HOSPITAL CASE MANAGEMENT

The essential guide to hospital-based care planning

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IMs gain importance as CMS focuses on discharge planning

Use documents as proof you talked to patients

If you aren't issuing the Important Message from Medicare (IM) as required by the Centers for Medicare & Medicaid Services (CMS), your hospital could face serious repercussions when surveyors review your hospital's compliance with the Medicare Conditions of Participation.

"The rule for issuing IMs is six years old, but it's more important than ever for case managers to make sure their hospitals are in compliance. CMS is paying close attention to patient rights and safety in the discharge process and looking for more evidence that hospitals are talking to patients about discharge planning," says **Jackie Birmingham**, RN, MSN, MS, vice president emerita, Clinical Leadership at Curaspan Health Group, Newton, MA.

The revised interpretive guidelines for the Medicare Conditions of Participation include a provision for surveyors to review current and closed charts for evidence that discharge planning was discussed in a timely manner, Birmingham points out. *(For details, see related article on page 106.)*

IMs, HINNs: more than just a chore

Medicare requirements for issuing the Important Message from Medicare (IM) and the Hospital-Issued Notices of Noncoverage (HINNs) have been around so long that they sometimes get short shrift. But if a surveyor or auditor finds that the IMs aren't being issued correctly, your hospital could suffer consequences. And if you don't issue a HINN, you can't bill the patient for services that Medicare doesn't cover. In this issue of *Hospital Case Management*, we give you details on when and how the IMs and HINNs should be issued and share one hospital's processes for ensuring delivery.

If hospitals fail to issue the mandated IMs as required, they could be fined or, since IMs are part of the Medicare Conditions of Participation, could lose their ability to receive reimbursement from Medicare, points out **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director for Huron Healthcare with headquarters in Chicago.

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CMS requires hospitals to give all inpatient Medicare beneficiaries the IM, which informs them of their right to request a review of a discharge decision, as close as possible to admission but no later than two days after admission. IMs can be delivered at preadmission as long as it is no more than seven calendar days before the admission. If patients remain in the hospital for two additional days, they must receive a second copy of the notice, frequently referred to as a "follow-up copy." Both notices must be signed by the beneficiary or his or her representative. Case managers should give patients copies of the IMs and place copies in their charts.

The rule applies to traditional Medicare beneficiaries, beneficiaries enrolled in Medicare Advantage programs, patients who are dual eligible when Medicare is a secondary payer, and other Medicare health plans that are subject to Medicare regulations.

IMs should be given only to patients who have been admitted for an inpatient stay, says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK. "I find that some hospitals are giving the IM to patients in observation and this is not appropriate," she says.

Instead, give outpatients, including patients receiving observation services, an Advance Beneficiary Notice of Non-Coverage (ABN) if Medicare is not likely to pay for services because they aren't covered or are not medically necessary. The ABN notifies the patients that they will be liable for the cost of services if they receive them,

EXECUTIVE SUMMARY

The Important Message from Medicare (IM), advising patients of their right to appeal their discharge, should be issued correctly or your hospital could be fined or lose the ability to receive reimbursement from Medicare.

- IMs should be given as close as possible to admission but no later than two days after admission. If patients remain in the hospital for two additional days, they must receive a second copy.
- Use the IM as an opportunity to discuss the discharge process with patients and families and to alert them to the expected discharge date.
- When patients appeal, drill down and determine the reason they appealed and use your finding to improve your discharge process.

Hale says. For instance, it would be appropriate for patients receiving observation services who are resisting going home, she adds.

Hospitals haven't been audited simply for compliance with IM regulations to this point, Sallee says. But surveyors who are reviewing hospitals for adherence to the Medicare Conditions of Participation may uncover problems with the delivery of the IMs or Hospital-Issued Notices of Noncoverage (HINNs), or state Quality Improvement Organizations or other auditors may determine that IMs and HINNs are not being issued as required in the course of auditing for other issues, she adds.

Karen Ford, MSN, RN, director of case management for Scottsdale (AZ) Healthcare system, points out that not everybody who interacts with patients has the expertise needed to deliver the IM and explain what it means, and recommends using case managers to deliver the IMs. "Case managers have the best understanding of CMS rules and education and have the expertise to answer questions. Some Medicare patients get confused and don't understand why they are being asked to sign the IM. That's why communication is so important," Ford says. *(For a look at Scottsdale Medical Center's IM and HINN training and delivery process, see related article on page 105.)*

Case managers should go beyond just handing patients a follow-up copy of the IM letter and checking off a box, Birmingham says. "Case managers should explain in detail what the IM means and use the IM as a tool to form a relationship with patients and let them know that the hospital staff really cares about what happens to them after they leave the hospital," she says.

In addition to being a good communication tool that case managers can use to start preparing patients for their discharge, the IM can provide documented evidence that case managers talked to the patient and/or his or her family member or caregiver about discharge options and their right to participate in their discharge plan, Birmingham says.

When a patient wants to appeal his or her discharge, case managers should point out the telephone number for the QIO on the IM but are not required to make the telephone call, Sallee says. Patients must appeal by midnight on the date the discharge order is issued in order for the appeal to be timely. If the QIO agrees with the hospital, the patient becomes responsible for the cost of the continuing stay at noon of the day following the notification of the determination. "If patients don't make the midnight deadline for an appeal, they are responsible for the bill, but they may get a refund if the QIO agrees with them," Sallee says. If patients receive the IM on the day of discharge, Medicare requires hospitals to allow patients to stay up to four hours after the IM is issued to give them a chance to appeal.

When patients appeal their discharges, case managers should deliver a Detailed Notice of Discharge to the patient or his or her representative as soon as possible after learning of the appeal to the QIO. The notice should explain in detail why the patient no longer meets criteria for a continued stay and why services no longer will be covered. It should include the estimate of the cost per day the patient will be responsible for if he or she chooses to stay when the QIO rules in favor of the hospital. Instances where the QIO disagrees with the hospital about a discharge rarely occur, Sallee adds.

Use the IM as a tool to track the times that patients appeal and how the QIO rules. Then conduct case studies to determine what happened to prompt the appeal, Birmingham suggests.

When patients appeal a discharge, it gives case managers a chance to review the discharge planning process, Birmingham says.

Drill down to determine why the patient felt the need to appeal and look for ways that the process could have been improved to avoid the appeal, she adds. Look at how long patients were in the hospital, how sick they were, whether they were screened for complex discharge needs, what the discharge plan was, and whether there were issues like resistance from the family or that the only post-discharge facility with appropriate available beds was too far from the patient's home. Track what your utilization review committee did to work through this particular issue. "Case managers need to use their internal resources, namely the utilization review committee, to come up with a process that can deal with this infrequent but anxiety-producing situation," Birmingham says.

Analyzing your appeals is a great opportunity to understand why people want to stay since most patients want to get out of the hospital as quickly as possible, Birmingham adds.

SOURCES

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Know your HINNs and when to deliver them

And when to use Condition Code 44

When hospitals determine that the care patients are receiving or are about to receive will not be covered by Medicare because it is not medically necessary, not delivered in an appropriate setting, or is custodial in nature, the hospital should provide the patient with a Hospital-Issued Notice of Noncoverage (HINN) to inform them that they will be responsible for the bill if they choose to stay in the hospital.

CMS requires hospitals to provide HINNs to patients before admission, at admission, or at any time during an inpatient stay if the hospital determines that the care the patient is receiving or is about to receive is not covered because it is not medically necessary, not delivered in an appropriate setting, or is custodial in nature.

If hospitals don't give patients a HINN when inpatient services aren't covered by Medicare, the hospital cannot bill the patient for the services later on, according to **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK. "If a HINN isn't issued, the hospital would be unable to collect payment from the patient for services rendered. CMS also provides hospitals with the option of using Condition Code 44 for correcting an unnecessary admission, but the physician responsible for the care of the patient must agree that the inpatient admission was unnecessary and the patient must be notified in writing before discharge," she says. When Condition Code 44 is used to change the patient's status from inpatient to outpatient, the hospital can collect payment from Medicare for Part B services, she adds.

Before Medicare began requiring hospitals to give patients the Important Message from Medicare (IM), notifying them of their right to appeal their discharge, there were 12 HINNs. The IM requirement eliminated HINNs 2 through 9, says **Linda Sallee**, MS, RN, CMAC, ACM, IQCI, director, for Huron Healthcare with headquarters in Chicago.

"CMS has very specific requirements about when each of the HINNs should be delivered and what the HINN letter should say. All of the HINNs must be signed by patients and a copy placed in their file," Sallee adds. If someone refuses to sign a HINN, a copy should be placed in their files and a notation made of their refusal.

Here's a look at the HINNs and when to use them:

The Preadmission/Admission HINN, also known as HINN 1, notifies patients that Medicare is not likely to pay for the admission because it is not likely to be considered medically necessary or can safely occur in another setting. The preadmission/admission HINN should be delivered when a physician wants to admit a patient who will not meet admission criteria or has already admitted a patient and the hospital determines that he or she never met admission criteria, Sallee says. Examples include social admissions when patients don't meet criteria but the physician doesn't want them to be at home, or patients who are admitted for procedures that should be outpatient procedures.

If the Preadmission/Admission HINN is delivered before 3 p.m., the patient becomes liable for charges on that day. If it's delivered after 3 p.m., the patient becomes liable the following day, Sallee says. The HINN should inform patients that they may ask the Quality Improvement Organization (QIO) to review the HINN 1. Case managers must get patients to sign the HINN, indicating that they received it, and put a copy in their files.

HINN 10 or the Notice of Hospital Requested Review (HRR) should be given to patients when the hospital has determined that the patient no longer meets inpatient criteria for a continued stay and the attending physician disagrees, says **Jackie**

EXECUTIVE SUMMARY

Hospital-Issued Notices of Noncoverage (HINN) inform patients that they will be responsible for the bill if they choose to stay in the hospital when the care they are receiving or about to receive will not be covered by Medicare.

- If hospitals don't give a HINN when services aren't covered by Medicare, they can't bill patients for services later on.
- CMS gives hospitals the option of using Condition Code 44 to change a patient's status from inpatient to outpatient to correct an unnecessary admission, then collect payment from Medicare for Medicare Part B services.
- All HINNs must be signed by the patient and a copy included in their file. If the patient refuses to sign, a copy should be placed in the file with a notation of the refusal to sign.

Birmingham, RN, MSN, MS, vice president emerita, Clinical Leadership at Curaspan Health Group, Newton, MA. The notice informs the patient that the hospital is asking the QIO to review the case and that the QIO may be contacting the patient for more information.

Before the HRR is issued, the hospital should go through the utilization review process, have the physician advisor contact the attending physician, and if there still is disagreement about the discharge, have the utilization review committee review the case and attempt to come to an agreement with the attending physician, Birmingham says. The hospital's utilization review committee, which must be chaired by a physician, must agree to request a QIO review of a continued stay, she points out.

"The case managers are not in this all by themselves. Their job is to get a discharge plan in place and document it and have their physician advisor and the utilization review committee concur with them," she adds.

HINN 11 (Non-Covered Services During a Covered Stay) notifies patients that their physician has ordered specific services, such as therapeutic or diagnostic services, that may not be covered because they are not medically necessary based on the reason for admission, but the patient still meets inpatient criteria for a continued stay. For instance, if the physician wants the patient to have a non-covered experimental drug, or a cosmetic procedure during a medically necessary stay, the HINN 11 notifies the patient that if they have it, they will be responsible for the cost, Sallee says.

The hospital must give a copy of the HINN 11 to the patient as well as to the attending physician. The HINN 11 also should include the actual total of the patient's financial responsibility if the services are received, Birmingham says.

HINN 12 (Non-Covered Continued Stay) notifies patients that the hospital believes Medicare may not pay for their continued stay beginning on a certain date. It should include, in plain language, the reason the stay will not be covered and the estimated cost of the stay for which they are potentially liable, Sallee says. This HINN should be issued in conjunction with the hospital appeal notices, she says.

The HINNs are only one of the ways hospitals can deal with an unnecessary admission or a continued hospital stay, Hale points out.

"I don't see many hospitals routinely issuing the HINN, as they prefer to address patients' healthcare through diplomacy and collaboration. For these hospitals, the HINN is the last resort and doesn't become necessary unless the case manager and physician are unable to gain the cooperation of the patient and family for services to be provided in a more appropriate setting than an acute care hospital," Hale says.

For information on the HINNs and to download the HINN requirements and letters for each, visit: www.cms.gov/Medicare/Medicare-General-Information/BNI/HINNs.html. ■

Hospital trains CMs on IMs, HINNs

Formal process ensures no one is missed

The administration at Scottsdale (AZ) Healthcare System thinks it so important for the Important Message from Medicare (IM) to be delivered correctly that all case managers go through extensive training on when and how the IM should be given to patients.

"We don't take the IM regulations lightly and have established a formal process for delivering the IMs and making sure patients and family members understand them. Otherwise, everybody may think someone else is talking to patients, and issuing the notices may fall through the cracks," says **Karen Ford**, MSN, RN, director of case management.

The course includes a demonstration video that shows the right way and wrong way to deliver the IMs, along with a series of PowerPoint slides. Following the training, case managers take a competency test. If they score 80% or better, they receive a certificate that goes into their file and shows that they are competent to discuss the IM with patients.

Case managers at Scottsdale Healthcare also go through training on how to deliver the Hospital-Issued Notice of Noncoverage and receive a binder with details on how and when to deliver the notices. "We don't use the HINN notices very often. We continually train our supervisors to guide case managers through the process to make sure we follow the Medicare regulations and stay on track," she says. Case management supervisors record it in the software system whenever the hospital issues a HINN letter. The hospital has prepared a training manual that instructs case managers on how to deliver the IMs and the HINNS.

The hospital's registration staff give patients the initial IM when they register. Case managers present the second IM two days before patients' antici-

EXECUTIVE SUMMARY

Scottsdale (AZ) Healthcare System provides training for case managers on delivery of the Important Message from Medicare (IM) and has developed a system to ensure that delivery of the IMs doesn't fall through the cracks.

- Case managers spend an average of 15 minutes discussing the IM with patients using a prepared script and give patients who may be confused a Medicare publication that explains the IM.
- To ensure that no one falls through the cracks on weekends when there is a smaller case management staff, the Friday case managers concentrate on delivering the IMs to patients who are expected to go home over the weekend.
- Appeals are rare and most of the time are made because the family expected the patient stay to be longer so they'd have more time to get ready at home.

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pated discharge.

Because there are fewer case managers covering the hospital on weekends than during the week, the Friday case managers focus heavily on defining who is likely to go home over the weekend and giving those patients the IM letter. "Since the coverage is not as robust during the weekend, that was when we might miss giving an IM, so we take a proactive approach on Friday to avoid missing anyone," she says.

The case management department has prepared a script that case managers use to talk to patients and family members about the anticipated discharge date, which often is within 48 hours.

The case managers spend about 15 minutes explaining the IM letter if the patients are awake and alert. Discussions with frail elderly patients may take up to 35 minutes. If patients are still confused about the meaning of the letter, the case managers give them a copy of the Medicare publication that explains the Important Message.

When they deliver the IM, case managers document it in the hospital's electronic documentation system. At the end of every week, Ford runs a report to track whether the IM has been given to every patient in case someone falls through the cracks. She conducts a chart review audit to ensure that the signed IM letter is included. "When we first began conducting the audits, we found that information technology was not scanning the IM letters. Now, the case managers put a copy of the IM in patients' charts and give a copy to their supervisor. If the audit shows that an IM letter is missing, we can upload it into the record," she says.

Scottsdale Healthcare System experiences a patient appeal of a discharge less than once a month. The majority of appeals of a discharge are from family members who are coming in from out of town and aren't prepared for the patient to go home, Ford says.

Ford estimates that 99% of the time, patients and family members appeal their discharge because of lack of communication by the treatment team. Many times, they were expecting the stay to be longer, that more tests were needed, and that they'd have time to get the home ready for the patient's return. "We focus on strong communication with patients and family members to eliminate surprises, and we have worked with our hospitalists and surgical team to reinforce the length of stay. We have found that if we are upfront with patients from the very beginning and explain their anticipated length of stay, they are prepared to be discharged when they no longer meet inpatient criteria and don't appeal their discharge," she says.

When the QIO notifies the hospital that a patient has appealed the discharge, the hospital gives the patient a Detailed Notice of Discharge, which explains why the services no longer will be covered. The notice includes an estimate of the cost-per-day that the patient will be responsible for if the QIO denies the appeal. The cost estimate is provided by the hospital's financial services department. While the appeal is pending, the case management staff continue to work with the family and patient on discharge options.

"We tell them that they are welcome to stay but that if the QIO agrees with us, they may have a change in coverage by Medicare and be responsible for a portion of the inpatient stay. Very few patients want to stay when the QIO agrees that they no longer meet criteria," she says. ■

CMS updates discharge planning guidelines

Document emphasizes importance of a plan

Continuing to stress the importance of discharge planning and preventing unnecessary readmissions, the Centers for Medicare & Medicaid Services (CMS) has issued a revised set

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of Discharge Planning Interpretive Guidelines that surveyors will use to assess a hospital's compliance with Medicare's Conditions of Participation. The guidelines do not apply to critical access hospitals, which must follow a different set of Conditions of Participation.

"There is increased emphasis on discharge planning by CMS, and these revised guidelines attest to the importance of a good discharge plan and a smooth transition, which can help to prevent unnecessary readmissions. CMS is encouraging hospitals to develop a discharge plan for all inpatients, whether they are Medicare recipients or not," says **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH.

CMS cites statistics that say one in five patients is readmitted within 30 days after discharge and a third of patients (34%) are readmitted in 60 days. Poor discharge planning and failure to do a plan of care can lead to readmissions, Dill Calloway says.

The 39-page document outlines what CMS expects hospitals to do in order to comply with the Conditions of Participation regulations and interpretive guidelines and includes instructions on what the surveyors should assess when they review hospital records. They include specific criteria for evaluating patients, creating a discharge plan, and improving transitions from the hospital to home or another level of care.

"Surveyors will be looking for documentation that hospitals are complying with the Conditions of Participation and initially will select a group of charts to review for evidence of discharge planning evaluation activities. If they see a pattern of noncompliance, they may review more charts, order the hospital to create an action plan for improvement, then come back for another review," says **Jackie Birmingham**, RN, MS, vice president emerita, clinical leadership for Curaspan Health Group. Ultimately, not being in compliance could lead to a loss of Medicare funding, she adds.

Birmingham suggests that case managers familiarize themselves with the guidelines and what the surveyors will be checking and use them as a guide for developing best practices for patient care and transitions.

New in this version of the Interpretive Guidelines are what CMS call "blue boxes," a tool that hospitals can use to promote better outcomes. The "blue boxes" make suggestions that hospitals can use in improving discharge planning and care transitions but are not required for compliance. *(For details on the "blue boxes" see related article on page 112.)*

The Interpretive Guidelines describe the four-stage discharge planning process required by the Conditions of Participation, including screening all patients as part of the admission assessment to determine their risk for readmission; evaluating the post-discharge needs of all patients identified by the assessment or when the physician requests an evaluation; developing a discharge plan; and implementing the discharge plan.

For the first time, CMS asks surveyors to employ the tracer methodology on several closed and open inpatient records to determine if hospitals comply with the Conditions of Participation. The guidelines specify that surveyors determine that there was a screening done to identify patients who need a discharge evaluation, if the hospital staff can demonstrate that the hospital's criteria and screening process for a discharge evaluation is correctly applied, and if there is a process to update the conditions or circumstances of patients if they were not initially identified as needing a discharge plan.

The revised interpretive guidelines provide more details about the hospital's role in ensuring a

EXECUTIVE SUMMARY

The need for timely and comprehensive discharge planning takes on new importance as the Centers for Medicare & Medicaid Services (CMS) issues revised Discharge Planning Interpretive Guidelines for surveyors to use to assess a hospital's compliance with the Medicare Conditions of Participation.

- Surveyors will use the guidelines as they review medical records to determine if hospitals are following CMS criteria for evaluating patients, creating a discharge plan, and communicating with the next level of care.
- The guidelines provide detailed information on how patients should be evaluated to determine the need for discharge planning, how a discharge plan should be developed, and how hospitals should ensure a smooth transition as patients move from one setting to another.
- For the first time, CMS has included "blue boxes," which give suggestions that hospitals can use to improve discharge planning and transition and urges hospitals to voluntarily adopt them, although they will not be considered in determining compliance.

smooth transition as patients move from one setting to another and emphasize the importance of thorough evaluation of patients' post-discharge needs and timely discharge planning. They have a new emphasis on hospitals' relationships with post-acute providers and making sure that care can be provided in the setting to which the patients transition. Here are some of the highlights:

The guidelines specify that a discharge plan must be created by an RN, a social worker, or another qualified person and discuss what discharge planners should consider in developing a discharge plan. Factors that should be taken into account when the discharge plan is created include functional status and cognitive ability, living situation, support at home, and the type of services the patient will need after discharge, Dill Calloway says.

"CMS wants discharge planners to assess that the patient's discharge needs can be met in their previous living environment and that patients and/or family members have the ability to take care of the patient's needs after discharge. If not, the discharge planners should make sure that there are community-based services that can provide the care and that needed services are in place when the patient is discharged," she adds. In addition, CMS discusses that the staff should evaluate the patient and family's ability to pay for post-acute services.

Make sure patients and caregivers fully understand what the patient will need after discharge and can demonstrate the tasks they will need to perform, such as dressing changes or injections, she adds.

Discharge planners should engage patients and family members in developing the plan of care and assist them in making informed decisions about post-discharge options, Dill Calloway says. "CMS emphasizes involving patients and families in the plan of care and points out that they will be more likely to follow the plan if they are involved in creating it. Discharge planners need to ask about what a patient can do or what the family is willing to do before creating a discharge plan," she says. For instance, family members may resist discharging a patient to a skilled nursing facility for a short time if they are willing to provide the care the patient will need at home.

The document calls for the identification of patients who need discharge planning early in the hospital stay. CMS recommends that the discharge planning process be performed at least 48 hours before discharge and requires surveyors to make sure the discharge wasn't delayed because the discharge planner didn't do a timely discharge evaluation.

If hospitals don't evaluate all patients for post-discharge needs, they should have a system to ensure that there is a way for the discharge planning staff to learn if a patient's condition changes to the point that he or she will need post-discharge services.

"The message is that hospitals should develop a system where discharge planners see every patient every day or review the record daily, or that there is a system where the staff makes discharge planners aware of if a patient's condition changes," Dill Calloway says. For instance, a patient who is expected to go home with no services may develop a deep venous thrombosis and may need home health. If the discharge planner isn't looking at the chart every day and the nurse doesn't notify the discharge planner, the patient could develop problems at home and have to be readmitted.

To read the guidelines, see http://www.cms.gov/edicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf.

SOURCE

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CMS gives tips on discharge planning

Suggestions not mandatory

In the newly revised Discharge Planning Interpretive Guidelines, the Centers for Medicare & Medicaid Services (CMS) includes what it calls "blue boxes" that advise hospitals on best practices in discharge planning and care transitions.

CMS suggests that hospitals voluntarily adopt these practices to promote better outcomes but states that they are not mandatory and surveyors will not assess the hospital's compliance during the survey process.

Here are some of the practices CMS advises hospitals to adopt:

• Consider providing an abbreviated post-hospi-

tal planning process for some outpatients, such as those receiving observation services or being discharged from same-day surgery and some patients being discharged from the emergency department. "Given the increasing complexity of services offered in the outpatient setting, many of the same concerns for effective post-hospital care coordination arise as for inpatients," the guidelines state.

- When you develop discharge processes, include input from post-acute facilities and professionals, such as home health agencies and primary care physicians, who provide care to discharged patients, as well as patients and patient advocacy groups.
- Provide a discharge plan for every inpatient to reduce the risk of problems after the patient leaves the hospital if the screening process doesn't adequately identify patients who need post-discharge planning.
- Take a multidisciplinary approach to discharge planning and include representatives from nursing, case management, social work, medical staff, pharmacy, and other healthcare professionals involved with the patient's care.
- Document it in the medical record if patients exercise their right to refuse to participate in discharge planning or to implement a discharge plan.
- To improve care transitions, schedule follow-up appointments with the patient's primary care physician, fill prescriptions before discharge, if appropriate, arrange remote monitoring technology, and follow up with phone calls within 24 to 72 hours after discharge.
- Refer patients and their families to Nursing Home Compare and Home Health Compare websites to help them in choosing post-acute providers. ■

ICD-10 means better documentation is a must

Clock is ticking to implementation

After a series of delays, the U. S. Department of Health and Human Services has set Oct. 1, 2014, as the firm date for implementation of the ICD-10 procedure and diagnostic coding set.

The implementation has been delayed several times in the past, but that's not likely to happen again, says **Deborah Hale**, CCS, CCDS, president and chief executive officer of Administrative Consultant Service, a healthcare consulting firm based in Shawnee, OK.

Unlike many other healthcare requirements, there's no grace period for the use of ICD-10, Hale points out. All claims submitted to any payer, Medicare, Medicaid, or commercial insurance on or after Oct. 1, 2014, for services provided in all healthcare settings, must use the ICD-10 codes for medical diagnoses and inpatient procedures. Otherwise, the claims may be rejected and providers will have to resubmit them using the ICD-10 codes, she says.

While ICD-9 uses five-digit numeric codes, ICD-10 is a seven-digit alpha-numeric coding system. The expanded fields make it possible to track much more detailed information about the patient's condition.

"The primary difference in ICD-9 and ICD-10 is the specificity of the documentation required," says **Kristen Lilly**, RHIA, CPHQ, MHA, consulting manager, clinical advisor services for Pershing, Yoakley & Associates in Atlanta. "For instance, in the ICD-9 code set, a diagnosis of a broken foot can be coded as 'closed fracture of metatarsal bone(s).'" ICD-10 documentation is required to specify which foot and which bones.

"There's a snowball effect because better documentation not only leads to greater specificity when coding but also has a positive impact to core measures reporting and quality measures such as value-based purchasing and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Improved specificity in documentation should lead to more accurate and thorough diagnoses and better outcomes," Lilly says.

When hospitals begin using ICD-10, establishing medical necessity will be much easier because the documentation must be so specific, adds **Joanna Malcolm**, RN, CCM, BSN, consulting

EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services has set Oct. 1, 2014, as the firm date for implementation of ICD-10.

- There is no grace period for implementation. All claims to any payer must use ICD-10 codes for medical diagnosis and inpatient procedures or they may be rejected and providers will have to resubmit them.
- The ICD-10 code set has more fields than ICD-9 and requires a more detailed level of documentation.
- Case managers need to understand what the new coding set means and how it will affect their work.

manager, clinical advisory services for Pershing, Yoakley & Associates in Atlanta.

Hospitals already should be assessing the impact of ICD-10 implementation throughout the organization, Lilly says. Conduct a gap analysis to see where the potential problems lie, she suggests.

Malcolm recommends that case management directors work closely with their hospital's information technology department to make sure the case management software can accommodate the changes. She suggests meeting at least monthly with information technology and coding representatives to look for deficits in the technology case managers use.

"ICD-9 codes are used in all the reports that case management directors use every day, such as quality indicators and core measures compliance. Case management software has to be updated to accept the expanded fields and to interface with all of the other information technology that uses ICD-10 codes," Malcolm adds.

Case management directors should be part of the overall ICD-10 team at their hospitals, Malcolm says. "They don't necessarily need to serve on the steering committee, but they should be part of the team. Case managers won't drive the changes, but they are going to be impacted by the changes and they should have a seat at the table when the hospital's strategy is discussed," she says.

Case managers might not need formal training on the specific codes, but they do need to understand the level of documentation specificity required by the new coding system, Malcolm adds. "Case managers need to understand the impact of ICD-10 and how specific the information needs to be so they can work with the physician team to make sure the documentation is what is needed for the hospital to get paid," she says.

SOURCE

• **Joanna Malcolm**, RN, CCM, BSN, Senior Consultant, Pershing, Yoakley & Associates, Atlanta. email: JMalcolm@pyapc.com ■

Caring for caregivers after Boston bombing

'Facilitated conversations' ease trauma

When two bombs went off near the finish line of the Boston Marathon, hospital clinicians had one thought: I have to get to work. A surgeon who had just run 26 miles came into Beth Israel Deaconess Medical Center and prepared to operate. Nurses and doctors treating the wounded wondered about their own family and friends.

The first victims arrived at Beth Israel within 20 minutes of the blast. (Many had initial treatment by medical personnel at the scene.) The hallways quickly filled with law enforcement officers looking for eye witnesses. The lobby overflowed with people looking for missing relatives. Ambulances raced in and out. Security officers screened people coming into the facility.

"Everybody goes into their instinctual mode, doing their job and doing it very well," says **Barbara Sarnoff Lee**, MSW, LICSW, the hospital's director of social work and director of patient-family engagement.

But while hospital employees from environmental services workers to advanced practice nurses were shifting into overdrive, the hospital also thought about how to care for the caregivers, Lee says.

"The leadership recognized that you can only be in that hyper-vigilant disaster mode for so long, and we needed to think about how we can keep our workforce resilient and able to do their job — as well as physically and emotionally," she says. "We moved pretty quickly into thinking about how we would help the staff and what the staff would need."

By the middle of the first week of the bombing, members of the social work, psychiatric and pastoral staff began holding "facilitated conversations" with employees. These conversations happened in small, natural groupings, particularly in the emergency department, ICU, and OR.

"The message we try to give people [is that] this is an abnormal event. What you are feeling, whatever it is, is a normal response to an abnormal event," Lee says. "We want to let people know that most of what they're thinking and feeling is normative."

Building an emotional connection

Just the act of gathering together and talking can be therapeutic, she says. "What happens in situations like this is that people feel their world is somewhat shattered. They feel they've lost connection," she says. "It's about bringing people together to build a connection."

Health care workers also need to know about possible physical responses. "There's a physiologic component of trauma," says Lee. "We talk to people about what to anticipate. People may be more irritable than they normally are. They may eat more, eat less, drink more."

They might have trouble sleeping, or find them-

selves being overly startled by a loud noise. Exercise, a good sleep schedule and regular eating patterns can help people cope, she says.

In the weeks after the event, Beth Israel held multiple facilitated meetings on multiple shifts to give employees an opportunity to gather, talk, listen, and get advice. The sessions included environmental services workers, dietary staff and transporters — people who were crucial to keeping the hospital running smoothly but were not as prominent as the direct caregivers.

On the Friday of the second week after the bombing, the hospital held a 15-minute service facilitated by the hospital's director of pastoral care. The hospital CEO and COO spoke. "They felt it was really important to pause and for senior leadership to thank employees," says Lee. Adding a spiritual component also opened an avenue for coping. "That was just another way of taking care of people," says Lee.

A month after the bombing, Beth Israel still held some open forums. "We felt it was important to communicate the message that not everybody is done with this and we still care about you," she says.

If employees continue to have significant problems more than a month after the event — trouble sleeping or concentrating, or other symptoms that interfere with daily life — they are advised to seek professional help, says Lee. The Employee Assistance Program can provide a link to counseling.

'Things happen every day'

The Boston Marathon bombing is a unique event, and in some ways, the support for staff was also unique. Hollywood celebrities and politicians visited the hospital and personally thanked health care workers.

There was a community outpouring, a sense of pride and unity in Boston that flowed into the hospitals where some bombing victims remained hospitalized for weeks. Donated tickets allowed hospital staff to go to Red Sox games or attend special events. The social work staff received a free Duck Boat tour. Cards and letters poured in from church and school groups.

Outside experts also bolstered Beth Israel's efforts. A team from the Israeli Trauma Coalition shared their advice. The U.S. Department of Health and Human Services sent mental health experts.

Yet the framework for emotionally supporting health care workers applies in many cases and for hospitals around the country, says Lee.

There could be an adverse event that led to an unexpected patient death. Or a sudden death of an employee on a unit. Or a more localized disaster that nonetheless is traumatic. Those are all opportunities for "facilitated conversations" to help people cope, Lee says.

"I urge people to remember that things happen every day that impact people," she says. ■

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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 healthcare 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

■ How your peers are preventing readmissions.

■ How the new IPPS rule will affect you.

■ Why culturally competent care is so important.

■ Meeting the special needs of seniors

CNE QUESTIONS

1. If Medicare is not likely to pay for services for outpatients because they are not covered or are not medically necessary, what document should hospitals give them?
   A. Important Message from Medicare (IM)
   B. Advance Beneficiary Notice
   C. Hospital Issued Notice of Non-Coverage (HINN) 11
   D. All of the above

2. If hospitals don't give patients a HINN when inpatient services aren't covered by Medicare, the hospital can't bill the patient for the services later on.
   A. True
   B. False

3. The newly revised Discharge Planning Interpretive Guidelines outline a four-step process for discharge planning. What are the four steps?
   A. Provide the right care, in the right setting, at the right time, to the right patient.
   B. Assess the patient, prepare a discharge plan, implement the discharge plan, and follow up.
   C. Screen patients to determine their risk for readmission, assess at-risk patients for discharge needs, create a discharge plan, and implement a discharge plan.
   D. Determine which patients need discharge planning, communicate with patients and family, share information with post-acute providers, and follow up within 48 hours of discharge.

4. What should case managers or case management directors be doing to get ready for the implementation of ICD-10 on Oct. 1, 2014?
   A. Meet with the information technology and coding staff to look for deficits in the software case managers use.
   B. Understand the level of documentation specificity needed for the new coding system.
   C. Work with the physician to make sure the documentation is what's needed for the hospital to get paid.
   D. All of the above

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CASE MANAGEMENT INSIDER
Case manager to case manager

Back to Basics: A Day in the Life of a Hospital Case Manager – Part 1

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Introduction

The role of the hospital case manager has taken many twists and turns over the past two decades. Case management started out as a sectioned-off role of utilization review without any relationship to the direct care providers or interdisciplinary care team. From those early roots we have evolved to departments that incorporate utilization management, discharge planning, patient flow, documentation improvement, transitions in care, and coordination of care. You can probably think of even more roles that we perform, or you may do different things in your specific department. Terms like coordination of care, transitions in care and patient navigation have become part of the lexicon of health care as we move through the beginnings of the Affordable Care Act and beyond. These terms have been common language in our field, but are now embraced by the wider spectrum of payers and health care providers at large. While exciting, we must ensure that we maintain a seat at the health care table and that our voice continues to be heard. We continue to carry the burden of shaking off the old perceptions of what case management "was," while helping others to embrace what we are "becoming."

As our roles and functions have evolved, some of our departments have remained staffed as if they were still departments of utilization review. Case management departments responded to the ever increasing requirements of health care, but without the staffing ratios to support the volume of work. This is why I decided to write about a "day in the life of a case manager" this month. You are probably one of the many case managers who struggles to complete your workload every day. You probably feel overwhelmed many days, or maybe most days. While appropriate staffing ratios are fundamentally important, your hospital may not be adding additional staff at this time. Despite the amount of work you must complete, you enjoy your job and want to do the best that you can every day for your hospital and for your patients. With that in mind, this month we will review some of the ways in which you can organize your work to help you be more effective with the time you have. First, we will also review the case management process steps.

The Case Management Process Steps

Each step combines elements of both utilization management and discharge planning, as well as patient flow and transitional planning. It is important to understand that these steps are not linear. You may find yourself circling back on them and/or repeating the process. You may even need to occasionally skip a step or the step may not be necessary to the particular situation. These steps are "guidelines" and are only meant to be used to give you direction and focus.

Step 1: Case Finding/Screening and Intake

On admission, or after the case has been assigned to you, you must immediately begin

the screening and intake process. Please note that this first step is critical to the entire case management process. If you do not follow every patient, then you must screen the patient for case management needs and follow him or her according to the criteria that your hospital uses for following patients. Then you can begin the case management admission process.

If you follow every patient, then you can begin the case management admission process. In order to admit the patient, you should have a standard admission assessment tool that you use to collect the data that you need to begin case managing the patient. If you do not have a standard tool, then you should document your findings in the progress notes section of the medical record. You should try to collect the same information each time you admit a patient, so this is why a standard tool is helpful. However, if you can't do that, then a consistent format for notes can work well too. Either way, the assessment should be placed in the medical record on the day of admission.

Once you have completed you admission assessment, you should complete your initial clinical review on the patient. The purpose of this initial review is to determine if the patient meets acute care criteria and has been appropriately admitted to the hospital. In other words, is the patient in the right level of care? It is important to make this determination as quickly as possible. If you do this immediately on admission, and the patient does not meet criteria, then you can apply Condition Code 44 to the patient if he or she is a Medicare recipient.

At the same time, you should be beginning your discharge planning. You should use the information you collect from the initial assessment to make a determination as to the discharge destination as best you can based on this initial information. It is understood that this initial destination may change as the patient progresses toward discharge. However, 70% of the time this initial discharge destination selection remains as the ultimate discharge destination. The Centers for Medicare & Medicaid Services (CMS) expects that an initial discharge destination be identified as soon after admission as possible.

Step 2: Assessment of Patient Needs

Once you have done your initial assessment as per above, you will need to synthesize the information and begin to identify the patient's needs while he or she is in the hospital and then for discharge, as mentioned above. As you begin this process, you will need to review the patient's financial status and insurance coverage so that you will be able to ensure that services they may need after discharge are available to them.

It is at this point that discharge planning conversations should also begin with the patient and the family. These initial conversations are important to the discharge planning process. In addition to insurance coverage, this is the point at which you should begin to talk to the family and assess their home environment as well as their ability to care for the patient at home. Even if the patient is going to sub-acute care after discharge, the home environment still needs to be reviewed as ultimately the patient will be going there.

Any plans, even initial ones, should be agreed upon with the patient's physician, the patient, and the family. By not skipping this step, you are more likely to have the cooperation of all parties at the time of discharge from the hospital.

Step 3: Identification of Actual and Potential Problems — Service Planning

By the time you reach step three in the case management process, you should have gathered enough information to begin to write a plan of action. This plan should include:

- the patient's inpatient plan of care;
- any barriers to achieving the outcomes of the plan of care;
- the items needed to meet the patient's post-discharge needs;
- services needed after discharge that require

TIP 1

Collect Data Once for Multiple Purposes

By obtaining the initial assessment on the day of admission, you can use the information you collect to do your clinical review and begin the discharge planning process at the same time. This is a time-saver and makes your work process more efficient!

authorization;

• a set of goals that are agreed on by the patient and family as well as the physician for the hospital stay and beyond discharge.

By assessing the patient at the beginning of the hospital stay, you should have all the information you need to create a plan of action as described above. The plan is an important step in ensuring that each day that the patient is in the hospital is optimized so that there are no delays and no denials. It is also important in terms of managing the expected length of stay against the patient's achievement of the expected outcomes of care. As the patient progresses, the outcomes and/or length of stay may have to be adjusted to meet the changing needs of the patient. This may mean a longer length of stay, but it may also mean a shorter length of stay in some instances.

It is critical to reassess the patient on a daily basis and to continuously re-evaluate the plan of care. As described above, this will ensure that things are moving along in sync with the patient's actual response to treatment.

Step 4: Linking Patients to What They Need

Step four in the case management process encompasses several elements. It begins with the communication of the daily reviews with the third-party payers. From there, the case manager must obtain any necessary authorizations. These steps are designed to be sure that patients have what they need upon discharge.

However, there is another important piece to this step that takes place within the walls of the hospital. That has to do with coordination and facilitation of care. The case manager has an important role to play in terms of linking patients to what they need while in the hospital, and to be sure that the services required are delivered on a timely basis. You may think of this step as "patient flow,' or the movement of the patient through the acute-care continuum. As case managers, this step is just as important as the discharge planning process. It is the manner in which we ensure an appropriate length of stay, appropriate resource use and consumption and appropriate movement of the patient toward expected outcomes.

Patient flow also assists the hospital in being as efficient as it can be with its internal resources by identifying barriers to care, delays and other opportunities to optimize daily resources for the patient and the hospital.

TIP 2

By managing resource consumption and patient outcomes each and every day, length of stay targets are much more likely to be achieved.

Step 5: Implementation of Interdisciplinary Plan of Care

During the implementation of the interdisciplinary plan of care, the case manager should be watching for delays in service. These delays can result in increased length of stay and/or a denial of payment if your hospital has per diem contracts. The patient should be monitored each and every day against the expected outcomes for that hospital day. The plan of care should be adjusted if the patient's progress is slower or faster than expected. During each day, the patient's progress should be evaluated so that the patient can be moved to the next level of care in a timely manner. It is the case manager's responsibility to determine the patient's state of readiness and to optimize that as soon as it happens.

It is during this step that the case manager should also be exchanging clinical information with the appropriate post-discharge agencies or facilities, as appropriate. By managing the discharge planning process throughout the course of the hospital stay, you will reduce the likelihood of last-minute details or problems on the day of discharge. This is why discharge planning MUST be considered a "process," not a "destination."

It is also during this step that the case manager should be monitoring and re-evaluating the selected discharge destination. As you are in communication with the third party to obtain authorizations, you may want to consider a "dual discharge plan" for those patients whose discharge destination may not be as clear.

For example, you may not be able to determine on admission if your fractured-hip patients will be able to go home with physical therapy or will need to go to sub-acute rehabilitation. The decision to go to the higher level of care, sub-acute, will be dependent on the patient's

response to physical therapy. If the patient has a good response, you should consider the lowest level of care appropriate to the patient depending on what the patient can tolerate. Because this type of decision can vary right up until the day of discharge, dual discharge planning can be used as a strategy to ensure that there is no delay on the day of discharge. Hopefully your insurance-based case manager will work with you to orchestrate these types of plans.

Step 6: Evaluation of Patient Care Outcomes / Monitoring the Delivery of Patient Care Services

As you move the patient toward discharge, you must continuously evaluate the patient's readiness for discharge based on his or her outcomes and response to treatment. As we discussed earlier, the case management process is not always linear, and you may find yourself circling back to specific steps in the process as you continuously move the patient toward discharge. This is to be expected and is appropriate.

At this point in the process you should have begun confirming the discharge destination with the patient and the family. As mentioned earlier, this discussion should begin almost upon admission so that the patient and family are in sync with the process as it moves along. Keeping them informed as you progress toward discharge will ensure a better outcome for all.

It is also critical to maintain communication with the patient's physician on a daily basis. The case manager and the physician must be coordinated in their approach to the discharge plan, too. You do not want the physician to say one thing to the patient and family while you are saying something else. This will surely sabotage the discharge plan. By working directly with the physician, all members of the team can communicate a standard message to the patient and family. Nothing will dissatisfy a patient more than having multiple providers giving him or her different messages.

At this point, you should have also obtained all necessary authorizations from the third party, if this is required. This will also ensure that there are no last-minute delays. If you had to do a dual discharge plan, as explained in step 5, then by step 6 you should be able to select which of the dual plans will meet the patient's post-discharge needs and begin to activate that plan.

If you maintain open lines of communication with the patient, the family, and the third-party payer, you will ensure that things happen as smoothly as possible. Of course, there are many things that can happen during the course of care, and things do change. However, if you are in constant communication and have a relationship with all parties involved, even necessary changes will be accepted more readily.

TIP 3

Maintain open lines of communication throughout the entire discharge planning process to ensure smoother outcomes for you, the patient, family and physician.

Summary

In this month's *Case Management Insider* we have begun to review the case management process. The process has a total of eight steps, and we have completed our review of six of them. Next month we will continue with the final two steps in the case management process and also discuss best practices for doing an admission assessment. We will also review a case study which should help you in applying the steps we have been reviewing! ■