Basics of Case Management

Pennie Bozeman, RN, BSN

Care Management Director

Definition

- A dynamic process that assesses, plans, implements, coordinates, monitors & evaluates to improve outcomes, experiences and value
- A collaborative practice including patients, caregivers, nurses, social workers, physicians, payers, support staff, other practitioners and the community
- Facilitates communication and care coordination through effective transitional care management
- Recognizing patient rights to self-determination, the significance of the social determinants of health & complexities of care
- Goals are achievement of optimal health, access to services and appropriate utilization of resources

Educational Requirements

Bachelor's Degree in a human services related field including but not limited to psychology, education, rehabilitation counseling or counseling and 1 year of paid experience in that field

Licensed Registered Nurse and 1 year of paid experience as a registered nurse

Bachelor's or Master's Degree in Social Work from a social work program and 30 hours of graduate level coarse credit in a human services related field (may be substituted for the one year of required paid experience)

4 Key Functions of the RN Case Manager

What is the difference of Case Management & Utilization Review?

- Case Management: Coordinates care and assists the patient to navigate the system to attain the highest quality of care
  - Hospital Case management is a team effort to ensure:
    - that care is efficiently provided in the most appropriate setting
    - Hospital is reimbursed for the services provided
    - Patient and family goals are identified and met
    - A safe and fiscally responsible post-hospital plan of care is established
    - Incorporation of vision for future function and care giving

- Utilization review: Examines how services are being utilized, whether or not the services are effective and how much money it costs to provide the service

Utilization Review Plan

- The hospital must have in effect a utilization review plan that provides for review of services furnished by the hospital

  (Federal regulations – 42 CFR 482.30 – Codes of Participation)

Utilization review examines how healthcare services are utilized:

By the patient

How long the services are utilized

Whether or not the services are effective

How much money the services cost

Utilization Review

- It is more than communicating with the payer and send the record
- First priority
  - Does the record support the setting ordered by the physician?
  - Will the patient require services outside of his hospitalization to obtain optimal health?
  - What resources are anticipated during the hospitalization for the hospitalization?
  - Does the patient's payment source require authorization for the hospitalization?
    - No…..Review as needed for LOS of management
    - Yes….then Send medical record & Follow up for authorization or denial
      - Authorization
        - Number of days
        - Continued stay review based on approved days
      - Denial
        - Agree w/clinical rationale for denial?
        - Discuss change in status w/treating MD
        - Disagree w/clinical rationale for denial?
        - Obtain additional documentation from treating MD
        - Document in UR noted clinical rationale to support ordered status

Case Management's Integral Role

- Case Management is concurrent
  - Adherence to payer contract requirements
  - Management of revenue (LOS management)
  - Revenue Cycle
  - Building the defense in the record
    - The care at the hospital level is appropriate for
      - Evaluation and treatment of
        - Disease
        - Condition
        - Illness
        - Injury
      - Is consistent with applicable standard of care

Case Management's Integral Role

- Case Management Priorities
  - Documentation of Authorization
    - Payer communication scanned to financial record
    - Indication of days authorized
    - Continued stay review scheduled the day prior to end of authorized days
  - Documentation of Concurrent Denial
    - Payer communication scanned into financial record
    - What is being denied and WHY?
    - Do you agree with denial?
      - If so, WHY?
      - If not, WHY?
    - What actions taken to overturn denial?
      - Discussion with treating physician
      - Additional documentation in medical record
      - Attempt at Peer-to-Peer
      - Discussion with payer

Case Management's Integral Role

- Documentation is in the Medical Record to support the level of care
- Case management documentation clearly indicate why THIS patient's care is necessary at the hospital level
  - Follow-up reviews timed based on plan of care and clinical documentation
- Payer is provided the documentation that supports the level of care
  - As per payer contract requirements
  - Continued documentation is sent only when REQUIRED
  - Don't give the payer ammunition
  - What does the payer contract require?
- Authorization or Denial is obtained from the payer
  - Continued Follow-up with payer until received

There are 2 Bill Types

- Outpatient
- Inpatient

- Patient "Status" has NOTHING to do with care/treatment
- "Status" is a BILLING Status NOT a care status

What is Observation?

- Medicare Reimbursement Manual
  - "Observation services are those services furnished on a hospital premises including the use of a bed, periodic monitoring by nurses or other staff which are reasonable and necessary to evaluate an outpatient's condition to determine the need for possible admission as an inpatient"

Outpatient Observation Services Defined

Defined by Outpatient Prospective Payment System Regulation

"Observation is an active treatment to determine if a patient's condition is going to require that s/he be admitted as an inpatient; or patient condition resolves itself so that the patient may be discharged"

Defined by Medicare Benefit Policy Manual

"Observation care is a well-defined set of specific, clinically appropriate services, which include 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."

Observation Rules

Observation must be ordered by:

- a physician; or
- other individual authorized by state licensure law and hospital bylaws to admit patients to the hospital or to order outpatient test

Observation order must CLEARLY indicate observation services are intended Date and time

Appropriate Observation Order:

- Place patient in outpatient observation
- Place in observation
- Observation status due to _____
- Register as Observation

Inappropriate Observation Orders:

- Admit to Observe
- Admit

Observation Rules – con't

- Documentation should indicate what we are observing
  - Reason for observation/physician intent
  - Treatment(s) initiated/planned
- Goals of care ordered, measurable point at which time goal is met
- Periodic assessment/reassessment
  - Based upon patient's condition, treatment and diagnostic test results
  - Status of unresolved problems

Medicare Observation Rules

- Patient is an outpatient
- Billed under Medicare Part B
  - Patient must have signed up for Part B benefits
- Medicare requires a minimum of 8 medically necessary observation hours to qualify for payment
- Payment is based on extended assessment composite APCs
  - Like a DRG
  - We get paid a "bucket" for observation services no matter how many "hours or units" are billed

MOON Notification

- Federal law
- Requires hospitals to:
  - Inform patients, orally & in writing
  - They are outpatient receiving observation services not an inpatient
  - The consequences of that status
- Must use the Medicare Outpatient Observation Notice (M.O.O.N)
  - Required for patients who have received 24 hrs of Observation services
  - Must be delivered no later than 36 hrs after Observation services are initiated
  - Must include the reason the individual is receiving Observation services
  - Must explain the financial and coverage implications of receiving outpatient observation services
    - Co-payment & deductible
    - Post-hospital eligibility for SNF
    - Home medications
  - Must be signed by the patient/representative
  - Copy given to patient/representative

Inpatient Level of Care

Medicare Benefit Policy Manual – Chapter 1 Inpatient Hospital Services Covered under Part A

"….However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit includes such things as: severity of signs & symptoms exhibited by the patient & the medical predictability of something adverse happening to the patient

Medicare's 2 Midnight Rule

If, at the time of the admitting decision, the physician reasonably believes the patient will require 2 midnights of hospital services (excluding delays) the patient should be an Inpatient

Healthcare Reimbursement

It's our money & we want it!!!

Reimbursement is Driven by Codes

- Coding systems are used to standardize definitions & billing
  - Medical/Surgical services = CPT Code
  - Signs/Symptoms/Diagnosis = ICD 10 Codes (used to support a CPT code)
  - Inpatient Hospital Services = DRG Codes
  - These codes are combined to claim payment (on a claim/bill) and the responsible payer reimburses for the services
  - Each service has a code assigned and a diagnosis to support the service
    - For Inpatient hospital services these are combined to create the DRG
    - For outpatient services each CPT is assigned a value for reimbursement

Health Care Reimbursement

- Per Diem
  - The hospital is paid for all services delivered to a patient during one day (a set amount PER DAY)
- Fee-for-Service
  - The physician or hospital is paid a fee for each service (medication, IV fluids, ECG, surgical procedure) provided based on:
    - Contractual fee schedule
    - Or Percent of charges
- Capitation
  - One payment is made for each patient's treatment during a month or year (largely HMOs; insurer is both the payer & provider; incentive to control costs)
- Diagnosis-related Groups (DRGs)
  - Hospital is paid one sum for all services delivered during one illness; there is a different set case-price for each of approximately 750 distinct DRGs (Medicare)

Health Care Reimbursement

- Reimbursement Overview
  - Document in the medical record the details necessary to support the patient's "need" for services
  - Codes are assigned based on this documentation
    - ICD-10 for diagnosis
    - CPT for procedures/services
  - All codes are placed on a standard claim form (HCFA 1500 Outpt/UB04 Inpt)
    - Claim is submitted electronically
    - Claim is submitted to a clearinghouse
    - Clearinghouse will reject the claim if there are errors
      - Goal is to submit a "clean claim" to the payer
    - Clearinghouse translates claims into a standard format compatible w/payer's software

Case Study # 1

Patient presents with SOB, fever and elevated WBCs (13.2) LLL pneumonia was evident on the chest x-ray. In the nursing admission assessment it was noted the patient had a pressure ulcer of the left buttock. Sputum culture and blood cultures are pending.

With no additional documentation we have the following:

Diagnosis

LLL pneumonia

MS-DRG	RW	GMLOS	$$$$$
195	.06997	2.9	$3,107.52

Stage III was noted by the physician. Sputum cx results Gram Negative Pseudomonas; Blood cx negative. Physician documents the type of pneumonia.

With additional documentation we have the following:

LLL pneumonia, gram negative
Pressure ulcer, buttock
Pressure ulcer, Stage III "MCC"

MS-DRG	RW	GMLOS	$$$$$
195	0.6997	2.9	
193	1.4550	5.0	
177	1.9934	6.4	$6,275.89

The higher relative weight the sicker your patient.
The higher the SOI (severity of illness) the sicker your patient

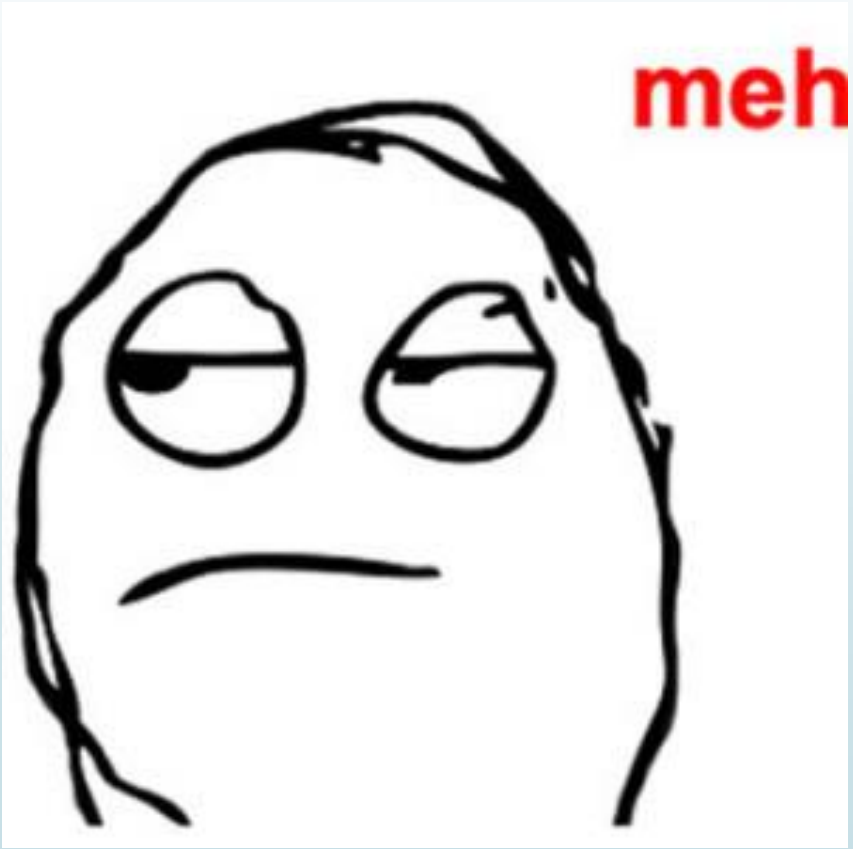
Example MS-DRG-Assignment – Acute Myocardial Infarction

Discharged Alive	MCC	CC	DRG	Reimbursement
Yes	Yes		280	$10,596
Yes	No	Yes	281	$6,137
Yes	No	No	282	$4,788
No	Yes		283	$12,296
No	No	Yes	284	$4,770
No	No	No	285	$3,262

The higher relative weight the sicker your patient.
The higher the SOI (severity of illness) the sicker your patient

CMS Medical Necessity

Does it even matter?



YES!!!!!

IT Matters!!!!!!!!!

- Medicare RAC audits
- All payer inpatient approval
- Denial avoidance
- Appeals & recovery
- Avoids calls to physicians from Case Management & CDI (Clinical Documentation Improvement) questioning status & requesting clarification

What is Medical Necessity?

- Concept that healthcare services and supplies must be appropriate for the evaluation and management of a given disease, condition, illness or injury.
- Judged against current medical standards of care
- Hospital Medical Necessity
  - The "services and supplies" being judged are at the hospital level of care
  - Just because the patient "needs" the services and supplies doesn't mean they "need" them at the hospital level of care
  - Inpatient is NOT appropriate because its easier to get the entire work-up done in the hospital as opposed to multiple outpatient encounters

CMS Mandate

- In order to substantiate inpatient admission/status, at least one of the following must be documented at the time the inpatient order is written:
  - The medical predictability of something adverse happening to the patient if not treated as an inpatient
  - The severity of signs/symptoms exhibited and why inpatient is required
  - Documentation that the stay would need to be at least 24 hours – best used in conjunction with 1 of the above
  - The above requirements may be met by documenting one of the following suggestions:
    - Co-morbidities
    - Signs & symptoms representing the need for an inpatient level of service
    - Patient is at risk for (sepsis, respiratory distress, arrhythmias, electrolyte imbalances due to diuresis
    - Failed outpatient treatment that consisted of: (po diuretics w/adjustments by MD clinic)

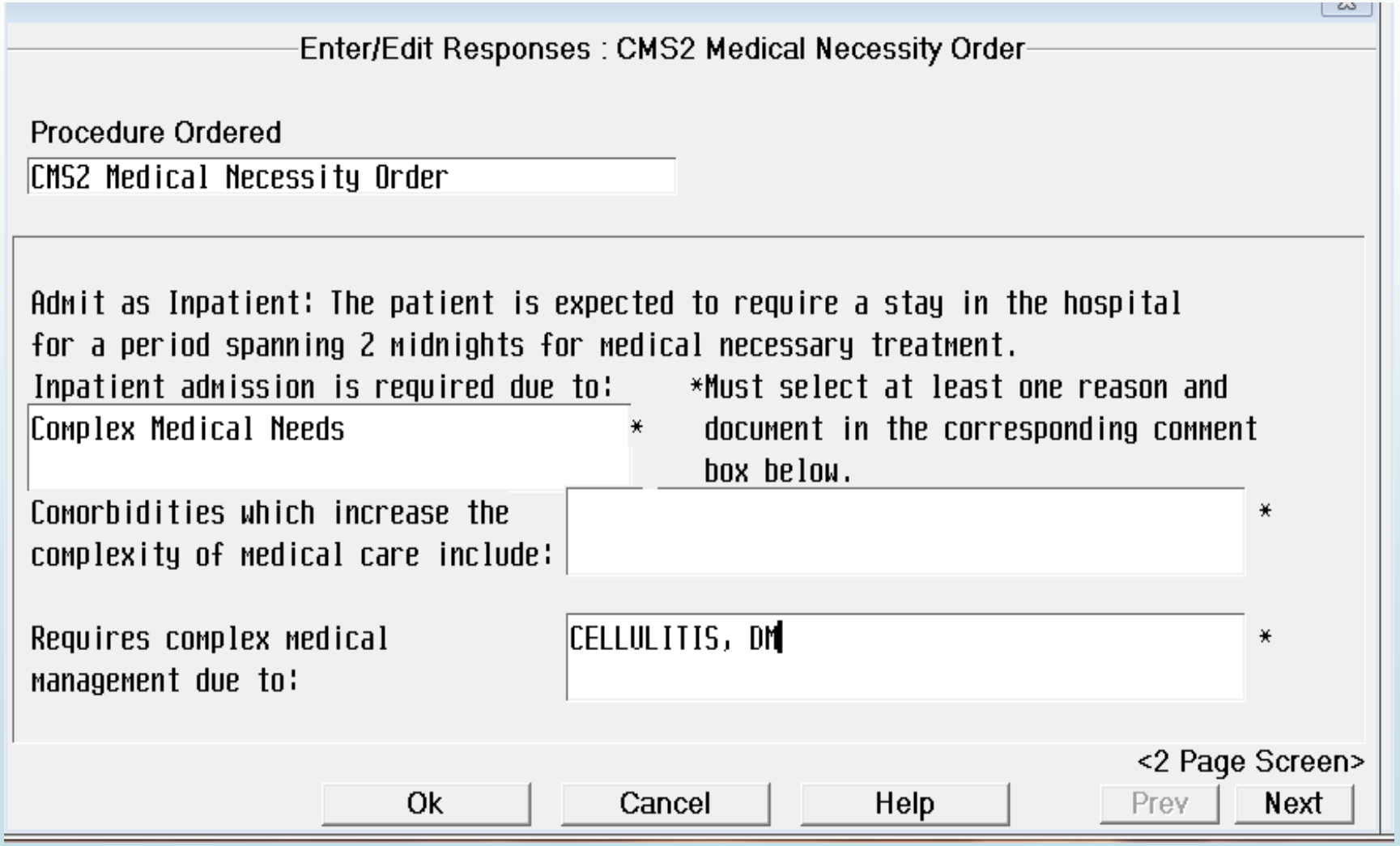
What should be considered

- Medical history
- Current medical needs
- Anticipated length of stay
  - Planned/expected treatment during the length of stay
- Types of facilities available to patient
  - Can the patient's medical needs be met at a lower level of care?
  - Home health not available in area where patient lives
- Relative clinical appropriateness of planned treatment

What SHOULD NOT be considered

- Factors that may result in inconvenience to patient or family
  - Family not available to stay with patient during the day
  - Patient not safe to stay alone
  - Financial impact to patient or family
    - Patient can't afford copayment for medications as an outpatient
    - Patient/Family cannot afford in-home caregiver
- If these factors IMPACT THE PATIENT'S IMMEDIATE HEALTH
  - Physician documentation must detail how and why
  - Describe short-term needs in inpatient setting and goal for long-term gain

Do Not -


Enter/Edit Responses : CMS2 Medical Necessity Order
Procedure Ordered
CMS2 Medical Necessity Order
Admit as Inpatient: The patient is expected to require a stay in the hospital for a period spanning 2 midnights for medical necessary treatment.
Inpatient admission is required due to:
*Must select at least one reason and document in the corresponding comment box below.
Complex Medical Needs *
Comorbidities which increase the complexity of medical care include: *
Requires complex medical management due to:
CELLULITIS, DM *
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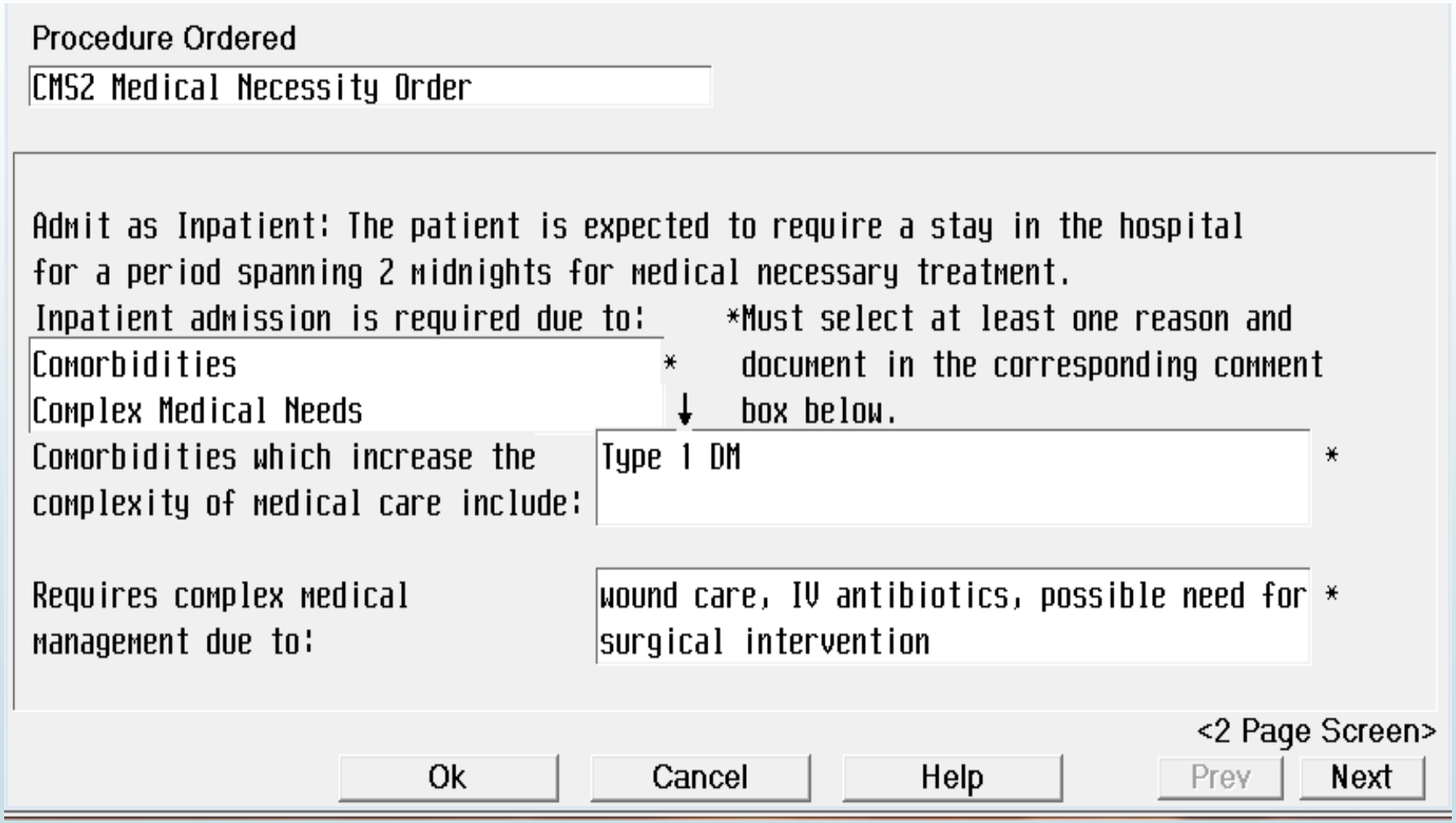

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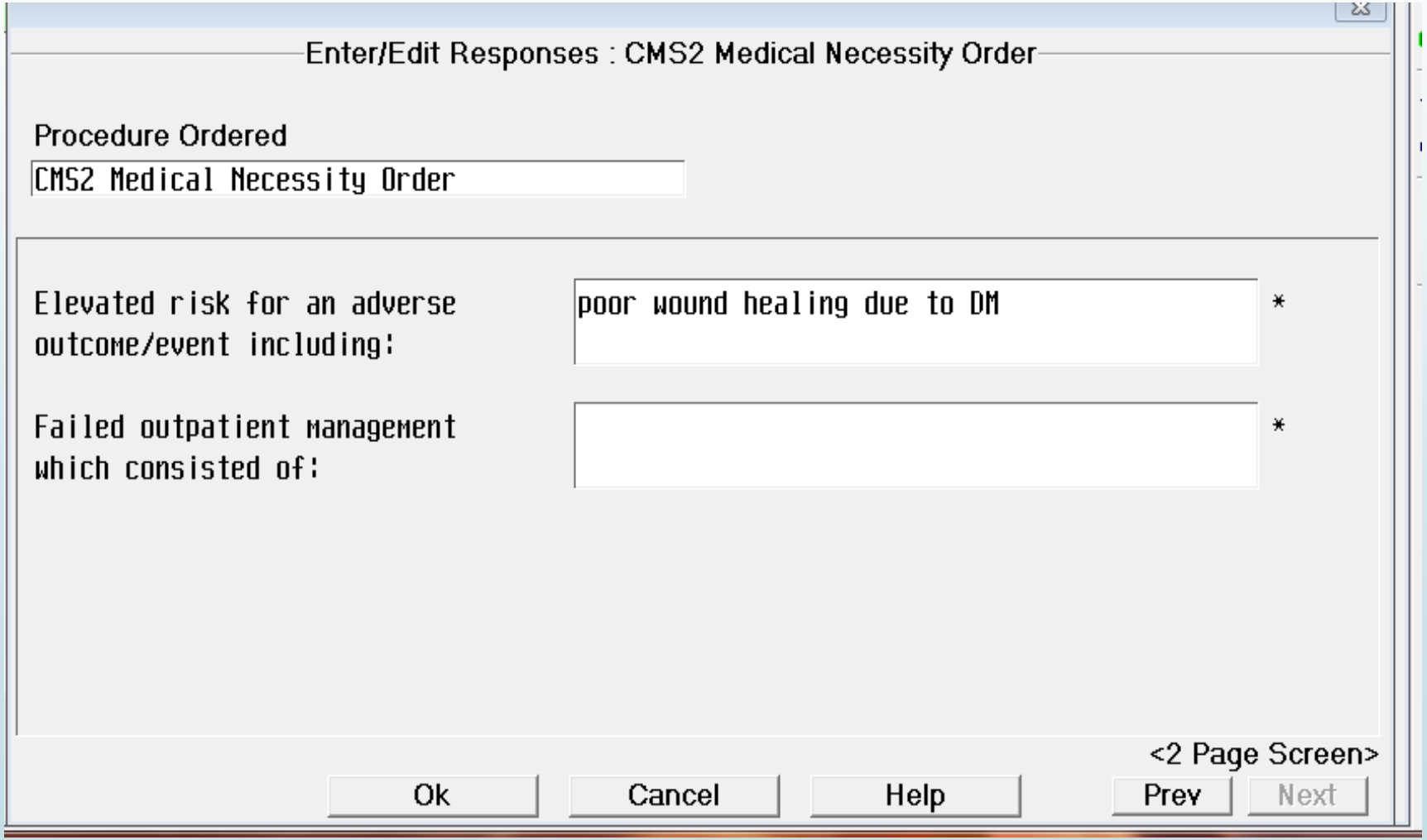
Enter/Edit Responses : CMS2 Medical Necessity Order
Procedure Ordered
CMS2 Medical Necessity Order
Elevated risk for an adverse outcome/event including:
poor wound healing due to DM
*
Failed outpatient management which consisted of:
*
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Prev
Next

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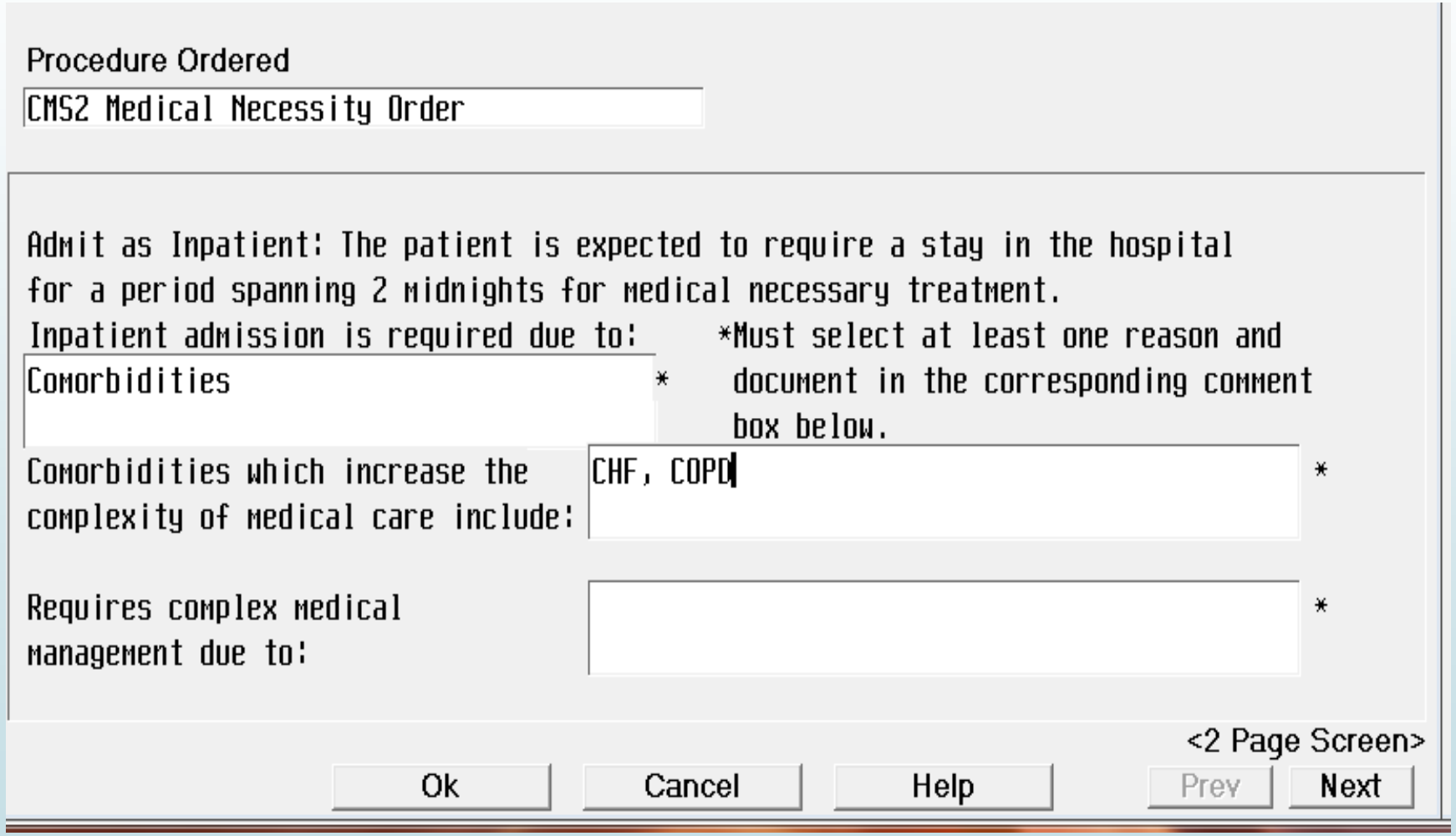
Procedure Ordered
CMS2 Medical Necessity Order
Admit as Inpatient: The patient is expected to require a stay in the hospital for a period spanning 2 midnights for medical necessary treatment.
Inpatient admission is required due to:
*Must select at least one reason and document in the corresponding comment box below.
Comorbidities
*
Comorbidities which increase the complexity of medical care include:
CHF, COPD
*
Requires complex medical management due to:
*
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Help
Prev
Next

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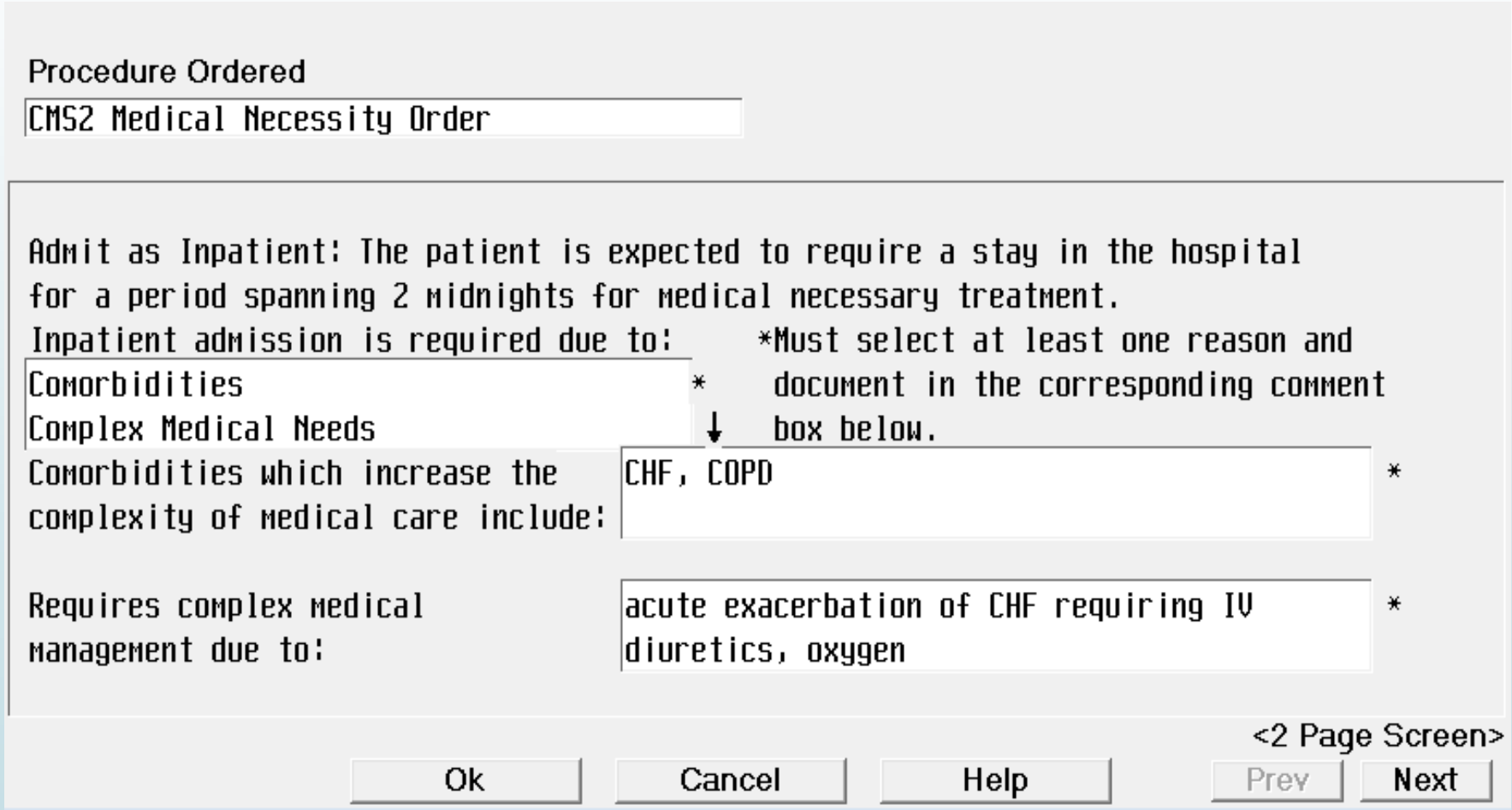

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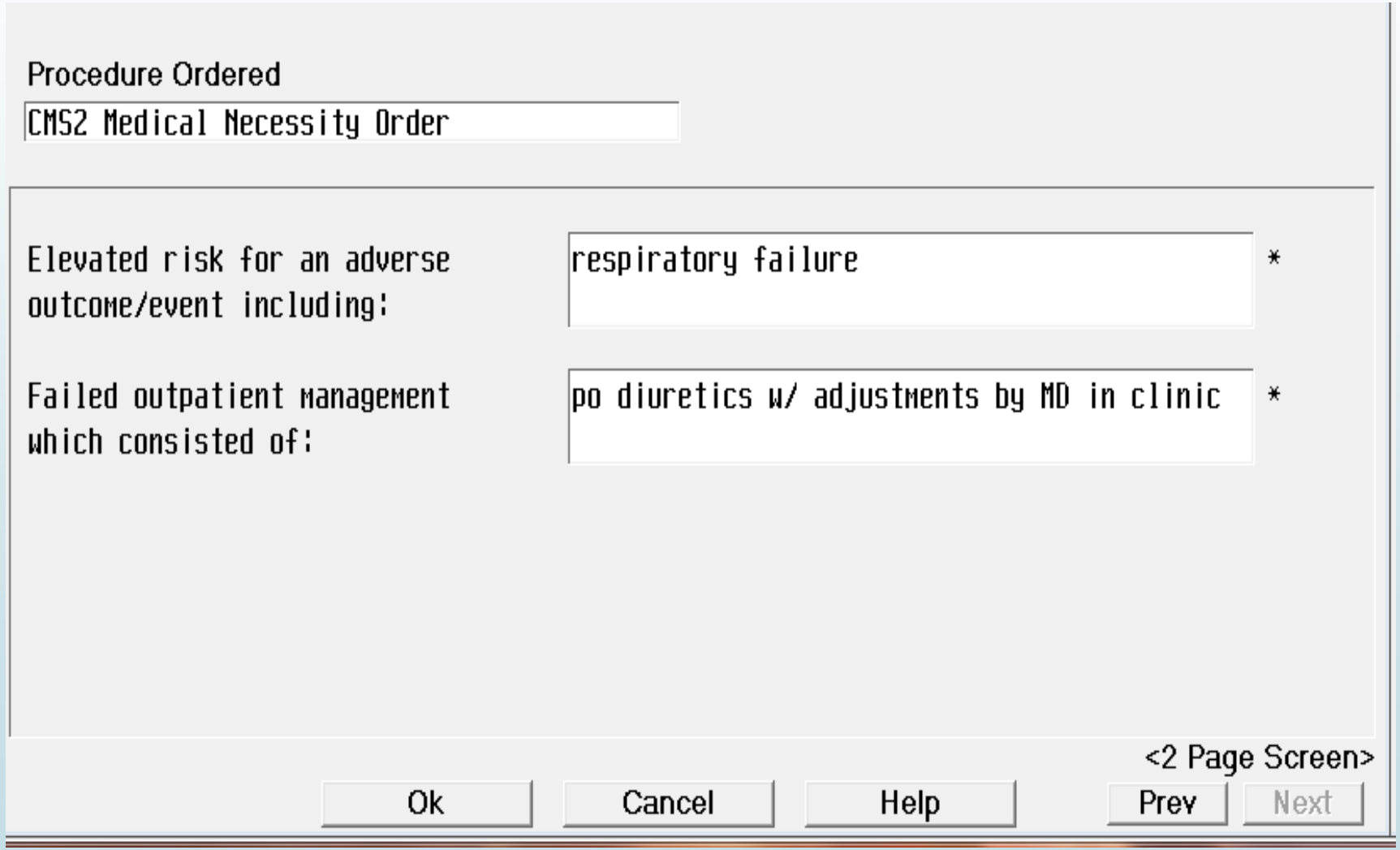
Procedure Ordered
CMS2 Medical Necessity Order
Elevated risk for an adverse outcome/event including:
respiratory failure
*
Failed outpatient management which consisted of:
po diuretics w/ adjustments by MD in clinic
*
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Cancel
Help
Prev
Next

Documentation: Critical Factors

- The judgment of the admitting physician referencing:
  - Standards of care
  - Evidence-based clinical standards
- Documentation of the "why" behind the "need"
  - If the UR nurse can't identify the medical decision-making associated with the justification for inpatient level of care…..the insurance company won't

Shall we play a game?!

Insurances

Medicare and Medicaid Basics

Medicare

- Health care coverage for:
  - People age 65 or older
  - People of any age with certain disabilities
  - People of any age with ESRD
- Medicare is the nation's largest payer of elderly inpatient hospital services and people with ESRD

Medicaid

- Health care coverage for:
  - Children
  - Elderly people
  - Low-income adults
  - People with disabilities
  - Pregnant women
- Eligibility varies from state-to-state
- Medicaid is the nation's largest source of health care coverage and covers mental health services, long-term care services, and births. Medicaid pays 42% of all births.

Medicare Options

Original Medicare

- Part A = Hospital
- Part B = Outpatient/MD office visits
- You can add:
- Part D = Drugs
- You can also add:
- Supplemental coverage (this includes Medicare Supplement insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid

Medicare Advantage

(also known as Part C)

- Part A = Hospital
- Part B = Outpatient/Md office visits
- Most plans include:
  - Part D = Drugs
  - Some extra benefits
- Some plans also include:
  - Lower out-of-pocket costs

Original Medicare vs Medicare Advantage

Original Medicare

- National coverage
- In most cases, you DON'T NEED a referral to see a specialist

Medicare Advantage (Part C)

- In many cases, you'll need to use doctors and other providers who are in the plan's network (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.
- You may need to get a referral to see a specialist
- More restrictive – Depends on the plan you buy
- Private insurance companies – have different rules for how you get services

What's Medicaid?

- Joint federal and state program
- Helps pay health costs for people with limited income and resources, or whose medical expenses exceed their available income
- Some people qualify for Medicare and Medicaid
- May cover services that Medicare may not of may partially cover, like nursing home care, personal care, and home and community-based services

Denial Avoidance

Think Like the Payer But Be the Patient

Vocabulary of Denials Prevention

https://www.healthinsurace.org

- The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional

HFMA

- Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers' technical guidelines, or failure to consistently document for the services provided.

Were we paid what was owed for all services provided?

Denial Strategy

Payer Thinking

- Hospital care is the most expensive care
- Beneficiaries don't NEED to be in the hospital
- We aren't denying CARE
- We don't make money by paying claims

Provider Thinking

- We have to provide care because the patient is here
- The patient NEEDS this care
- If the patient needs the care the insurance should pay for it

Winning Denial Strategy

- Building the Defense in the Medical Record…Inadequate documentation is one of the top reasons for medical necessity denials
- MEDICAL NECESSITY KEY DOCUMENTATION
  - Delivery of care is not feasible/clinically appropriate in outpatient setting
    - Tell me why
  - Delineation of any failed outpatient treatment
    - This alone isn't enough
  - Concern for serious outcome if patient is not closely monitored in hospital setting
    - Doesn't mean it has to happen

Winning Denial Strategy---Playing Offense, Not Defense (While Still Building the Defense)

- Medical Necessity for Inpatient is based on:
- WHAT THE ADMITTING PHYSICIAN KNEW AT THE TIME THEY ADMITTED THE PATIENT
  - Send payer 24-48 hours of documentation
    - ER note
    - H&P
    - Any OP note
    - 1 progress note if it adds to the initial determination of inpatient medical necessity
- DON'T ALLOW THE PAYER TO WAIT AND SEE WHAT HAPPENS

Now that I have blown your minds!!!

QUESTIONS?