# HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

AHC Media LLC


## IN THIS ISSUE




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# OPPS final rule expands observation services, requires quality reporting

*CMS moves toward packaged payments*

The Centers for Medicare & Medicaid Services (CMS) has announced sweeping changes to the Outpatient Prospective Payment System (OPPS) that may significantly affect your hospital's revenue.

The final rule, which went into effect Jan. 1, expands the number of services packaged into ambulatory payment classification groups (APCs), requires hospitals to report outpatient quality measures for the first time, and introduces composite ambulatory payment classification groups, which provide one bundled payment for several major services.

In announcing the changes, CMS reiterated its goal of controlling growth of OPPS payment by moving away from service-specific payments to packaged payments.

"Hospitals will now have additional incentives to deliver the right service to the right patient in the right setting at the right time," says **Kerry Weems**, CMS acting administrator.

The final rule creates a new type of APC called a composite APC that provides one bundled payment for several major services received on the same day, rather than paying for the services individually under service-specific APCs. In some cases, hospitals will receive a single payment for services across the entire patient encounter.

The major change for case managers is the creation of two new composite APCs, which will pay for observation services for appropriate patients, regardless of the diagnosis, says **Deborah Hale**, CCS, president of Administrative Consultant Services in Shawnee, OK.

"We continue to believe that observation care is a clinically appropriate hospital outpatient service that includes ongoing short-term treatment assessment and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital," CMS said in announcing the changes.

In creating the new composite APCs for observation services, CMS made a 180-degree shift from its original proposal in the proposed rule issued in August, Hale points out.

## Original proposal

The Institute of Medicine's report *Hospital-Based Emergency Care: At the Breaking Point*, issued in June, recommended that CMS help hospitals cope with emergency department throughput and overcrowding by creating an incentive for hospitals to move patients to observation status, Hale says.

But in its proposed rule, CMS initially planned to eliminate the outpatient observation APC established in 2002 that provided separate observation payment for chest pain, congestive heart failure, and asthma. The proposed rule had no provision for observation payment other than a small across-the-board increase in the facility high-level emergency department payment to compensate for the elimination of the observation APC.

In the final rule, CMS followed the advice of the APC Observation and Visit subcommittee and created separate payments for observation for all diagnoses for which observation is indicated.

"The main thing for case managers to realize is that observation payment is made for any diagnosis by packaging it into a composite APC that includes both the emergency department payment and the observation payment. The hospital must make sure that the observation services are properly documented to support the medical necessity of the hospital's claim," Hale says.

## Observation care requirements

To qualify for observation care under the new composite APCs, services must meet the same requirements related to physician order and evaluation, documentation, and observation beginning and ending times.

Beneficiaries must be under the care of a physician who has explicitly assessed patient risk to determine that the beneficiary would benefit from observation care, Hale says.

The medical record must include admitting, progress, and discharge notes that are timed, written, and signed by the physician, she adds.

The two new observation composite APCs are:

- **APC 8002**: Any patient who is admitted directly to the hospital for observation care or a patient who is admitted from a hospital-based clinic following a high-level (Level 5) clinic visit. Hospital services must be greater than eight hours. If the hospital has provided any service with a "T-status" on the day of admission or the previous day, the patient does not meet criteria for observation status. ("T-status" indicator means the patient also had a major procedure that is a separately payable APC. T-status procedures are subject to the OPPS multiple procedure reduction rules and will be discounted by 50% if another T-status indicator is performed.)

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The national payment rate for APC 8002 is $351.04.

• **APC 8003:** Any patient who is admitted for observation services from the emergency department following a Level 4-5 or critical care emergency department visit.

Hospital services must be greater than eight hours. If the hospital has provided any service with a T-status on the day of admission or the previous day, the patient does not meet criteria for observation status.

The national payment rate for APC 8003 is $638.66.

The observation services are bundled with the emergency department services, which means that the hospital gets only the flat rate, and not payment for a Level 4 or 5 emergency department visit as well, points out **Bill Hannah**, southeast leader, Healthcare Advisory Practice at KPMG.

However, it does not include payment for other billable services and procedures such as diagnostic tests by laboratory and radiology, infusions, injections, catheter insertions, etc., Hale adds.

In the past, when patients with heart failure, chest pain, or asthma were admitted for observation after an emergency department visit, the hospital received payment for an ED visit as well as observation if the observation was in relation to the predetermined diagnosis, Hannah adds.

Other new composite APCs created in the final rule will be used to pay for mental health services, low-dose rate brachytherapy, and cardiac electrophysiologic evaluation and ablation services.

The final rule expands the CMS packaging approach by bundling seven categories of ancillary services into the primary diagnostic or treatment procedures with which they are performed.

Packaging means that many ancillary services for which hospitals have been receiving separate payment no longer will be paid separately, Hale says.

Packaged services include guidance services; image processing services; intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media, and certain observation services.

This year, CMS is requiring that hospitals report seven outpatient quality measures including five emergency department acute myocardial infarction transfer measures and two surgical care improvement measures. Hospitals must report the applicable outpatient quality measures beginning in April 2008 in order to receive the full-market basket update in 2009. Otherwise, the update will be reduced by 2%. **(For details on the quality measures, see related article, below.)**

In issuing its final rule for 2008, CMS reaffirmed its policy to pay for procedures on the "inpatient-only" list only when the patient was an inpatient at the time that the procedure was performed.

There has been speculation over the years that CMS will eliminate the inpatient-only list, but every year, CMS has stated its commitment to keep the list for the safety of Medicare patients**,** Hale says.

The 2008 rule did delete 13 procedures from the inpatient-only list.

Case managers should stay abreast of the CMS changes to the inpatient-only rule because of its implications for payment, Hale adds.

In order for case managers to be effective at making sure the surgery is performed in the right setting, they need to review the level-of-care order at the time the procedure is scheduled, Hale says.

"If the order for an inpatient admission is not written or verbalized until after the inpatient-only procedure has been performed, the hospital is not entitled for payment for the procedure," she says.

Hospitals will get paid for follow-up care if patients are admitted after a procedure on the inpatient-only list is performed as an outpatient procedure. However, in those cases, the hospital will not be paid for the surgical procedure. ■

# Outpatient payments to be linked to quality reporting

*Hospitals must report on seven measures in 2008*

In its final rule for the Outpatient Prospective Payment System for calendar year 2008, the Centers for Medicare & Medicaid Services (CMS) took the first steps linking payment for outpatient services to the quality of care received by expanding the Hospital Outpatient Quality Data Reporting Program and requiring hospitals to report on outpatient quality measures for the first time.

Case managers will have an opportunity to impact their hospital's performance on the outpatient quality measures by educating staff on the importance and evidence supporting the measures

and by conducting retrospective reviews to identify areas where the processes can be improved, says **Carolyn C. Scott**, BA, BSN, MHA, director, KPMG healthcare risk advisory services.

The seven quality measures, which have been endorsed by the National Quality Forum, include five measures of standards of care in the emergency department for acute myocardial infarction (AMI) patients transferred to other facilities for care and two outpatient surgical care improvement measures.

In order to receive the full OPPS payment update in 2009, hospitals will be required to submit data on the outpatient quality measures for services furnished on or after April 1, 2008.

If hospitals do not comply with the quality reporting requirement in 2008, their OPPS update will be reduced by 2% in 2009.

## Move toward value-based purchasing

The outpatient quality measures are proposed to be included in the CMS value-based purchasing initiative, which links payment to quality, rather than just the delivery of services, Scott says.

CMS is required by the Deficit Reduction Act of 2005 to have a plan for value-based purchasing in place by 2009, she adds.

Value-based purchasing ultimately will replace the current hospital quality reporting system and will include both public reporting and financial incentives to drive clinical quality, Scott says.

Case managers are in a position to help their hospitals prepare for the time when payment for outpatient services will be linked to quality, rather than just delivery of services, Scott says.

The emergency department AMI measures include aspirin at arrival; median time to fibrinolysis, fibrinolytic therapy received within 30 minutes of arrival, median time to electrocardiogram, and median time to transfer for primary percutaneous coronary intervention (PCI).

Perioperative care measures include timing of antibiotic prophylaxis and selection of prophylactic antibiotic.

CMS originally had proposed going beyond these seven measures including outpatient measures for heart failure, community-acquired pneumonia, and diabetes, Scott says.

The agency reduced the number of measures for 2008 after numerous people who commented on the proposed rule said the additional measures would be too difficult to implement at this time, she says.

However, CMS has announced its intention to develop a list of additional outpatient quality measures to be implemented in future years.

## ED quality measures

The emergency department quality measures that hospitals must track in 2008 apply only to AMI patients who are being transferred to other hospitals with cardiac catheterization laboratories and won't affect hospitals that can perform the procedure in-house since patients treated with PCI and not transferred are captured in the current reporting requirements for the Inpatient Prospective Payment System, Scott points out.

"Many hospitals don't have PCI capability in-house and have to transfer the patients to another facility. CMS and the American College of Cardiology want to get a better understanding of how well the transferred patients are being treated. The outpatient data on transferred AMI patients will pick up patients that hospitals don't capture in their inpatient data collection for their inpatient AMI performance since these patients never are admitted to the inpatient setting," Scott says.

Case managers probably won't have an opportunity to affect the AMI measures because of the short time the patient will be at the hospital if the emergency department is efficient, Scott points out.

"If a hospital is doing it well, these patients won't be in a facility very long. They should be transferred to another hospital in less than an hour if the emergency department staff are good at identifying patients who are having a heart attack and arranging for the transfer. In most cases, they should be out the door before the case manager knows they're in the hospital," she says.

However, case managers can play a big role in the educational piece for the AMI measures and should be prepared to discuss with staff why the measures were selected and what they mean, she adds.

## Where CMs fit in: The retrospective review

The new AMI measures represent a good opportunity for retrospective review in order to identify areas where processes and patient throughput can be improved, Scott points out.

"It's particularly valuable if someone can conduct the review as soon as possible when the patients aren't transferred as quickly as they

could be. This will enable the hospital to do a mini root-cause analysis and take immediate action to correct the problem for future patients," she says.

The two outpatient surgical measures revolve around antibiotics that are given within an hour of surgery. Documentation for outpatient surgical patients should include what antibiotic was administered and what time it was given.

"Case managers cannot affect the antibiotic selection for surgery patients nor the time at which it is given but they can they can take action retrospectively by analyzing the reports to determine any patterns in failure to comply, such as the practices of specific surgeons," Scott says.

The case managers can examine the patient record to make sure that the order was written and that the antibiotic was given in a timely manner specified by the quality measures.

In addition, case managers can make sure that the patient record shows that the antibiotic selection falls within guidelines; if it does not, that the reason is documented.

Case managers could be effective in increasing compliance with the perioperative antibiotic prophylaxis measures by educating the staff about why it's important to give the antibiotics in a timely fashion, Scott suggests.

"The evidence is clear on the effectiveness of these antibiotics in preventing infections if they are administered within one hour of incision time for most antibiotic types and what it means if they are given too early or too late. Clinical people always want to do the right thing for the patient and that is more likely to happen if they understand why the measures recommend specific practices," she says.

*(Editor's note: For more information, contact* ***Carolyn Scott*** *at e-mail: carolynscott@kpmg.com.)* ■

# UPMC denial management program saves $1 million

*Central department handles retrospective appeals*

A multilevel denials management process generates $1 million or more in recovered revenue annually for inpatient accounts at the University of Pittsburgh Medical Center (UPMC), a larger health system with 20 medical facilities.

The hospital system's denials management process starts with the concurrent appeals conducted by the hospital case managers who can elevate the process to the attending physician or the hospital medical director. When a hospital stay is still denied, a central department handles the retrospective denials, requesting a review by an external source if necessary, says **Charleeda Redman**, RN, MSN, ACM, director of care management at UPMC.

The systemwide denials process was implemented in 2002 when the hospital organization installed the electronic case management system and created the centralized department to assist with care management. The appeals process model is based on the multilevel appeals process being used by one of the largest hospitals in the system.

Before the new system was implemented, case managers at other hospitals in the system managed the entire appeals process, making a concurrent appeal and following up with a retrospective appeal of denials.

"This system is much more consistent and effective. We have gained many process efficiencies by centralizing the retrospective appeal of denials," Redman says.

Redman's department has a staff of about 25 and is responsible for training and development of case management and social work care management in addition to handling retrospective inpatient and outpatient denials and appeals for medical necessity and authorization.

Hospital-based case managers are responsible for the day-to-day management of concurrent denials and use the case management software system to track their efforts.

## A 'threatened' day

When the payer indicates to the care manager that it is not going to allow another acute care day, the hospital system labels it as a "threatened day."

"It's not technically a denial. The care manager notes in the software that the payer has denied a request for another acute care day or would authorize only a lower level of care," she says.

When an insurer indicates that a continued stay or admission might be denied, the nurse case manager determines why the stay is being denied and takes action to overturn it.

For example, if it's a medical necessity issue, the case manager looks for additional clinical information, such as missing laboratory values. The case manager then touches base with the

physician, reports that the insurance company believes the patient could be discharged or be transferred to a lower level of care, and asks the physician if there is additional information that could justify the patient stay.

"That phone call could provide key information that the case manager could communicate to the insurance company," she says.

## Getting threatened status overturned

If the additional information isn't enough to get the threatened day overturned, the case manager can escalate the case to the attending physician who can call the payer and request a peer-to-peer review.

If for any reason, the attending physician is unwilling or unable to call the insurer, the case manager refers it to the physician advisor who reviews the chart and makes the decision of whether to appeal. The physician advisor then calls the attending physician to get information about the patient and calls the payer.

If the hospital's physician representative determines that the payer is right, the case manager works with the physician to facilitate discharge to home or to a lower level of care.

The case managers document the final outcome of the concurrent appeal in the case management software.

"The software has the ability to run a report within the application to show any outstanding cases that did not have an outcome. The organization generates an e-mail report every day to the director of case management, the nursing leadership, the CEO, and the CFO in each individual hospital, listing any patients' whose continued delay has a threatened denial without a resolution," she says.

For instance, a patient may come to the emergency department with chest pain and the attending physician believes the patient needs to be admitted as an inpatient.

"Unless patients have certain clinical values, many payers will approve only admission to an observation level of care. In this case, we would enter the information as a threatened day because the physician wants to admit the patient and the payer suggests observation," she says.

If the patient is admitted and the payer doesn't agree, the hospital makes a retrospective appeal.

Redman generates monthly reports tracking whether the denial was overturned, the hospital accepted a lower level of care, or the appeal was denied. She meets regularly with the CEO, CFO, and director of case management at each hospital to review denial information.

"We look at how well we are doing, what are our payer issues, and whether the nurses and doctors are successful when they try to get denials addressed concurrently," she says.

When the hospital case managers can't get the denial overturned concurrently, Redman's department reviews the case and decides whether to take action. Two nurses in the department are responsible for reviewing the cases handled by the inpatient case managers. The nurses request the entire medical record if necessary or view it on-line.

"If the nurse feels there is enough information and criteria to support an acute care day, we file an appeal. If we can't find supportive documentation in the medical record, the physician advisor for our department reviews the information to determine if documentation can be adjusted on the back end to give us grounds for appeal," she says.

## Escalation process

The first level of appeal is a written appeal from a nurse in Redman's department.

"If we are unsuccessful at the first level, we review the case with the medical director and determine if there is information to warrant a second level of appeal." All letters written at the second level of appeal come from a physician who requests a peer review hearing.

If the second level of appeal is unsuccessful, Redman's staff review the information with the medical director to determine if it would be useful to ask for an external review from a third party.

"When we ask for external review, we make sure that our contentions are supported and we are not taking unnecessary cases to that level. We don't fight everything at that level. We just ask for the external review when we believe that the care was medically necessary and appropriate," she says.

The hospital system is successful in 80% to 85% of the cases it submits for external review.

Many of the denials are overturned retrospectively because additional information was not available at the time the care was denied.

"Most of the time it is frontline communication

*(Continued on page 27)*

# CRITICAL PATH NETWORK™

## Six Sigma projects add efficiency to discharge process

*Hospital system improves patient throughput*

Six Sigma projects at Sharp HealthCare hospitals have dramatically shortened the time that elapses between the time that discharge orders are written and the time the patient leaves the acute care setting.

The Six Sigma team at Sharp Chula Vista (CA) Medical Center shortened the time it takes for patients to be transferred to skilled nursing facilities after the discharge orders are written from a median of four hours to a median of 3.3 hours. Projects at Sharp Grossmont Hospital and Sharp Memorial Hospital shortened the median time between discharge orders and actual discharge from 2.2 hours to a median of about 1.5 hours.

The teams determined that using the median was a better measure than using averages because there are always outliers that unduly influence the average, says **Patricia Atkins**, MS, RN, CNS, director of Lean Six Sigma and a certified ASQ Six Sigma Black Belt.

"The case managers were involved in all phases of the projects because they are involved with the patients from admission through the discharge process," Atkins adds.

Sharp HealthCare's case management department includes RN case managers and care coordinators, who are clinicians but who are not RNs. For instance, some are foreign-trained physicians who are not licensed to practice in this country; others are licensed vocational nurses.

Case managers are unit-based with an average caseload of one to 25 cases. Their primary responsibilities are utilization review and discharge planning.

The health system has a centralized Lean Six Sigma department that works on projects with the staff at each of the system's four acute care hospitals.

### *Identifying projects*

The hospitals identify potential projects proactively by reviewing performance indicators for key health care processes and reactively by reviewing customer complaints and quality variance reports in problem areas.

Each hospital submits proposed projects and the executive steering committee sets priorities for the health care system. Each Lean Six Sigma project is developed and carried out by a multidisciplinary team. The projects typically take four to six months, and often longer if they are complex, Atkins says.

The Lean Six Sigma projects at the different hospitals had similar high-level processes and goals but the strategies and tools were tailored to conform to the systems and structures at each individual hospital, she adds.

"We ran our projects concurrently with separate teams at each hospital and a project manager [that] collaborate to share the best practices we discover along the way with the teams at all the hospitals. This approach works best because there are different cultures and systems within the different entities," Atkins reports.

Before beginning the discharge project at Sharp Chula Vista, the case management department went through the Team Resources Management (TRM) training to improve their teamwork skills.

The TRM program includes training on work distribution, conflict resolution, hand-off strategies, and communication improvement strategies, such as checking to make sure a message

was received.

"The program was offered throughout Sharp HealthCare to give the staff the tools they need to be effective in working with each other. The participants learned what their expectations are as a team member, within the hospital as a whole, and on the unit level. This training on working as a team creates a foundation to make it easier to change long-standing processes," Atkins says.

When the staff at Chula Vista Medical Center reviewed discharge times, they determined that they had the most opportunity to affect the discharges to skilled nursing facilities, says **Cheri Graham-Clark**, RN, MSN, PHN, director of quality improvement and care management/patient safety officer.

The majority of patients are discharged to the 100-bed skilled nursing facility located on the hospital campus or one of six other facilities within 10 miles of the hospital in locations that are most convenient to the patients' families.

## *Smoothing discharge to SNFs*

The Chula Vista Six Sigma team started by looking at the time that elapsed from when the physician issued the discharge order until the patient actually left acute care.

"When we started the project, it was taking approximately 10 hours from the time the discharge orders were issued until the patient was transferred to a skilled nursing facility. Our goal was to get the time down to four hours," Graham-Clark says.

The team reviewed patient records to find out the roadblocks to a speedy discharge and drilled down to determine what could be done to increase efficiency and decrease the delays.

"Many of the reasons for the delays were around standard work flow and teamwork issues. There was not a standard process for handling skilled nursing facility discharge forms, limited knowledge of what facilities could take what kind of patients, and gaps in communication between the case managers and other providers," says **Jason Broad**, MBA, certified Six Sigma Black Belt.

The team determined that the case managers were spending a lot of time providing information to skilled nursing facilities that wasn't necessary for the facility to make a decision as to whether it could provide appropriate care for a patient.

The hospital invited all of the key stakeholders in the skilled nursing referral process to a meeting to brainstorm on what information case managers should provide when they refer patients. Participants included the hospital case managers, and case managers from the Sharp skilled nursing facility and from others in the immediate area.

At the time, each of the skilled nursing facilities had different requirements for information they needed in order to decide if a patient was appropriate.

The Six Sigma team members worked with the skilled nursing facility to create standard expectations so that case managers could provide the same information for each referral. By doing so, the team was able to reduce the information that the case managers were sending by 30%, Broad says.

This step saved the case managers 10-15 minutes or longer for each patient referred to a skilled nursing facility.

The team determined that case managers were spending a lot of time contacting facilities that could not provide services to a particular patient. The case managers on the team came up with a list of the types of patients who were difficult to place, such as those who needed wound vacs or ventilation equipment.

The team created a list of skilled nursing facilities throughout the county, contacted them, and found out which kinds of patients they could accept.

"This helped to narrow down the choices for patients and families and eliminated telephone calls to facilities that were not appropriate for a particular patient," Broad says.

The team tackled improving efficiency in the case managers' work stations using a Lean Six Sigma approach called "the 5S," a five-step methodology for improving the flow and organization in the workplace. The steps are: sort, straighten, shine, standardize, and sustain.

"The purpose of the 5S is to make the environment efficient so that workers have everything they need where they need it and when they need it and there is no wasted time looking for things," Atkins says.

The team looked at the design and placement of the workspace, the computer access, the efficiency of the work process, and the flow of information between the physicians, nurses, and the case managers.

At the time of the project, the case managers' work stations were located in a corner, where people had to seek them out.

"They were not in the natural flow of the physicians and nursing providers. Simply relocating the

workstations so the case managers were visible and available to the physicians was a key to improving communication," Atkins says.

### *Observing workflow*

By observing the workflow on the unit, the team determined that the case managers were spending a lot of time walking out of their work area to the other end of the unit to the fax machine. Moving the fax machines to a more convenient location and, in one case, purchasing an additional fax machine for the unit saved time for the case managers.

When the Lean Six Sigma teams at Sharp Grossmont Hospital and Sharp Memorial Hospital looked at improving discharge times for routine discharge, they determined that the delays were occurring because the staff were often being reactive to the physician's discharge orders, rather than taking a proactive approach to discharges that were going to occur in the future.

"The treatment team wasn't systematically talking today about tomorrow's discharges. They were waiting until the physician actually wrote the orders. We wanted to develop a systematic way of keeping the team aware that a patient is probably going to go home the next day so they can be prepared," Atkins says.

Solutions to the project included creating an icon placed on the spine of the chart, notifying staff that a patient is likely to be discharged the next day, a discharge checklist inserted into the communication forms on each unit, and a standardized computerized screen for home care education.

"With this project, it was difficult to come up with a meaningful figure to measure because there are so many outliers whose discharge takes longer than average for so many reasons," Atkins says.

The team decided to measure median time from discharge order to the time the patient was out the door. The median dropped from 2.2 hours to 1.5 hours.

"It is really hard to change a median, so even though it seems like a small improvement, it is statistically significant," Atkins adds.

Instead of documenting probable discharges in the chart and raising the possibility that an insurance company could issue a denial, the team created an icon that anyone on the treatment team can place on the spine of the patient's chart if the patient is likely to be discharged the next day.

The icon is a sticker of a car, in keeping with the theme of the project: "Way to Go."

The car icon calls the treatment team's attention to the fact that the patient is expected to be discharged and alerts them to make sure that all the patient's discharge needs are met.

"This is not like an actual discharge order but it encourages the team to start talking to the family, arranging transportation, setting up home health care or durable medical equipment deliveries, and taking care of other discharge needs," Atkins says.

The team created a discharge checklist to insert into each unit's communication form.

Since each department in both hospitals uses a different type of form to communicate between staff and has different information needs, the Lean Six Sigma team decided not to create a new form, Atkins says.

Instead, they took whatever communication form each department used and inserted the items that need to be double-checked before discharge, such as durable medical equipment, home health services, transportation, and patient education.

Before the Lean Six Sigma initiative, the case managers, nurses, and physical therapists documented home care instructions on a different screen. The team created a centralized documentation screen so everyone on the team could communicate potential barriers to discharge and proactively work together to address those barriers.

*(Editor's note: For more information, contact* ***Patricia Atkins****, e-mail: patricia.atkins@sharp.com.)* ■

# Program increases patient, family involvement

*Patient safety initiative honors NPSG*

Increased patient involvement in their own care is encouraged by The Joint Commission and other organizations as one of the keys to improving patient safety. In fact, "encouraging patients' active involvement in their own care" is one of the National Patient Safety Goals.

In recognition of the importance of such an approach, Community Health Network in Indianapolis has launched a new patient safety initiative, Call FIRST (Family-Initiated Rapid Screening Team), in all five of its hospitals.

As part of the program, patients and their family members are encouraged to make a phone call when there is a change in the patient's condition and they feel their concerns are not being addressed. A designated internal phone line has

been established for the program at each facility.

When the number is called, a nursing supervisor or consult nurse will provide help within 15 minutes at the bedside to evaluate and stabilize the situation. The program is intended only for serious concerns in the change of a patient's condition. If there is confusion about the condition or treatment plan, Call FIRST also can assess the situation.

According to Community Health officials, the program is based on the "Condition H" program started by the University of Pittsburgh Medical Center in 2005.

"One of the reasons we started the program was because we are changing our culture to a safety culture," explains **Eleanore Wilson**, RN, MA, BSN, vice president of nursing at Community Hospital North. "We want to be sure our patients are safe."

The Community Health version of the program was developed by its senior leaders and safety trainers, she says, and it was launched last September.

To help prepare staff for the program, discussions were held during regular staff meetings, and "team days" were held where staff education was provided. During these half-day sessions, Wilson discussed the purpose of the program and how it would increase patient safety.

As for the patients and their families, there are several vehicles of communication. For example, there is written information provided at admission and Call FIRST signs have been posted in the patient areas to make patients and families aware of the initiative. The sign says: "Please ask us — we want your involvement." **(For more details, see box, right.)** "It also explains that we are dedicated to creating an exceptional experience, and that we want the patients and families to be our partners in care," says Wilson.

"When a patient is admitted, we give them a brochure that talks about the program," adds Wilson. "When the nurse admits them, she also explains the program to the patient and lets them know it is available."

The patient and family are told that if the patient does not feel they are being heard, he or she should call the number, and that staff want to be sure a manager responds within 15 minutes. In the brochure itself the question, "When is Call FIRST appropriate?" is posed, and then answered as follows: "If there is a change in condition and you feel your concerns are not being addressed."

Since the program is so new, there are not yet much data available. However, Wilson says, the feedback from patients, families, and staff has been positive. "One of the hospitals received a call from a patient who was being discharged and did not feel they were ready to leave the hospital," she shares. "The manager went over the case and explained that it was time for the patient to go. In addition, she said if the patient felt she needed any additional help, such as home care, that it would be provided." In short, says Wilson, "all her questions were answered."

There are a number of situations in which the program can prove beneficial, says Wilson. "For example, there could be a case of a woman who has been with her husband for 20 years and knows he is not acting normal," she says. "The family members might recognize something that we don't."

Because of this added level of communication, she adds, "we feel family involvement will increase patient safety."

*[Editor's note: Contact **Eleanore Wilson**, RN, MA, BSN, 7150 Clearvista Dr., Indianapolis, IN 46256. Phone: (317) 621-6262.]* ■

## Informing patients about Call FIRST program

Signs are posted throughout the hospitals in the Community Health Network system in Indianapolis to remind patients about the Call FIRST program. Here are some excerpts:

As a partner,we encourage you to do the following: Call FIRST (Family Initiated Rapid Screening Team) at 1-7699 (Internal Extension).

- If there is a change in your condition and you feel your concerns are not being addressed. Your family members can also Call FIRST.
- If after speaking with a member of the health care team, there is confusion about your condition or treatment plan.
- When you Call FIRST, a member of the team will provide help within 15 minutes.
- Please do NOT call for routing questions or concerns. Your care manager can address those directly.

SPEAK UP to your care team

- If you have any questions at all about your care.
- If you are unsure about any of the medications given you.
- If your armband is not checked, or your name is not confirmed before you are given a medication or treatment.
- If you are unsure if your caregiver has clean hands. ■

(Continued from page 22)

between one nurse and another nurse. The nurse on the payer side has criteria to follow to determine if something is medically appropriately," Redman explains.

The nurses on the payer's side have to follow the payer's criteria to determine if something is medically appropriately, she points out.

"If the payer nurse questions the medical necessity of care, it has to be escalated to the physician level. If there is one piece of data that isn't available at the time, that could be a reason for the denial," she says.

For instance, the payer may determine that the patient didn't meet acute care criteria, based on the payer's criteria. When the hospital system conducts the retrospective appeal, there may be information in the medical record that shows that the care was medically necessary even though it didn't meet standard criteria, Redman says.

Sometimes the appeal was denied concurrently because the physician who reviewed the case for the payer was not an expert in the condition for which a patient was being treated, Redman says.

For instance, a physician with a background in internal medicine may conduct the concurrent review of a continued stay for a patient with a transplant-related condition.

"Most payer laws state that the second level of review must be done by a physician of similar specialty," she says.

Redman works with corporate contracting to represent case management issues in negotiating contracts with payers.

By using the case management software system, the hospital system can track payer trends across multiple hospitals and has been successful in renegotiating contracts with two major payers to address issues for denials.

For instance, many denials occur because of a delay in service on the weekend. When the contract was renegotiated it included language stating that if a patient meets InterQual criteria, the hospital will be paid for those days when test results that would affect the next level of treatment or intervention are pending. For instance, if the patient couldn't be safely discharged until the pathology results were in, the hospital would be paid for acute level of care until the results are in.

In another instance, the payer had contracts with a limited number of skilled nursing facilities in the area. The hospital system successfully negotiated that if the hospital could provide that none of their approved facilities could accept the patient, the payer would reimburse the hospital at the skilled or subacute level of care, rather than outright denying a continued stay.

*(For more information, contact* ***Charleeda Redman****, e-mail: redmanca@upmc.edu.)* ■

# Medicare compliance team reduces denials

*CMs collaborate with physician advisor company*

Having a team of case managers dedicated to Medicare compliance reduced the number of admission denials from 221 in 2006 to just two by late December 2007 at The Valley Hospital in Ridgewood, NJ.

The goals of the Medicare compliance team are to improve physician documentation and ensure appropriate billing and appropriate reimbursement, says **Maryann Vecchiotti**, director of case management/social work.

The Medicare compliance team works six days a week and is backed up by a physician advisor company with which the hospital contracts to provide advice on Medicare issues, she says.

"We increased our revenue by reducing denials, reducing inappropriate observation, and having written documentation for compliance, particularly on the cases that fall into gray areas between inpatient and observation status," says Vecchiotti.

Much of the revenue the hospital has been able to recoup comes from ensuring that patients are in the appropriate status, she adds.

"We found that a lot of the problems arose because the attending physicians and our internal hospital physician advisor were overusing observation. They were automatically writing it because they were afraid of repercussions from Medicare if the patient didn't meet inpatient criteria," Vecchiotti explains.

## Navigating gray areas

Having outside consultants who are extremely knowledgeable about Medicare regulations and admissions criteria has helped the hospital place patients into the proper status, she adds.

"There are a lot of cases that fall into a gray area. The outside doctors are the experts on

Medicare and InterQual. A lot of times, they feel that the cases we question actually meet medical necessity guidelines," she says.

The hospital participated in a year-long project with the state Quality Improvement Organization (QIO) and 15 other hospitals. As part of the project, the hospital was required to produce monthly reports and undergo on-site audits.

"In April 2007, our state QIO recognized our compliance program, best practices, and successful completion of the pilot. We have received only a handful of cases that were questioned on retro-review by our QIO. This proves that our concurrent review system is working," Vecchiotti says.

The Valley Hospital is a large community hospital with 422 beds, including a cardiac surgery program, and about 850 private attending physicians. The hospital's overall length of stay is 2.9 days.

"We have one of the shortest lengths of stay in New Jersey and we have to move proactively to ensure that the patient is in the right status; it's time-sensitive. If we didn't have a dedicated staff to get the necessary information to determine patient status up front, we could be missing revenue and have compliance issues. This way, we can call the doctor and get the orders changed to inpatient status if appropriate. We can make the changes in real-time and get the record right before discharge," Vecchiotti says.

The hospital staff started its Medicare compliance program a year ago after a retrospective study of short-stay patients showed that patients were erroneously being put in observation, rather than inpatient status.

## Observation vs. inpatient status

"Like people at other hospitals, we have been struggling to understand what is observation and what is inpatient. When we did a study of our one- to three-day stays, we found that we didn't always apply criteria correctly and consequently were putting too many patients in observation status," Vecchiotti says.

To alleviate the problem, the hospital administration decided to create a Medicare compliance team that handles nothing but Medicare issues. The team includes a supervisor and 2.5 full-time equivalent case managers and works from 8 a.m. to 5 p.m. Monday through Saturday.

"We promoted one of our experienced unit-based case managers, Janet Reyes [RN, BC,] to Medicare compliance supervisor. She was responsible for implementation as well as hiring a team of experienced utilization case managers. We saw immediate results, with no denials in the first three months of the program," Vecchiotti says.

The Medicare compliance case managers work closely with the emergency room case managers and the unit-based case managers to ensure that all patients' needs are met.

At Valley, the unit-based case managers perform utilization review and discharge planning and work with the managed care companies.

"You come to a point when the unit-based case managers are handling too many things. Our unit-based case managers' primary focus should be with the patients and families and providing a timely discharge plan. We needed to implement a concurrent, time-sensitive Medicare compliance program with case managers looking at what the status should be and working with the attending physician to get the patient in the right status up front," she says.

The hospital contracted with a physician advisor company that specializes in hospital compliance issues to work with the case managers on Medicare questions. The physician advisor company has a dedicated team of doctors who work with the Valley Hospital case managers and medical staff.

"These physicians understand the guidelines and the compliance regulations. That is their job. Often the physicians on the hospital level have so many other things going on and they aren't as knowledgeable about Medicare rules and regulations," she says.

## Medicare compliance team

The Medicare compliance team is part of the case management department but works only on Medicare issues. They work out of the medical library but move throughout the hospital using laptop computers and portable telephones.

When the Medicare compliance case managers started work in January 2007, they initially reviewed all of the high-risk diagnoses, such as chest pain and syncope, and are now moving toward reviewing 100% of all Medicare admissions.

The team reviews Medicare patients admitted through the emergency department, from the physician offices, and those transferred from other hospitals.

The Medicare compliance case managers review the charts of all Medicare patients who come through the hospital to determine if the patient should be admitted as an inpatient or

placed in observation and makes sure the documentation is complete.

"We are looking at the proper setting for the patients, what their needs are, where they fit into the guidelines, and whether the physician documentation supports it," she says.

If she has a question or needs more information after reviewing the chart, the case manager calls the attending physician and can take verbal orders if necessary to ensure that the documentation supports an acute care admission.

If the patient still doesn't appear to meet InterQual criteria, the case manager refers the case to the physician advisor company for review.

"The nurse who did the review calls up the physician advisor company and gives the physician a case summary. He or she will ask questions and make a decision on whether the patient can be admitted as an inpatient," Vecchiotti says.

When patients are admitted from a physician office, often it's only a matter of getting additional information from the physician, she points out.

"The doctor may want to admit a patient for near syncope, which doesn't meet inpatient criteria but he knows other information that would make an admission appropriate. Instead of basing admission on the initial information the doctor had, we find out about other issues, such as failed outpatient treatment, patient safety issues, and risk factors that may have influenced the decision to admit her," she says.

The physician advisor company conducts a review of every case referred to them and makes a decision by the end of the day, and then provides a letter explaining the rationale to the hospital. A copy of the letter goes in the medical records and in the billing folder.

"The staff inputs the cases into a shared database on a daily basis so we know concurrently what is going on with Medicare patients," Vecchiotti says.

Medical records and patient accounts have access to the database and have staff dedicated to the concurrent process.

"This allows questions to be addressed concurrently and not months later. This team approach ensures that we have a quality review process," Vecchiotti says.

When the Medicare compliance case managers come in each morning, they print out a list of all Medicare admissions within the past 24 hours and divide up the workload.

"We look at everyone with an overnight stay and determine if it should have been inpatient or observation and make sure that it is documented if the patient has any complications," she says.

*(Editor's note: For additional information, contact **Maryann Vecchiotti** at e-mail: mvecchi@valleyhealth.com.)* ■

## CNE *questions*

5. The Outpatient Prospective Payment System final rule retains the "inpatient only list" for surgical patients but removes how many procedures from the list?
A. 13
B. 28
C. 52
D. 77

6. How many outpatient quality measures must hospitals report on in 2008 in order to receive the full market basket payment update in 2009?
A. Seven
B. 10
C. 14
D. 26

7. How much does the University of Pittsburgh Medical Center recover each year through its multilevel denials process?
A. $150,000
B. $250,000
C. $500,000
D. $1 million

8. How many admission denials did The Valley Hospital receive in 2007 after implementing a Medicare compliance team?
A. Two
B. 15
C. 22
D. 30

**Answer key: 5. A; 6. A; 7. D; 8. A.**

## 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. ■

AMBULATORY CARE
QUARTERLY

# More patient-friendly bills ongoing industry goal

*Discrepancies often undetected*

Making patient bills more user-friendly — not to mention ensuring that they are actually accurate — continues to be a focus in the health care industry.

One in four consumers polled by PNC Financial Services Group Inc. (www.pnc.com) said they believe their insurer had denied a legitimate claim and, of those, many reported paying the claim out of their own pocket, probably motivated by the fear of getting their credit damaged.

In the same poll, one in three Americans reported having trouble understanding the explanation of health benefits they received from their insurer.

### *Common billing issues*

Common billing mistakes include medical coding errors, errors in how annual deductibles are applied, and confusion about which providers are in or out of network.

One of the biggest patient billing issues is related to the need for better reconciliation between what goes onto the bill and what services are actually provided, says **Susan Johnson**, a Chicago-based senior consultant for Watson Wyatt Worldwide.

"The hard thing is that very rarely do hospitals submit detailed bills — just major revenue codes," she adds. "Drugs are ordered but never given and then the patient is discharged. Once [the drug] is ordered by the physician, it shows up on the bill even if the patient never receives it."

With the way bills are submitted now, such discrepancies aren't revealed until a hospital bill audit is conducted, Johnson points out. Providers may say it doesn't matter that care is not reimbursed at a line-by-line level — because of diagnosis-related groups (DRGs) — but she contends that the lack of detail ultimately increases health care costs.

"It looks like this many drugs, this many services [were provided], but they weren't," Johnson says, "so on an accumulated basis, it drives up rates."

Diligence is required at the front end by the staff who are putting the bill together, she notes. "[Detailed information] typically doesn't make it to the insurer or the biller — they're just [using] revenue codes, but nobody will know what's really going on until somebody digs in.

"There needs to be better reconciliation before the bill is actually generated," she adds. "The internal audit process needs to be tighter."

Johnson says she has observed during her own hospital experiences that all orders — and charges — are entered on a computer in the patient's room. Employees also should record the fact that the drug, for example, has actually been given to the patient, she adds.

With staffing shortages at most facilities, that doesn't always happen, Johnson notes. "The same thing happens with tests."

There is a similar lack of precision with physician billing, she says. "What we tend to see is that people get one code and use it for everything."

On a routine office visit, for example, staff may use the "new patient comprehensive" code, Johnson adds. "You have that code being used over and over for the same patient."

One reason might be that with frequent staff turnover, generic codes are overused because it's the "easy thing, instead of making [employees] think," she says. "You don't want to think it's intentional. The fraudulent or less ethical [explanation] is they're using maximum codes all the time to see if they will slip through."

If this "upcoding" isn't discovered — and often it is not — "the provider gets more money," Johnson notes.

On the physician side, "in terms of pure accuracy," she adds, the biggest problem is probably the lack of modifiers. With the CMS 1500 billing form, for example, "you can put as many diagnosis codes as you want, and then there are six or seven lines for charges that have to have CPT codes and on the right, an area for each charge line and which diagnosis code goes with that charge.

"You can be that specific, but a lot of providers don't submit that level of detail," Johnson says. "If you want to list a 'well-woman' visit plus a secondary diagnosis code for hypertension, if it's not clear on the charge line — if that doesn't match — the claim can be denied."

The latest Patient-Friendly Billing (PFB) Project report from the Healthcare Financial Management Association (HFMA), "Reconstructing Hospital Pricing Systems," is a call to action for hospital leaders to do as much as they can to achieve a rational pricing system, according to **Richard L. Clarke**, the

organization's president and CEO.

The report describes a pricing system fraught with subsidies, hidden taxes, and conflicting incentives that is incredibly difficult for the general public to understand, inhibits transparency and price comparisons, and is costly for providers and payers to administer.

Hospitals already are making improvements to support patient-friendly pricing practices, the report states, noting that 97% of respondents to an HFMA survey say they are making "some" or "significant" progress in setting discount policies for uninsured patients. Forty-one percent report progress in creating a systematic approach to establishing rational, easily accessible pricing information, and 71% report progress in ensuring staff who interact with patients understand the organization's key pricing and payment principles.

Survey respondents said the top barriers to improving hospital pricing systems include Medicare charge structures, private payer contracts, community response, and uncompensated care.

The report, available at www.patientfriendlybilling.org, offers recommendations on how hospitals can address each of these barriers, as well as principles for improving their overall payment systems.

Since 2005, HFMA has led a collaborative effort to promote patient-friendly financial communications with support from the American Hospital Association, the Medical Management Group Association, providers, and other interested parties.

State organizations are following that lead, including the Georgia Hospital Association (GHA), which is partnering with the Georgia chapter of HFMA to assist members in implementing recommendations from some of the PFB reports, says **Robert Bolden**, GHA's senior director of data services.

"We've set up a billing policy workgroup, and are working over the next few months to provide some [implementation] strategies," Bolden notes. The impetus for the PFB project, he adds, is to "come up with ways to provide patients a better experience with the billing process."

Recommendations include such things as trying to do as much work as possible up front to get patients qualified for any financial assistance programs that might be appropriate, Bolden says, as well as having a strong focus on collecting payment at or before the time of service.

The whole idea behind the Georgia initiative, he points out, "is not to say you need to do this, but to find ways to facilitate and educate — to make [members] aware of what the recommendations are, and to guide them in how they might remove barriers."

Limitations in computer systems, for example, might prevent hospitals from having a patient-friendly description of a treatment or procedure in the bill, Bolden says.

"If you're allowed a certain number of characters and use medical jargon, [the bill] might say 'cholecystectomy' instead of 'gallbladder removal,' which would be the patient-friendly term," he adds. "If the patient sees that on the bill, he won't know what it is."

The solution, Bolden says, might be working with the vendor community to modify systems to be more patient-friendly.

Patient focus groups have cited such billing issues as "being overwhelmed by papers," he notes. "They may get a hospital statement — not a bill yet — saying the insurance has been billed, and then later a hospital bill, and then a bill from the surgeon, the anesthesiologist, and the radiologist, and then an explanation of benefits from the insurance company."

## CNE objectives

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

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■

## COMING IN FUTURE MONTHS

- Understanding the business side of case management
- Putting the new MS-DRGs to work for you
- Why documentation enhancement programs are more important than ever
- How your peers are managing the care of the uninsured

With that many different pieces of correspondence, Bolden says, "it's easy to put it all in a drawer and forget about it."

Emory University Hospital in Atlanta is working on a Patient-Friendly Billing project, says **Peter A. Kraus**, CHAM, business analyst for patient accounts services. While mostly a patient accounts endeavor, he notes, the project has patient access implications.

Patient access staff become directly involved, Kraus points out, in the following ways:

• **Notifying patients when a patient-friendly billing initiative is implemented or about to be implemented.** In addition to changes in statement formats, Kraus says, access to viewing and paying accounts on-line may be new and different for patients unless they have used the process through banking and credit card accounts.

• **Getting good patient address data and formatting them correctly.** The product being used at Emory, for example, uses an address scrubber that follows United States Postal Service parameters for abbreviations and other formatting choices, he notes. "Basically, it can stop a statement with a bad address from being sent, saving us the postage. But the address must be updated."

While the address may be "bad" in the usual sense when this happens, it could also be a matter of what words were abbreviated and how, Kraus adds. "We're not sure what the impact will be, but [the access department] has been alerted."

• **Patients get to see more about their accounts than with traditional billing.** If insurance plans are entered incorrectly, misspelled, etc., patients may see the results of careless work, he says. ■