to ensure that the contracts are not unduly restrictive to the hospitals' ability to manage patients' care, she says. "I have an opportunity to see many of the contracts they negotiate to understand how the payers are held accountable," Redman says.

She is notified when any contract or payer changes come through contracting or the business office, and Redman shares the information with the care management directors of each hospital. The frontline case managers in each hospital are educated on how contracts are negotiated and given the basics of each contract.

When Redman meets with the chief financial officers for each hospital, she updates them on payer trends. "We look at how level of care determinations and other issues impact revenue and how process changes and new payer requirements affect the hospital's bottom line," she says.

Any time there are changes in the medical

EXECUTIVE SUMMARY

At the University of Pittsburgh Medical Center, members of the case management department work closely with the contracting and business department by pointing out payer issues and keeping the chief financial officer informed about payer requirements that could affect reimbursement.
- Case managers track payer issues on a day-to-day basis and report trends to the contracting department.
- Contracting staff obtain input from members of the case management department when negotiating or renegotiating contracts.
- Changes in payer contracts are communicated to the case management staff.

necessity criteria set, Redman brings it back to the revenue cycle team so they can conduct an analysis of how it will impact the hospitals, she says. For example, when InterQual moved some inpatient procedures to its list of procedures that are appropriate only on an outpatient basis, Redman notified members of the revenue cycle team. They determined how the change was going to affect admissions and what it would mean to the organization. ■

Revenue integrity team follows the patient stay

CM department ensures reimbursement

At DCH Regional Medical Center and DCH Northport Medical Center, both in Tuscaloosa, AL, the case management department includes a revenue integrity team that reviews the patient record through the entire stay until the final, correct payment has been posted and verifies that the hospital is being paid appropriately.

The revenue integrity team includes three nurses and four business office patient financial service experts who know how claims get paid and how to work with insurance companies. The team, which is part of the case management department, analyzes underpayments and denials to determine if the hospital was paid for services that were precertified. They determine the best way for the hospital to get paid, whether it's by reviewing the case with the insurance company, correcting the coding, or appealing it.

"We know from the time of admission through the final payment what we need to be paid," says **Brian Pisarsky**, RN, MHA, ACM, CPUR, corporate director of case management services. "We look at every case to determine if the patient got the services he or she needed, and that we are being paid exactly for the services the patient needed and received and not one dime less."

The case management department begins following patients before admission and follows them throughout the stay, Pisarsky says. The pre-certification case manager makes sure the patient's stay is precertified and that all pertinent information is in the record. The emergency department (ED) case manager follows patients coming in through the ED until they are in a bed. The department includes utilization review nurses who interact daily with case managers and social workers.

Throughout the stay, case managers enter all patient reviews and approvals into the software, which allows the revenue integrity team to track the patient throughout the stay. "We attempt to cross every 'T' and dot every 'I' from pre-admission through discharge to make sure we will be paid appropriately and the patient gets the world-class care they deserve," Pisarsky says. "It takes the entire team."

If it appears that the hospital is not paid appropriately for a claim, the software system has documentation to show whether the patient's admission was precertified in the right amount of time and if the insurance company was called to approve services the patient received. "If our records show that we got everything approved in a timely manner and the hospital isn't being paid what we contracted to be paid, we appeal," Pisarsky says.

If there is a pattern of behavior on the part of the insurance company, the team works closely with the contracting department to ensure that the hospital gets paid appropriately. For example, one insurer specified InterQual for medical necessity, and then hired a third-party company to review admissions and verify that the precertification was correct. The third-party auditors didn't follow InterQual criteria and erroneously denied some of the cases that met medical necessity. "We reviewed the cases and determined that they did meet InterQual medical necessity criteria, and then contacted the insurance company," Pisarsky says. "We would have lost tens of thousands of dollars on each case if we hadn't been watching."

The revenue integrity team reviews random

(Continued on page 75)

EXECUTIVE SUMMARY

At DCH Regional Medical Center and DCH Northport Medical Center, both in Tuscaloosa, AL, nurses and financial service experts comprise the revenue integrity team in the case management department. The team reviews the patient record through the entire stay to make sure everything is in place for the hospital to be paid appropriately.
- Members of the team analyze underpayments and denials to determine if an appeal is in order.
- They look for patterns of denials and decide what action to take to correct them.
- The team audits every case manager and social worker each month to determine whether he or she is documenting correctly and completely.

CASE MANAGEMENT INSIDER
Case manager to case manager

Follow these sure-fire tips to sort through data and measure outcomes in your department

Use step-by-step instructions, and demonstrate your value to administration

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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[Editor's note: This is the second part of a multi-part series on demonstrating the value of case management to your organization. Last month, we discussed the vast array of financial and clinical outcome measures to evaluate the effectiveness of your department as well as to demonstrate its impact on the bottom line of the organization. This month, we discuss the tremendous amount of data that can be collected and used for performance improvement, within the department and across the institution. Next month, examples of case management report cards will show how to present this data in a usable format.]

The process for setting up your outcome measures requires careful thought and consideration. Consider the purpose and use for the outcomes you are selecting. Some example of these purposes and uses are:

- for internal evaluation of the department;
- for internal evaluation of specific employees;
- for communication to senior management;
- for communication to the organization;
- to justify staffing or the addition of staffing;
- ad hoc reporting and specific requests.

Once the department has selected its outcome measures, you should identify the benchmarks that correlate to those outcomes. You then can measure the department's outcomes against these benchmarks.

Benchmarks are standard measures against which you can evaluate your own outcomes. Each outcome should also have a timeframe associated with it. Some outcomes might need to be measured monthly; some might need to be quarterly. The decision as to the frequency of measurement should be based on the sensitivity of the measure. Sensitivity has to do with how frequently the measure changes and to what degree. If you are unsure as to how often you might want to report a specific measure, you might want to discuss it with your finance or decision support staff. You can change it later if needed.

National benchmarks can be found in many publications and organizations including The Joint Commission, the Centers for Medicare and Medicaid Services (CMS), the Healthcare Financial Management Association's (HFMA's) publications, and your own state's quality and financial indicators. *(See graphic, below.)* When possible, update your benchmarks as the literature changes so that you remain as current as possible.

Financial Benchmarks

Length of Stay	Medicare Medicaid Managed Care Regional Case — Type Specific Physician
Average Cost per Day/Case	National Rates Hospital-Specific Based on Direct Costs Such as Lab, Radiology, or Pharmacy
One-Day Stay Patients	Identify Types Appropriateness of Admission

Case management financial benchmarks

As discussed in part one of this series, the most common financial outcome measures include third-party payer denials, length of stay (LOS), average cost per day/case, and one-day LOS patients.

When reporting on third-party payer denials, denial rates can be reported in several ways. The denials should be reported in days and cases. By reporting in days, the hospital can determine the impact of these non-reimbursed days on capacity management and throughput. Cases are also important, as Medicare, Medicaid, and many managed care contracts are paid on a case-rate basis. Case reporting is easier to correlate to actual dollars lost.

Finally, the denials should be reported as a percentage of patient days. This metric places the denials in a more accurate competitive basis as it demonstrates the loss to the bottom line in terms of patient days in which care was rendered. If 4% of patient days were denied, then the hospital knows that 4% of the care provided was not paid for. This is more accurate a measure than just saying that 100 days were denied or 30 cases were denied, because these numbers don't provide a context or correlation with the overall performance of the hospital.

In addition to final denials, you also will want to report denials recovered on appeal and the number of appeals written. These are indictors of the performance of your department in the appeal recover process and can be translated to actual dollars, which is always a helpful benchmark. (*See graphic, above right.*) Examples of clinical denials would include admission denials, continued stay, and any other reasons that fall into the medical necessity category. Technical or administrative denials are non-clinical and typically relate to denials associated with the hospital not meeting its contractual obligation to the third-party payer. Examples of these denials would include clinical information not provided, medical record not provided, and billing errors.

Additional financial benchmarks

LOS is one of the earliest and most traditional outcome measures used in case management. It still is considered one of the most important tracking tools, and it is used as one of the baseline indicators for virtually all case management departments.

Denial/Appeal/Recovery Benchmarks

Denial/Recovery Rates	Benchmarks
Overall Denial Rate	< 4% of Patient Days
Clinical Denial Rate	< 5% of Patient Days
Technical Denial Rate	< 3% of Patient Days
Appeals overturned Rate	40-60% of Submitted Appeals

Source: Healthcare Financial Management Association, 2005.

While it is a common indicator, there remains a lot of variation in terms of how it is categorized and monitored. Even if your hospital's LOS is within your expected benchmark, there still might be some opportunity within a specific diagnosis, DRG, or physician practice. Therefore, monitoring indicators for LOS might need to be more specific than they might have been in the past. Consider any of the following categories when monitoring your LOS:

- by diagnosis related group (DRG);
- by payer;
- by ICD-9 code;
- by service line;
- by physician.

When looking at DRG or payer benchmarks, the LOS targets should be adjusted according to the indicator. Different payers will and should have different LOS targets. For example, Medicare's LOS targets likely will be longer than the targets for commercial managed care, and Medicaid might be somewhere between the two. Your state should be able to provide you with benchmarks for your state's DRGs, if used in your state.

When looking at LOS by DRG, remember that DRGs are heterogeneous and contain a variety of diagnoses within any one DRG, which might have different LOS targets. This information is important to know because any corrective actions aimed at reducing the LOS will need to address the specific causes of the increased LOS in that particular DRG.

Service line measures also are important because your targets for surgery, medicine, or OB/GYN will vary considerably. Always remember that the more specific you are, the easier it will be to determine how to improve the particular benchmark. Once you have looked at your budgeted targets for medicine, for example, you then might want to determine which DRGs or diagnoses within medicine present with the most

opportunity for improvement. (*See story on case mix index, below.*) ■

Key to understanding case mix index

By **Toni Cesta**, PhD, RN, FAAN
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The case mix index (CMI) is an average of the relative weights for the hospital's diagnosis related groups (DRGs) for a given period of time.

Each hospital is assigned a base rate that determines how much the hospital will be paid per 1.0 relative weight. The base rate is based on your hospital's location, overhead costs, graduate medical education costs, indigent patients served, etc. Variation in the base rate allows for the significant swings in costs associated with different parts of the country.

The base rate is multiplied by the relative weight for the DRG, and this number determines the amount of reimbursement to the hospital for that discharge. CMI usually is monitored by the finance department. Small reductions in CMI can have a large affect on the finances of the hospital. It is an example of an extremely sensitive outcome measure. In the sample CMI analysis, right, you can see an example of the financial impact of a change of 0.1 in CMI for a sample hospital with a base rate of $4,500 per relative weight. (*See story on tracking cost avoidance, below.*) ■

Sample Case Mix Index (CMI) Analysis

- CMI FY 2009 = 1.567
- CMI FY 2010 = 1.467
- CMI Difference = 0.10
- Hospital-Specific Rate = $5,000
- Discharges = 5,000 patients
- Decrease in Reimbursement per Discharge = $450 (0.10 x $4,500)
- Reduced Reimbursement = $2,250,000 ($450 x 5,000 = $2,250,000)

CMs should track cost avoidance

By **Toni Cesta**, PhD, RN, FAAN
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Case managers (CMs) should quantify the interventions made that result in cost avoidance and length of stay (LOS) savings to the hospital. Case management departments spend time intervening on issues that would otherwise have resulted in longer stays or higher costs for specific patients. These interventions require time and expertise on the part of the department.

In this first example, the case management department prevented the admission of two patients who did not have any clinical needs, but were unable to care for themselves in the community. Had case management not intervened, they would have been inappropriately admitted to the hospital. These types of admissions are known as social admissions: patients admitted for social rather than clinical reasons. Preventing these types of admissions can be calculated as cost savings. In addition to the dollars saved, preventing these admissions helps with bed capacity and also can avoid a red flag to a recovery audit contractor (RAC).

Savings for example one: Two social admissions from the emergency department (ED) per month avoided at an average direct cost of $800/day and LOS of two days equals $38,400 per year.

In example two, the hospital paid for services needed for a patient to facilitate a discharge. Examples of such services might include air travel to the patient's country of origin, medications to be used in the community, or even a nursing home bed. The out-of-pocket costs to the hospital can be factored against the cost of keeping the patient in the hospital. Less difficult to quantify are the positive side benefits of freeing up a bed for an acute patient and the inappropriate use of resources, as well as the exposure of the patient to the acute care setting.

Savings for example two: Two patients per month with expedited discharge (up-front expense to facilitate disposition) at an average direct cost of $800/day and decrease in LOS of 2.5 days equals $48,000 per year. Remember to aggregate the cost and then delete the cost of the service provided (airfare, medications, etc.). (*See story on clinical benchmarks, p. 74, and story on service and productivity benchmarks, p. 74.*) ■

Measure benchmarks for service, productivity

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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Brooklyn, NY

Patient satisfaction benchmarks should be based on the internal expectations of the hospital and should represent an improvement over current performance. Because all hospitals measure patient satisfaction, an assessment of the questions your hospital is using is important. Check to see if the questions truly reflect the work of case management. If they do not, you may request to have specific questions added to your questionnaire.

In terms of staff and physician satisfaction measures, if the hospital does not have previous data for physician or staff satisfaction as it relates to case management's performance, then the department should monitor changes in these scores over time.

Productivity benchmarks should be generated internally for the department's specific use. These measures reflect the volume of work done. They should not be used as outcome indicators, but rather should be used as a way of tracking the volume and complexity of the work being performed. Examples of these include number of patients discharged with specific services, such as home care, sub-acute, nursing home, etc. Benchmarks must reflect an improvement in these numbers over time.

One of the most important benchmarks that every case management department should be tracking is the number of patients discharged without services. This number should be reduced over time. For example, you would like to see an increase in the number of patients referred to home care. With increased focus on reduction of readmissions and inappropriate admissions, a more stringent approach to referrals to home care can have a positive affect on these numbers. Determine your baseline and then set an improvement target from there.

The target should be to reduce the number of patients discharged without any continuing care services and increase the number of patients discharged with home care or other services. This target might indicate that the department is accessing and intervening on behalf of a greater number of patients.

Other productivity measures might include the number of clinical reviews completed by case manager. These measures can be difficult as they are driven by the payer mix, something outside the control of a case manager.

If the case managers in your department are responsible for identifying and intervening on avoidable delays, this measure might be another one to track as a productivity benchmark. Some case managers might do a better job on collecting this information than others, so this measure can be an important one in terms of how well they are identifying and correcting patient flow issues. ■

Don't forget clinical benchmarks

By **Toni Cesta**, PhD, RN, FAAN
Senior Vice President
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Brooklyn, NY

Case management crosses the clinical as well as the financial arenas; therefore outcome measures must include both categories. Some clinical outcome indicators are less tangible than financial indicators, but they are no less important. Benchmarks for these indicators should reflect national standards.

Readmission benchmarks can be included in the clinical category. Readmission benchmarks should be based on the readmission timeframe in question. While the Centers for Medicare and Medicaid Services (CMS) calculates a readmission as one occurring within 30 days, some states might calculate the readmission cut-off with a shorter time frame such as 15 days. In addition, you might want to take a look at your readmissions that are same day or next day as well, as these probably indicate a problem with the discharge plan.

Your hospital's definition of long-stay patients, another quality indicator, will be dependent on your overall average length of stay (LOS). Long-stay patients should represent those that are at least two standard deviations from your average LOS. Your finance department can help you make this calculation.

Turn-around times (TATs) are another quality indicator. These are internal benchmarks and relate to service delivery. For example, the case management department should know the expected TAT for results of a CT scan, MRI, or any diagnostic test. Time frames might be different for a preliminary versus final results. For example, if the radiology department's TAT for results reporting of an MRI is 12 hours, anything beyond that time is outside the benchmark. ■

(Continued from page 70)

cases coordinated by each case manager and social worker each month to make sure the documentation is correct and the precertification information is accurate. If there is a trend that results in denials, Pisarsky educates the entire staff. If the problem is with an individual employee, the supervisor discusses it with the employee. "Every employee is audited every month," he says. "Sometimes, particularly with new employees, they aren't sure how to input the information into the computer system. We re-educate these individuals to put the right number in the right block so our records will be accurate and complete."

DCH Health System assigns some of its utilization review nurses to work exclusively with a large health plan that has about 500 admissions a month, and the system has delegated DCH to conduct its own utilization review. "They audit us to make sure we are doing it correctly," Pisarsky says. "Even if it costs more to have individuals assigned to do their utilization review, it's worth it to avoid any potential error up front, which would cost us a lot more in the end." ■

Rule for conditions acquired at hospital

Ensure full documentation for each patient

Now that the Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule that would prohibit payment for healthcare-acquired conditions for Medicaid beneficiaries, it's more important than ever that case managers work with physicians to ensure that conditions that are present on admission are clearly documented in every patient's chart, says **Deborah Hale**, CCS, president of Administrative Consultant Services, a health care consulting firm based in Shawnee, OK. (*For information on accessing the proposed rule, see resources on p. 76.*)

The proposed rule, mandated by the Patient Protection and Affordable Care Act, would require states to develop rules to reduce provider payment for healthcare acquired conditions that would otherwise result in an increase in payment. The rule would require states, at a minimum, to use the Medicare list of hospital-acquired conditions for which providers are not paid and gives them the option to add other conditions to the list. CMS has set a target of July 1 for implementation.

"Medicaid's adoption of payment reduction for hospitals for certain hospital-acquired conditions isn't surprising given the current national focus on value-based purchasing and pay-for-performance, Hale says. Commercial payers are likely to follow suit, she adds.

Case managers can help protect the hospital's reimbursement and quality report cards with attention to adherence by developing performance improvement initiatives and ensuring that patient records have the proper documentation to help coders distinguish between the conditions that were present on admission and those that developed during the hospital stay, Hale says.

The proposed rule, when implemented, means case managers must give the same attention to documentation in the charts of Medicaid beneficiaries as they give those of Medicare patients, says **Joanna Malcolm**, RN, CCM, BSN, consulting manager of clinical advisory services for Pershing, Yoakley & Associates in Atlanta. "It's important that all documentation be standard, not matter who the payer is," Malcolm says. "All payers are moving in the direction of reducing reimbursement for hospital-acquired conditions, and that means that case managers need to make sure the physicians' documentation includes hospital-acquired conditions."

The documentation must be completed when the patient is still in the emergency department or is being admitted, she says. Case managers should work with the physicians who assess patients on admission and prompt them to document correctly so the hospital can prove that the condition was present on admission, Malcolm says.

EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule that would stop payments for hospital-acquired conditions for Medicaid beneficiaries. State Medicaid agencies would be required to use the Medicare list of hospital-acquired conditions and would have the option to add additional conditions for non-payment.

- Hospitals must carefully and completely document all conditions on the list that are present on admission.
- Case managers should work with admitting physicians to ensure that the documentation is in the chart.
- Documentation for all patients must have the same scrutiny as for Medicare patients.

Be sure that patients who are transferred from another hospital or nursing home are assessed for conditions that are present on admission, she adds. Pressure ulcers and urinary tract infections are fairly among the common among nursing home patients, Malcolm points out. "CMS has stringent requirements for documentation of pressure ulcers," she says. "Case managers have to make sure that the nurse has clearly documented the size and depth of the ulcer during the admission assessment so the hospital can get paid. If the patient is bed-bound or very elderly and the case manager doesn't see the documentation, he or she should query the nurse to ensure that the patient was assessed for pressure ulcers on admission." ■

SOURCES/RESOURCE

For more information, contact:
- **Deborah Hale**, president of Administrative Consultant Services. E-mail: dhale@acsteam.net.
- **Joanna Malcolm**, RN, CCM, BSN, Senior Consultant, Pershing, Yoakley & Associates. E-mail: JMalcolm@pyapc.com.
- The proposed rule, Medicaid Program, Payment Adjustment for Provider-Preventable Conditions Including Health Care Acquired Conditions, is available in the Feb. 17, 2011, *Federal Register* at http://healthreformgps.org/wp-content/uploads/hac.pdf.

Home monitoring cuts cardiac readmissions

Program gets patients to follow treatment plan

When Ocean Medical Center in Brick, NJ, and Meridian At Home care agency collaborated on a remote monitoring program for heart failure patients, the readmission rate for heart failure dropped from 14.93% before the program began to 4.84% in the first eight months of the pilot program.

The project received the first-ever Excellence in Quality Improvements Award from the New Jersey Hospital Association.

The program provides appropriate heart failure patients with remote monitoring devices on a temporary basis in an effort to get them in the habit of weighing themselves daily and calling the doctor when their symptoms indicate that they are experiencing exacerbations, says **Sandra Elliott**, director of consumer technology and service development at Meridian Health. A remote monitoring nurse case manager continues the education the patients received in the hospital and helps them understand what is causing their weight gain and how excess weight can impact their ability to breathe, she says. "Rapid weight gain in heart failure patients can signify water retention, which is a tell-tale sign that something is wrong with the operation of the heart," Elliott says. "This program offers great benefits to the patient. They can remain under the watchful eye of the hospital in the comfort of their own home, and the patient's health can be monitored and tracked in an extremely accurate and safe manner."

When administrators of the health system began analyzing the impact that healthcare reform would have on its hospitals, they determined that hospital readmissions are one area in which the health system is at risk for losing reimbursement. Ocean Medical Center was chosen for the pilot project because the hospital serves a large population of older retirees with chronic diseases and was experiencing a high rate of readmissions for heart failure, Elliott adds. When the heart failure readmissions prevention team reviewed the medical literature, it determined that many patients with heart failure who were readmitted were not comfortable in assessing their own symptoms, which led them to delay seeing their doctor until the symptoms were so severe that they ended up in the emergency department or were readmitted to the hospital. The team looked at available technology and explored ways to make it work financially.

"We wanted something that was easy to implement and low cost and that easily could

EXECUTIVE SUMMARY

A collaboration between Ocean Medical Center and Meridian At Home care agency in Brick, NJ, to provide remote monitoring for heart failure patients has resulted in a drop in readmissions from 14.93% before the program began to 4.84% in the first eight months of the pilot program.
- Program aims to get patients accustomed to monitoring weight gain and other symptoms.
- Hospital case managers screen patients for appropriateness for the program.
- Eligible patients receive a daily automated phone call, answer questions and record their weight on a remote monitoring device connected to the remote monitoring nurse.
- Nurses work with patients to reinforce hospital teaching and determine the causes of exacerbation.

be adapted at other hospitals in the system," she says. "I got involved because my role is to focus on everything outside the traditional health system walls to help people through technology to take care of themselves as best as possible."

Case managers at Ocean Medical Center assess their heart failure patients for eligibility in the program and work with the pilot project coordinator to educate the patients and their families about the program and enroll them. Patients who are eligible for the program must be cognitively capable of using the equipment, be able to manage at home without help, and have eyesight that enables them to read a scale. Patients who are in active treatment for other major diseases, such as cancer, are not appropriate for the program, Elliott says.

The nurse case manager in the hospital educates the patients about heart failure, the importance of monitoring their weight, ways to keep the condition under control, and signs and symptoms that indicate they should call their doctor. The nurse case manager at the home health agency continues the education after patients are enrolled in the program.

A home care agency nurse installs a comprehensive remote monitoring device in the homes of patients receiving home care. The device measures vital signs including weight and blood pressure and asks the patient questions about their health every day. Patients without home care services receive a wireless scale and a cell phone communicator, a special type of cell phone that is pre-programmed to transmit data to the home care agency computer system. They are signed up to an automatic calling system that places a call every day and asks patients key questions, such as their weight, any swelling, breathing problems, or other issues.

When patients submit answers that indicate they might be having an exacerbation, the telemonitoring nurse receives an alert. That nurse calls the patient and talks with them to find out what has been going on. "Many times, the patient just needs some additional education," Elliott says. "The nurse repeats the education the hospital case manager presented but often education at the right moment is more effective." For example, the nurse was able to identify that one patient's weight gain occurred when he ate rotisserie chicken from a particular market and wasn't aware of the high sodium content. "No booklet tells patients that rotisserie chicken has so much sodium it will adversely impact their condition," Elliott says. "The nurse takes advantage of the teachable moments."

When the remote monitoring nurse calls patients, she assesses the situation and often suggests that the patients call their physicians. The nurse might call the doctors' offices to alert the staff to expect the calls, but has the patients make the calls themselves so they'll become accustomed to taking charge of their own healthcare, Elliott says.

Patients who do not receive home care services stay in the remote monitoring program for a minimum of 30 days and have the option of continuing the monitoring for an additional 60 days at no charge. Patients who are receiving home care services are switched to the wireless scale and cell phone communicator monitor when their home care visits are completed.

The organization is analyzing whether making daily automated phone calls without providing the wireless scale and cell phone communication is as effective as the combination of the phone calls and the technology. The calls cost less than 10 cents a day, compared to $600 for the wireless scale and cell phone communicator, Elliott points out. "The purpose of this program is to get patients accustomed to monitoring their weight and symptoms so they know when to see the doctor and avoid emergency department visits and hospitalizations," she says. "It takes about three weeks of monitoring to change behavior. When we identify the most cost efficient ways to help patients avoid rehospitalization, we plan to roll the program out to other hospitals." ■

ACCESS MANAGEMENT
QUARTERLY

Surge in underinsured, self-pay? Use these tips

The utilization of services by self-pay patients has increased by 6.9% over the last fiscal year at St. Joseph's Hospital and Candler Hospital, both in Savannah, GA, says **Susan M. Younggreen**, director of patient financial services.

As a result, Younggreen says that members of the patient access staff recently have become more proactive about informing patients on how they can receive help with their bills.

Registrars refer patients to the hospital's financial counselors and/or the Medicaid eligibility vendor, inform them of prompt-pay and self-pay discounts, and provide financial assistance applications with

instructions, says Younggreen. "This is really not a new role for the patient registrars," says Younggreen. "They are just providing more information than before, and are doing so without being asked."

Access staff have done point-of-service collections for inpatients, same-day-surgery, imaging, and ED patients for about four years, says Younggreen, but over the past two years, collections have been slowly decreasing. "We are currently in the process of implementing an initiative to increase collections," she reports. "We have identified the most successful collectors and are having them coach the others."

The coaches do some role-playing, which gets less experienced staff more comfortable with collecting from patients, says Younggreen. "We are emphasizing that customer service and respect for the patient is more important than collections," she adds. "This was just initiated at the beginning of the year. We have no results yet, but we are optimistic."

While the hospital's financial counselors are a part of patient accounts, these individuals work closely with the registrars, notes Younggreen. In November 2010, the hospital revised its financial assistance process, which included a 65% self-pay discount for uninsured patients, she adds. "We increased the visibility of our financial assistance program on our web site, as well," says Younggreen.

Patient satisfaction is always a priority, says Younggreen, so staff members attempt to address any concerns the patient has about his or her bill as soon as possible in the patient experience. "This may be at pre-registration time or the day of the visit," she says.

The coaches offer refresher sessions to the registrars, which review the different methods of financial assistance, says Younggreen. "We provided scripting for the registrars to use when offering the financial assistance application," she adds. "The scripting was designed to put the patient at ease. We offer assistance in a way that is not embarrassing."

Major changes made

The hospital's financial assistance program was already "fairly liberal," according to Younggreen.

"We use a sliding-fee scale. Anyone applying who makes 250% or less of the poverty guidelines qualifies for a 100% write-off of their balance, even including the deductibles and copayments after insurance," she reports.

A person making up to 500% of the poverty guidelines could qualify for a percentage discount ranging from 15% to 90% of the balance, depending upon income and the size of the bill, adds Younggreen.

The sliding-fee scale also changed, so the least amount of discount a patient without insurance now receives is 65%, says Younggreen. "In November 2010, our charity write-offs were 21% over budget, but we were still running 4% less than last year," she reports. "The full impact of the change has yet to be determined."

New access roles

Lee Anna Mull, patient access manager at Mission Hospitals in Asheville, NC, says, "We have seen a steady increase in self-pay/underinsured patients in the past two years." Managers recently created a financial counselor position to focus solely on the inpatient "self-pay" patient, due to greater volumes of these patients.

"Currently, we have someone on site that gets a report each day on the self-pay patients," says Mull. Staff screen these patients to see if they have insurance that was possibly not entered into the system, or if a patient might be eligible for vocational rehabilitation or Medicaid, explains Mull. "If the patient is a true self-pay, a financial counselor will visit the patient's room and complete a charity care application," says Mull.

In the emergency department, financial counselors meet with self-pay and underinsured patients at the time of their visit, adds Mull. "They meet with any patient who needs financial assistance or has an outstanding balance," she says. "We are hoping to reduce the amount of uncollected dollars in A/R."

"We have many options for self-pay patients expecting a large balance," says Mull. "We are able to offer the patient a prompt-pay discount. We can assist them with an affordable, interest-free monthly payment plan."

The patient can apply for a charity care discount based on federal poverty guidelines, household size, and income. Staff offer a catastrophic discount for balances of $10,000 or greater, if the patient is incurring large hospital bills.

"Financial counselors actively pursue collection efforts on bad debt accounts that have been placed with a collection agency," says Mull. "Accounts are placed with an agency, if all attempts to work with the patient have been exhausted."

These steps are taken before an account goes to collection, says Mull:

1. The patient receives a series of monthly billing statements requesting payment in full.

"Those with insurance do not get a statement until after their insurance has paid," Mull notes.

2. Patients receive a past-due statement if they do not respond.

A collection representative might place a call to the patient and offer a payment arrangement or a discount for payment in full, says Mull. "They also take financial assistance applications for charity care consideration over the phone with the patient," she says.

3. Patients receive a final notice statement prior to their account being placed with a collection agency.

"Ample time is given for the patient to settle their account balance before moving it to an agency," says Mull. ■

Don't let staff settle for misleading copay data

If some particularly dismal copay collection data came to your attention, chances are you'd want to scrutinize it carefully before presenting this to senior leaders.

At Cincinnati (OH) Children's Hospital Medical Center, the patient access and outpatient preregistration department is working with the hospital's Information Services (IS) department to automate its co-pay auditing processes, says **Michelle C. Gray**, MHA, director. "Technology, in general, has helped us work smarter," says Gray. "We are constantly stretching our imagination and working collaboratively with our IS department to get the best results from our systems."

With the new co-pay auditing process, Gray expects to see increased copay collection rates and the ability to provide more accurate co-pay collection rates to senior level executives.

Although outpatient areas are considered to be centralized registration, there also are some decentralized registration areas, notes Gray. "In the centralized areas, we have always audited copays," she says.

In 2010, one of the decentralized areas presented its copay percentage during a presentation to senior leadership. "It wasn't very high, and so, our new CEO/president wasn't very happy with that. They knew we could do better," Gray recalls. "What came out of this meeting was an intense, hospitalwide focus on copay collection."

The presentation "kind of lit a fire under all of us," says Gray. "Before, it was an area that really wasn't discussed. It became a topic that was on everybody's top list to look at and do a better job at."

Patient access leaders were skeptical about the accuracy of the department's copay data, because it seemed low compared to what was being collected in centralized registration areas, Gray reports. Those areas audited copays daily, she says.

"Our numbers weren't close to theirs at all. We started to question, just how accurate is this data?" says Gray. "Our copay collection rate was being rolled into everyone else's."

Gray and her colleagues set out to work with the department that generated the original report to develop a more accurate copay report to distribute to senior level executives. An auditing tool was developed that every registration department could use, Gray says. ■

CNE OBJECTIVES

After reading each issue of Hospital Case Management, the nurse will be able to do the following:

- identify the particular clinical, administrative or regulatory issues related to the profession of case management
- describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the health care industry at large
- discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

■ The latest on where the RACs are focusing

■ Why documentation assurance is more important than ever

■ Extending case management beyond the hospital walls

■ How your peers are working to reduce readmissions

CNE questions

17. A multidisciplinary team that reviews high cost cases at Medical City Dallas Hospital has found that although patients do not have a lifetime maximum on their insurance, they might have an annual limit of how much?
A. $1 million
B. $500,000
C. $250,000
D. $100,000

18. Charleeda Redman, RN, MSN, ACM executive director of corporate care management for the University of Pittsburgh Medical Center, acts as the care management department's liaison with what health system entities?
A. The contracting department and the 20 hospital's chief financial officers
B. The finance department and contracting department
C. The business office and finance department
D. The chief financial officers and the business office

19. According to Joanna Malcolm, RN, CCM, BSN, consulting manager of clinical advisory services for Pershing, Yoakley & Associates in Atlanta, documentation for conditions present on admission must be completed when the patient is in the emergency department or at admission.
A. True
B. False

20. In the heart failure readmission reduction program at Ocean Medical Center and Meridian At Home, how long do patients who are not receiving home health care stay in the remote monitoring program?
A. A minimum of 60 days
B. A minimum of 90 days
C. A minimum of 30 days
D. A minimum of two weeks

Answers: 17. D; 18. A; 19. True; 20. C

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the June issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■