# Demonstrating ROI with Case Management

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# Objectives

01

## Value Proposition

Understand methods to demonstrate service value

02

## Key Performance Metrics

Identify specific metrics relative to Case Management

03

## Impact Analysis

Increase knowledge on evaluating financial impacts

04

## Clinical Value

Increase knowledge on clinical outcome measures that impact financial results

05

## Results

Understand ways on Tracking results and telling the full story related to value of Case Management services

# Specific Challenges Related to Case Management

# CASE MANAGEMENT CHALLENGES

1

## PAYORS

Major payor mix shifts are happening everywhere. Higher managed care often results in higher denial rate.

2

## DOCUMENTATION

Documentation and coding rules are a challenge so much focus is needed.

3

## CRITERIA VS MEDICAL NECESSITY

Many misconceptions of these two categories. Clear understanding of CMS rules and how to utilize MN screening tools.

4

## LENGTH OF STAY

Managing within LOS targets is important for inpatient and outpatient stays. Navigating barriers is a challenge with decreased resources. Ensuring LOS targets are accurate is another important factor.

5

## QUALITY & READMISSIONS

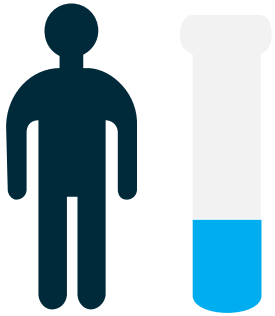
Quality outcomes impact financial results. Need to mitigate risks and track outcomes that can impact overall reimbursements.

CHALLENGE


PAYORS
Total
SEVEN BAHT AND
Vat
7%
Total Amount
ment until the buyer has done.
ผู้จ่ายของ

# PAYORS

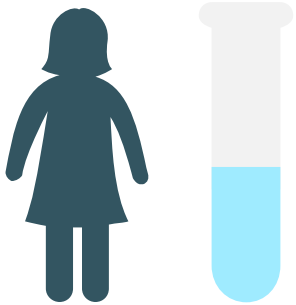
DENIALS PRESENT MANY CHALLENGES



## 19%

### IN-NETWORK CLAIMS DENIED

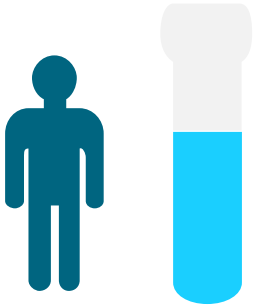
Nearly 1 out of 5 insurance claims are denied on submitted claims



## 34%

### DENIALS FOR "OTHER" REASON

16% for excluded service, 9% for authorization, 6% for medical necessity



## Up to 54%

### HIGH VARIATION DENIALS

EXAMPLES: BCBS 35%, UHC 33%, MOLINA 26%

*KFF analysis- https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/

# Investing in Denials Management

**83%**

Appeals resulted in either full or partial approval

**48%**

Do not have sufficient resources to appeal

**18%**

Fewer than 1 in 5 authorization denials are appealed

62% do not appeal as they presume denial will be upheld

https://www.ama-assn.org/practice-management/prior-authorization/over-80-prior-auth-appeals-succeed-why-aren-t-there-more

# Case Management Strategy

### Know payor rules

Have a clear understanding of payor guidelines and rules. Know your contracts and use the provider manuals to follow requirements

**CONTRACTS AND PAYOR PROVIDER MANUALS**

### Documentation

Accurate documentation supports appropriate DRG assignment but also validates medical necessity for level of care. Collaborate closely with CDI team.

**QUERY/CLINICAL VALIDATION**

### PEER TO PEER (P2P)

Best defense is completing P2P within timelines. Coordinate with payor and involved providers on the case.

**INVOLVE YOUR PROVIDERS**

### RECONSIDERATION AND APPEAL

When you feel the stay is in the appropriate level of care be prepared to timely file any reconsiderations or appeals. Know the rules and follow the timelines!

**DENIAL WORKFLOWS**

# TURN DENIAL$ INTO DOLLAR$

1

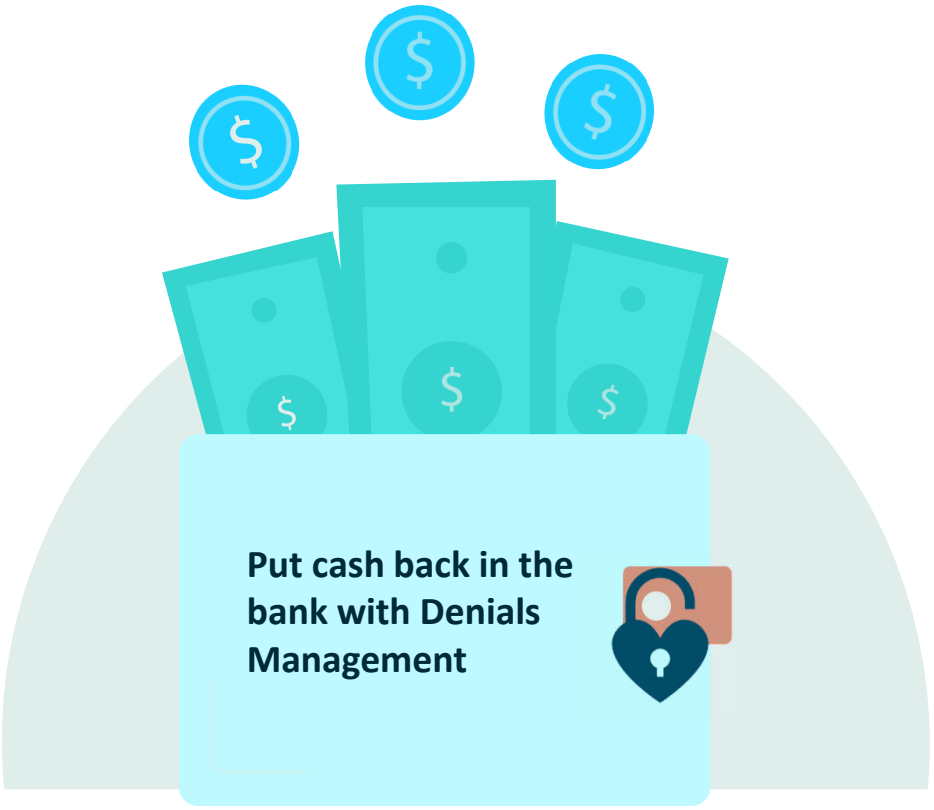
**Reporting of denials**

Identify denials timely and follow payor timelines

2

**Clinical Denials**

Specific staff for clinical denials that are trained on payor rules and requirements




3

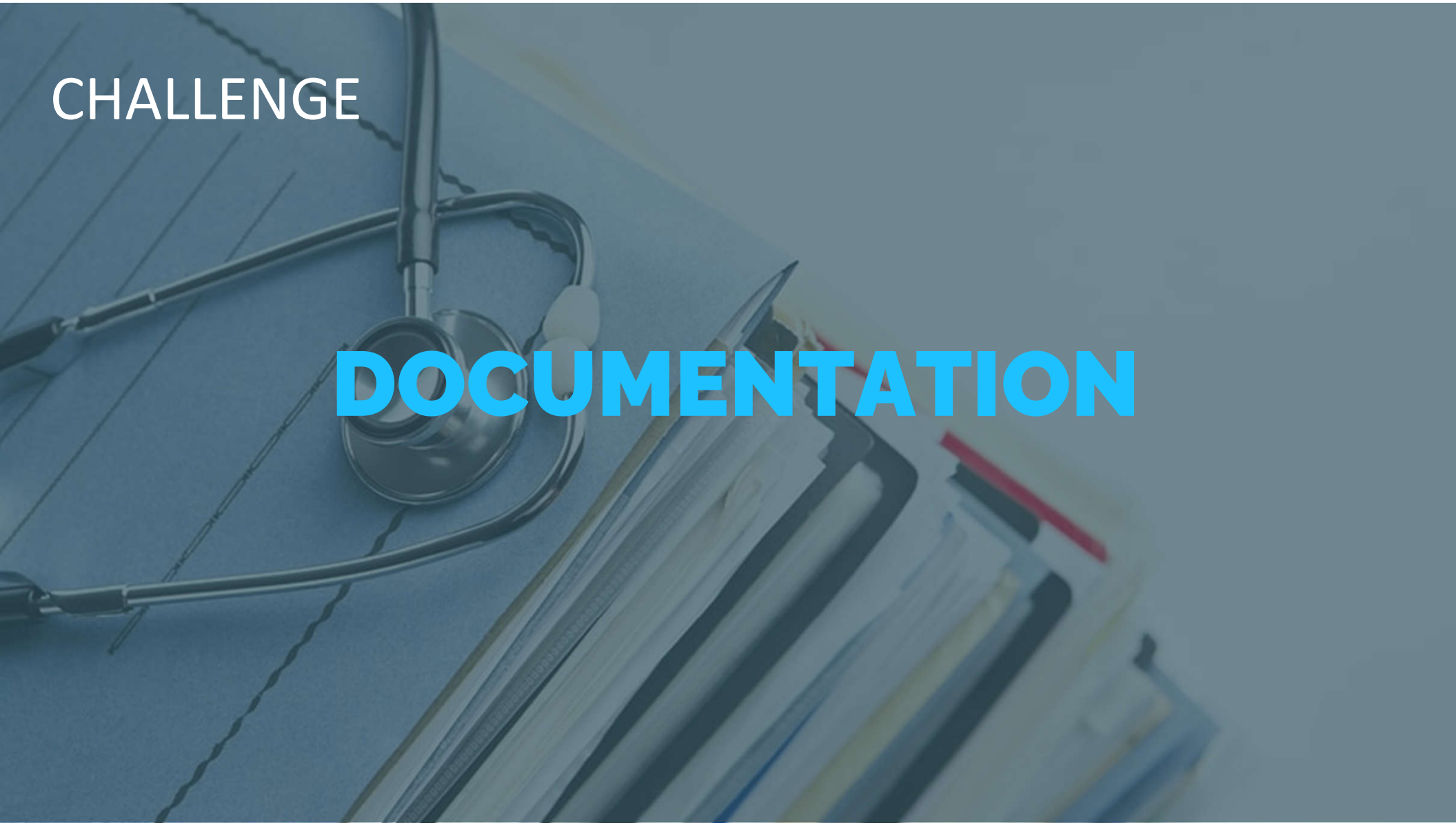
**Appeal Tracking**

Track/report on appeals
Report overturn rates and recovered dollars

4

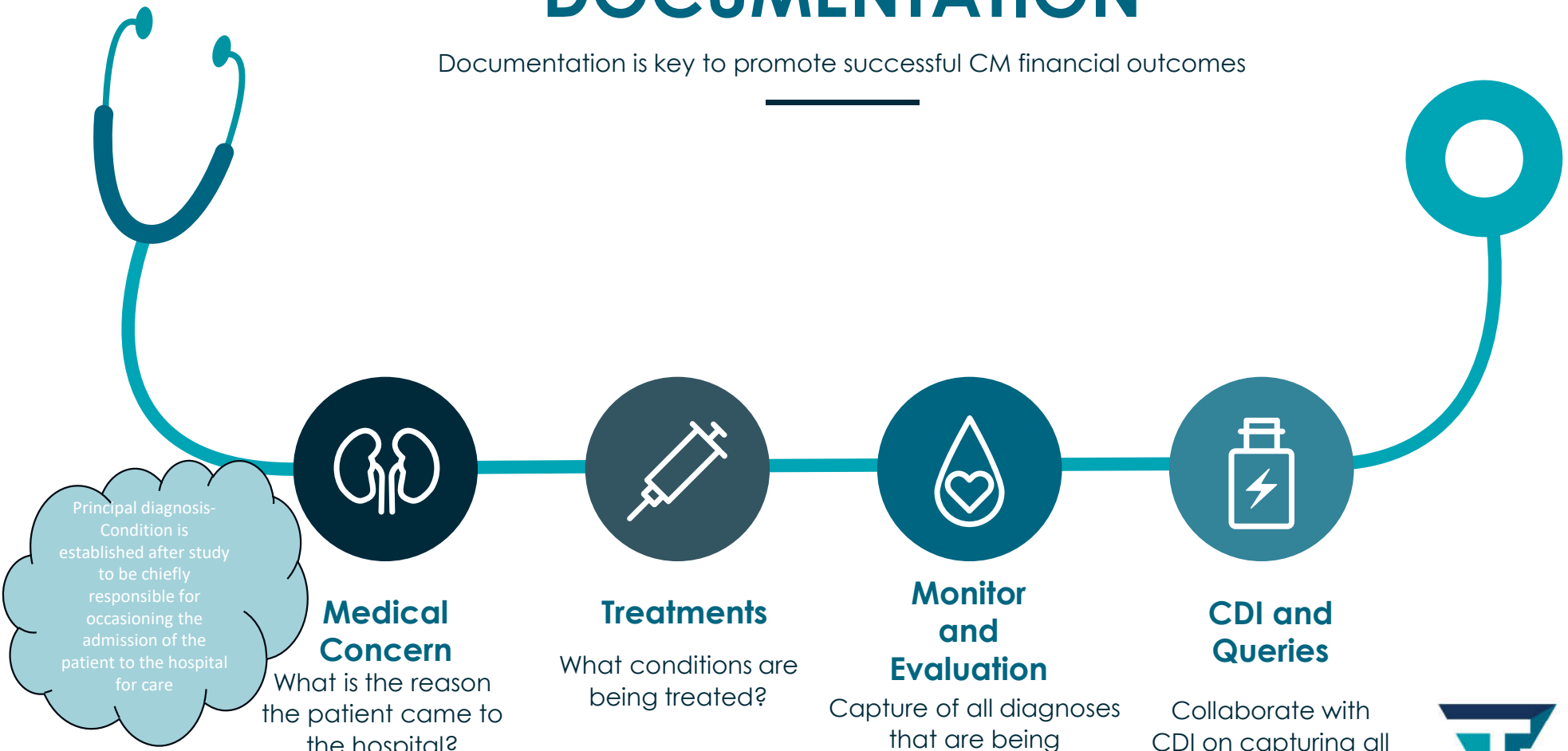
**Improvement**

Goal is to prevent denials and proactive management


CHALLENGE
DOCUMENTATION

# DOCUMENTATION

Documentation is key to promote successful CM financial outcomes



Principal diagnosis- Condition is established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care

## Medical Concern

What is the reason the patient came to the hospital?

## Treatments

What conditions are being treated?

## Monitor and Evaluation

Capture of all diagnoses that are being monitored and treated

## CDI and Queries

Collaborate with CDI on capturing all diagnoses

# Query Required?

Engagement of CDI and/or coding team

### DIAGNOSIS

Determine conditions that are clinically evident but not clearly documented

### PRESENT ON ADMISSION

Determine if signs/symptoms were present on admit for condition

### CLINICAL VALIDATION

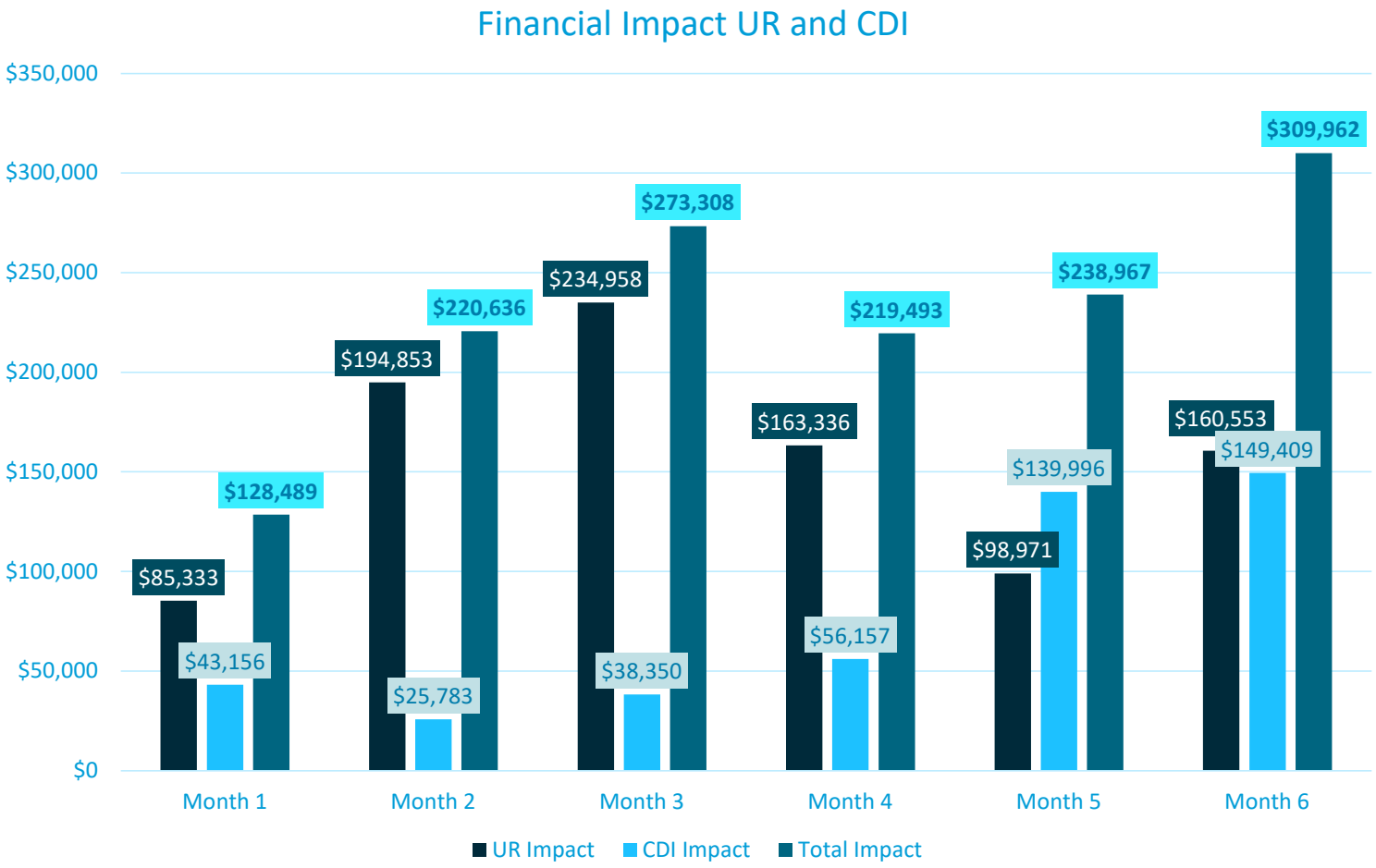
Clarification of diagnoses documented based on whether it is clinically relevant

### COMPLICATIONS

Clarification if complications exist and present for stay

### VALIDATE FINDINGS

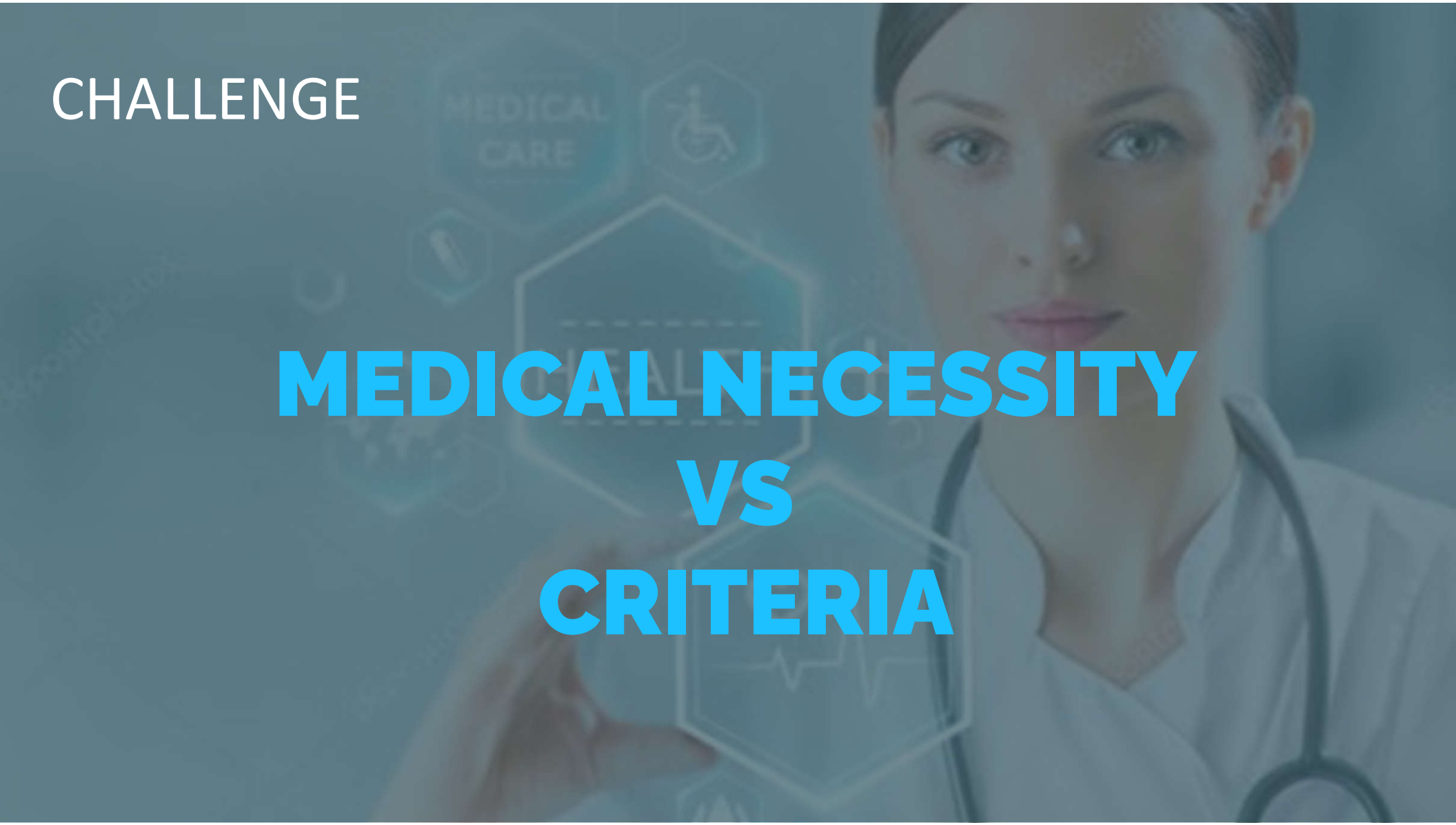
Clarify if diagnoses are related to the stay and relevant




+$1.39M impact over 6- month period

*Based on CM initiating status change for UR changes; CDI queries resulting in DRG change for CDI impact

CHALLENGE




# MEDICAL NECESSITY VS CRITERIA

# Medical Necessity Review Requirements

- CMS requires hospitals to perform utilization review

- The Medicare Program Integrity Manual Chapter 6, Section 6.5.1 Screening Instruments states that screening instruments are required to be utilized as part of the medical review process

  - CMS does not support any specific screening instrument
  - InterQual and MCG are most widely recognized
    - QIO and MAC utilize InterQual
    - Many commercial payors utilize MCG

  - Most important to remember that these screening instruments are a **GUIDELINE**
    - Medical necessity is based on physician documentation, treatments and clinical judgement

# Inpatient Regulatory Guidance

- *10.2 Medicare Benefit Policy Manual, Chapter 1- Inpatient Hospital Services Covered under Part A*

- **Hospital Inpatient Admission Order and Certification:**
- **B. Inpatient Order**:

- *"A Medicare beneficiary is considered an **inpatient of a hospital if formally admitted as an inpatient** pursuant to an order for inpatient admission by an ordering practitioner. As stated in the FY 2014 IPPS Final Rule, 78 FR 50908 and 50941, and as conveyed in 42 CFR 482.24, if the order is not properly documented in the medical record prior to discharge, the hospital should not submit a claim for Part A payment. Meeting the two midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A. Rather, as provided in Medicare regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by an ordering practitioner."*

- *2 Midnight expectation should be documented in the medical record along with supporting documentation to support the inpatient stay*
- *In the instance that the LOS is less than 2 midnights, the physician should document the rationale of rapid recovery to justify the shorter length of stay*
- *Documentation is key to justifying IP level of care*

# Inpatient Regulatory Guidance

"An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight."

- CMS IOM Pub. 100-02 Benefit Policy Manual, Chapter 1, section 10

"Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting."

- CMS IOM Pub. 100-08 Program Integrity Manual, Chapter 6, section 6.5.2(A)

Physicians are recommended to use a 24-hour period as a **benchmark** when making a determination on an inpatient admission. However, admissions are not deemed covered, or non-covered, solely on the basis of the length of time the patient actually spends in the hospital. Additionally, when a patient presents for a minor surgical procedure, or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients, regardless of the hour the patient presented to the hospital and if that patient remained in the facility over the midnight census.

- 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. In general, the decision to admit a patient should be primarily based on the severity of illness and intensity of services rendered. Medical necessity at the time of admission to the hospital must be clearly documented in the medical record.



# Medicare Advantage Final Rule 2024

The Final Rule addresses concerns raised by providers and patients that some Medicare Advantage plans are denying services that would have been covered by traditional Medicare, thereby violating Section 1852 of the Social Security Act (codified at 42 U.S.C. 1395w-22(a)). In addressing inpatient admissions specifically, CMS stated:

- [U]under [42 C.F.R.] § 422.101(b)(2), [a Medicare Advantage] plan must provide coverage, by furnishing, arranging for, or paying for an inpatient admission when, based on consideration of complex medical factors documented in the medical record, the admitting physician expects the patient to require hospital care that crosses two-midnights (§ 412.3(d)(1), the "two-midnight benchmark"); when an admitting physician does not expect the patient to require care that crosses two-midnights, but determines, based on complex medical factors documented in the medical record that inpatient care is nonetheless necessary (§ 412.3(d)(3), the "case-by-case exception"); and when inpatient admission is for a surgical procedure specified by Medicare as inpatient only (§ 412.3(d)(2)).

- The Final Rule does require that, when auditing inpatient claims, Medicare Advantage plans must make the clinical criteria they use to determine medical necessity available in a "publicly accessible way."

# Medicare Claims Processing Manual, Chapter 4 Part B Hospital

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

There is no limitation on diagnosis for payment of APC 8011; however, comprehensive APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8.



# Key Points to Consider

- Inpatient admission is a complex medical decision that can only be made by a physician after consideration of multiple factors
- Medical necessity screening tools are ONLY a guideline
- 2 MN benchmark expectation is a key indicator
- Documentation is a priority and important to validate the level of care
- Medicare advantage should be following same CMS guidelines for level of care

# Example of Case Management Dashboard

| | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Case Management Dashboard -2024** | | | | | | | | | | | | |
| **Medicare Compliance** | | | | | | | | | | | | |
| # of One-Day Medicare Stays (less than 2 days) | 31 | 21 | 22 | 17 | 26 | 16 | 22 | 25 | 12 | 13 | 22 | 14 |
| % of Total Medicare Observation to Medicare Admissions | 9.1% | 19.2% | 14.2% | 27.0% | 16.2% | 22.0% | 16.0% | 21.3% | 15.3% | 18.6% | 12.0% | 17.8% |
| # of Medicare Observation Patients with LOS >/=48 Hours | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 1 | 0 |
| % of total Medicare Observation Patients with >/=48 Hours | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 19.0% | 3.4% | 0.0% |
| % of Total Managed Medicare Observation to Total Managed Admissions | 37.8% | 47.3% | 43.7% | 48.7% | 50.0% | 48.6% | 57.7% | 47.9% | 55.0% | 47.5% | 46.5% | 48.0% |
| Total Inpatient Managed Medicare Discharges | 94 | 78 | 80 | 81 | 72 | 74 | 64 | 73 | 55 | 52 | 84 | 77 |
| Total Inpatient Medicare Discharges | 153 | 100 | 117 | 101 | 132 | 101 | 105 | 109 | 100 | 93 | 103 | 102 |
| % of One-Day Medicare Stays | 20.3% | 21.0% | 18.8% | 16.8% | 19.7% | 15.8% | 21.0% | 22.9% | 12.0% | 14.0% | 21.4% | 13.7% |
| # of Code 44 determinations | | | | | | | | | | | | |
| **LOS Management** | | | | | | | | | | | | |
| Acute Medicare LOS | 4.3 | 4.40 | 4.0 | 3.7 | 4.1 | 3.9 | 3.8 | 3.7 | 3.9 | 3.7 | 3.5 | 4.5 |
| Acute Managed Medicare LOS | 6.0 | 5.70 | 5.8 | 4.7 | 5.9 | 5.0 | 5.5 | 4.4 | 5.9 | 5.6 | 6.3 | 6.6 |
| Acute Medicare CMI | 1.55 | 1.62 | 1.51 | 1.48 | 1.47 | 1.55 | 1.55 | 1.42 | 1.43 | 1.18 | 1.32 | 1.42 |
| Acute Medicare CM Adjusted LOS | 2.77 | 2.72 | 2.65 | 2.50 | 2.79 | 2.52 | 2.45 | 2.61 | 2.73 | 3.15 | 2.65 | 3.17 |
| All Payor LOS | 4.70 | 5 | 4.40 | 3.80 | 4.10 | 3.70 | 4.20 | 4.10 | 4.20 | 4.30 | 4.20 | 4.90 |
| Readmissions Medicare | 42 | 17 | 22 | 23 | 17 | 19 | 17 | 27 | 20 | 32 | 27 | 34 |
| Readmission % Medicare | 27.5% | 17.0% | 18.8% | 22.8% | 12.9% | 18.8% | 16.2% | 24.8% | 20.0% | 14.0% | 10.6% | 13.5% |
| Readmissions (all Payors) | 68 | 44 | 47 | 51 | 44 | 54 | 35 | 46 | 43 | 46 | 37 | 52 |
| Readmissions % (all payors) | 11.6% | 8.3% | 8.6% | 8.9% | 7.1% | 9.7% | 6.4% | 8.4% | 8.50% | 9.7% | 7.5% | 10.6% |
| **Avoidable Days** | | | | | | | | | | | | |
| Physician Delay | | 1 | 1 | | | | | | | | | |
| Departmental Delay | 3 | 1 | 1 | 1 | | | | 2 | | 1 | 2 | |
| Family Delay | | 5 | 2 | | | 3 | | 2 | 9 | 1 | 1 | 6 |
| Discharge Planning Delay | | 4 | 1 | 2 | | 2 | 1 | | | 3 | 2 | 2 |
| Transport Delay | | | | | | | | | | | | |
| Delay in procedure | | | | | | | | | | | | |

**Positive Findings**

Observation rate
Length of stay

**Opportunities**

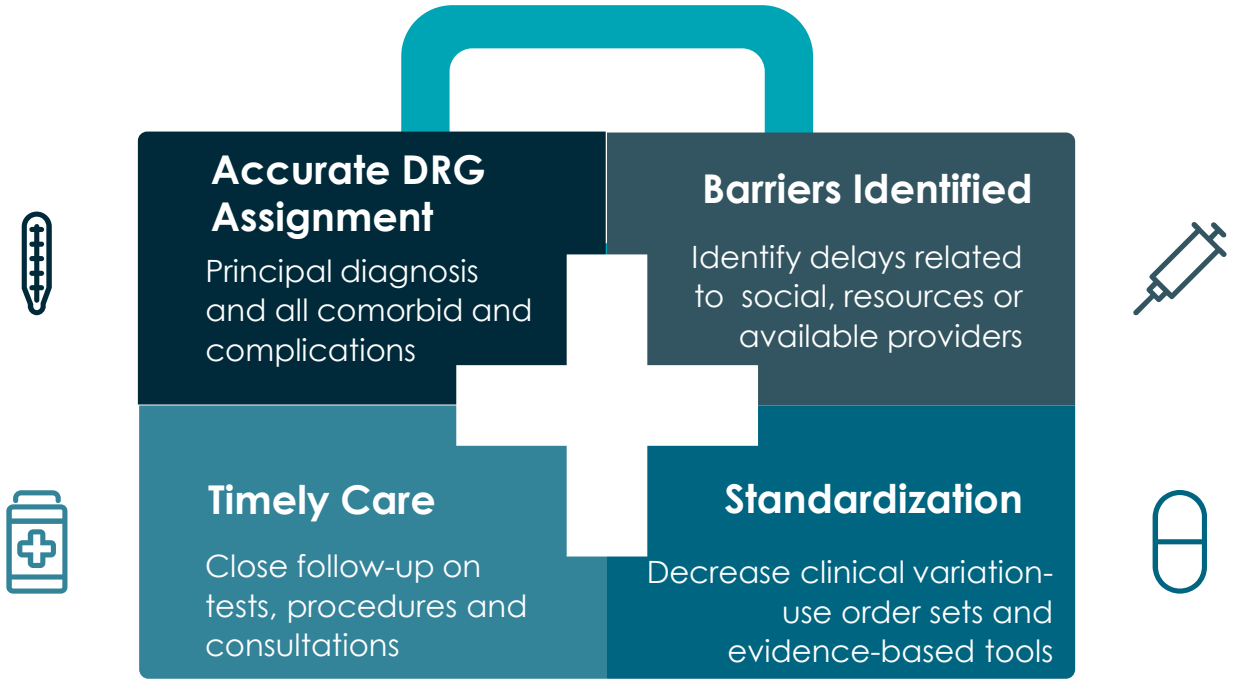
Readmissions
Managed
Medicare

Avoidable Days- These are days that could have been avoided resulting in additional LOS


CHALLENGE

# LENGTH OF STAY

# Length of Stay Strategies



# Length of Stay

Key Performance Indicators

### Length of Stay (LOS)

Calculated on number of days from admission to discharge

### Average LOS (LOS)

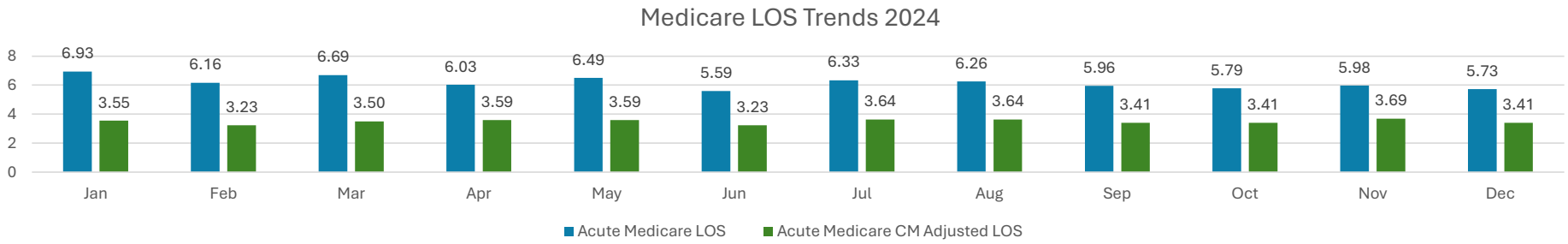
Calculated by dividing the total number of inpatient days by the number of discharges

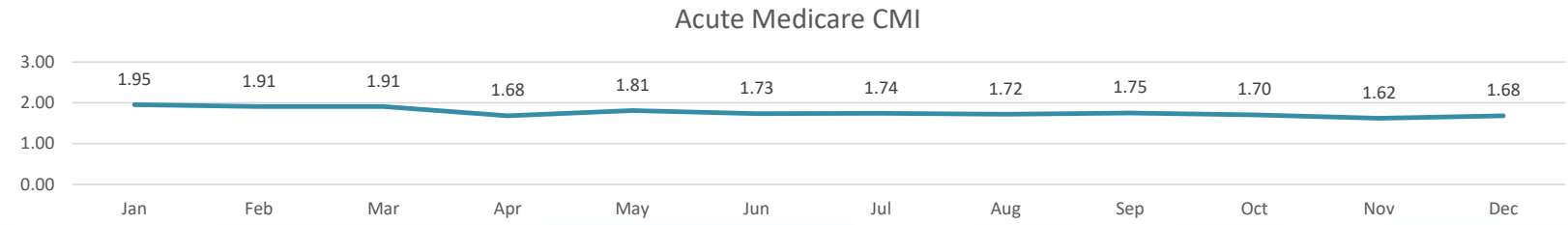
### Geometric LOS (GLOS)

A statistical approach used to identify expected LOS for particular DRGs (Good way to identify variations)

### ALOS- Case Mix Adjusted

A method of measuring LOS to include acuity based on DRGs



# KPI's

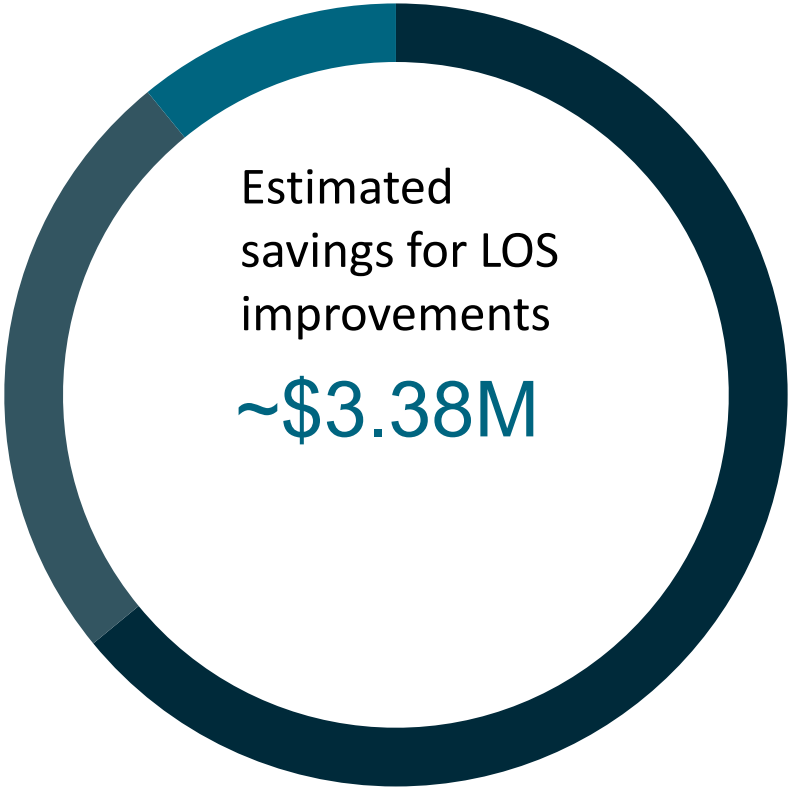
# Example of GLOS Analysis for PPS Facility

Patient days exceeded from GLOS target

4,230

LOS exceeded goal average

+1.66



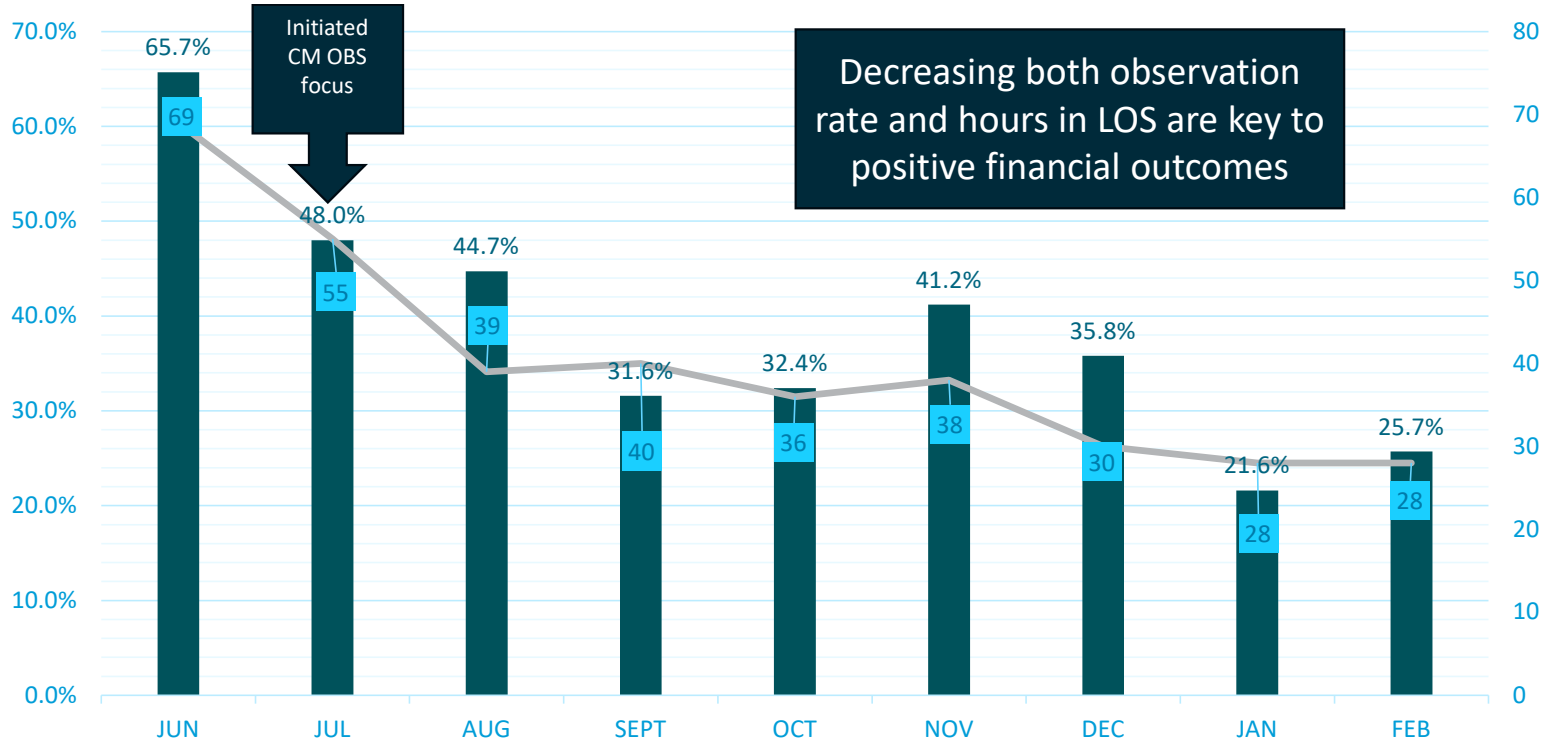

LOS targets

GLOS 3.77

LOS 5.43

*Based on estimated cost of $800/day

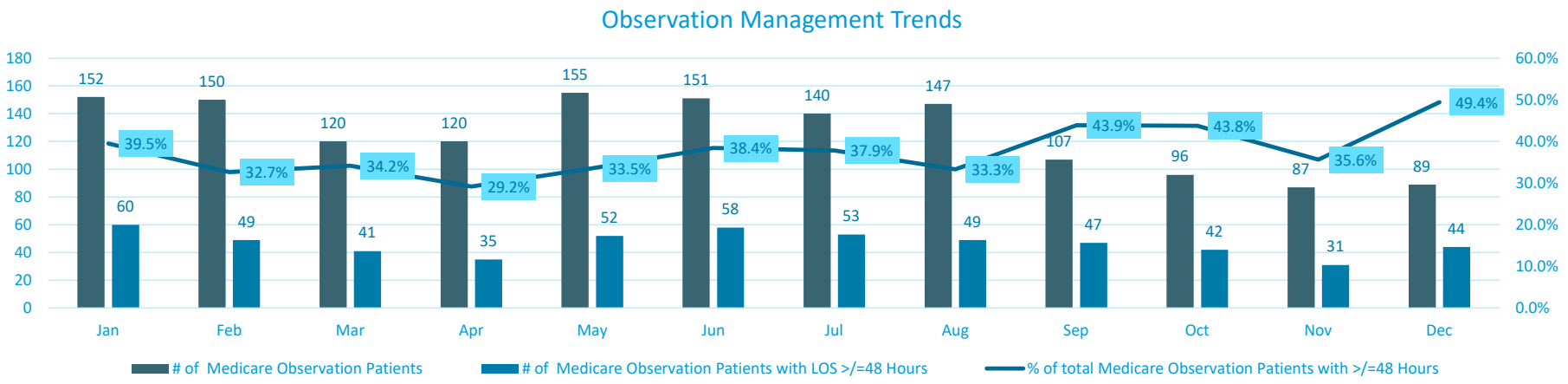
# Example of Observation Tracking/Trends




**Case Management Changes Created a Positive Impact on KPIs and Financial Outcomes**

Comprehensive APC 8011 for observation pays ~$2,400 vs inpatient DRG

# Observation KPIs- Tells a Story




Key Takeaways

- High volumes of longer observation stays
- Likely over utilization of services (testing/procedures)
- Disposition issues causing delays
- Missed opportunities for upgrade to inpatient

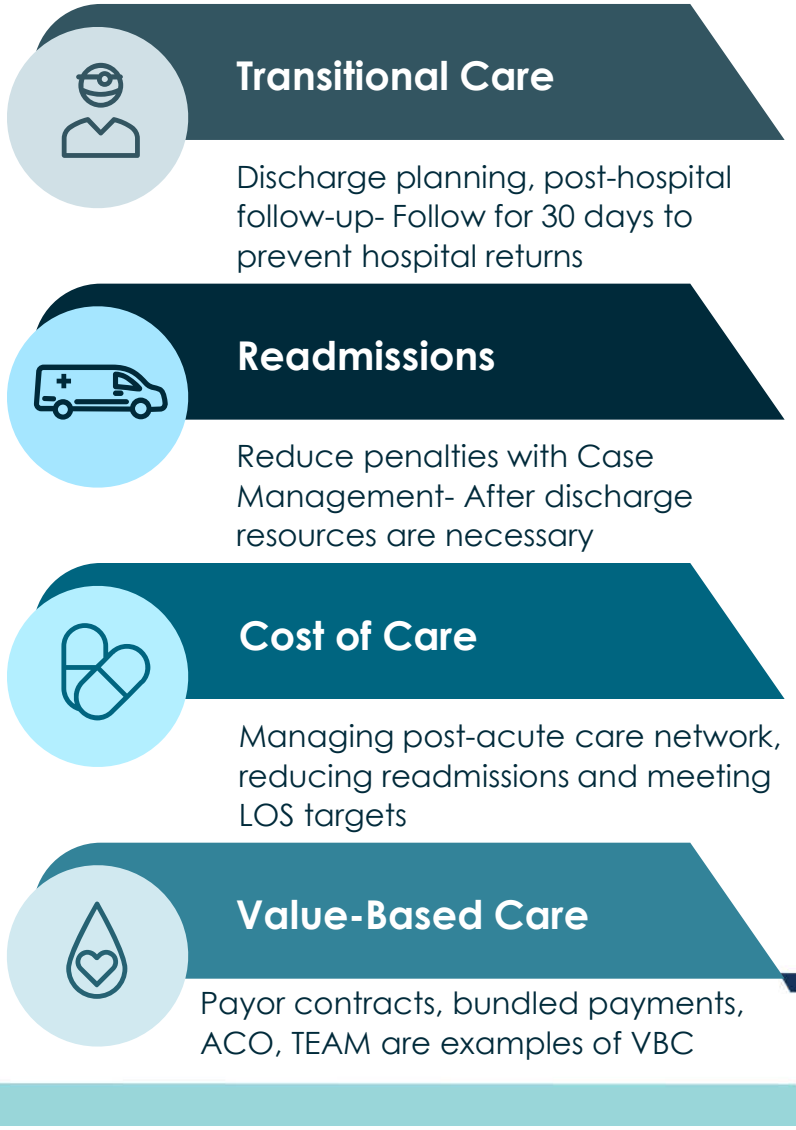
All lead to financial loss

Observation can be profitable
IF managed appropriately

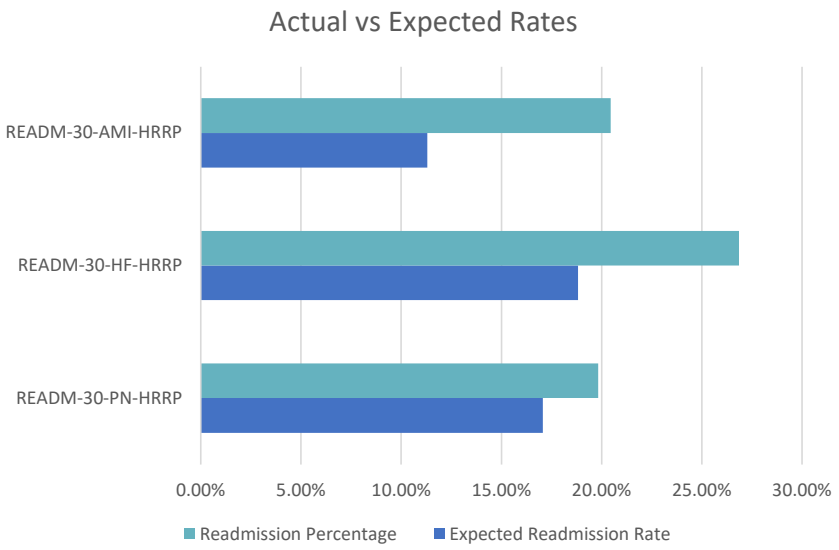

CHALLENGE
QUALITY AND READMISSIONS

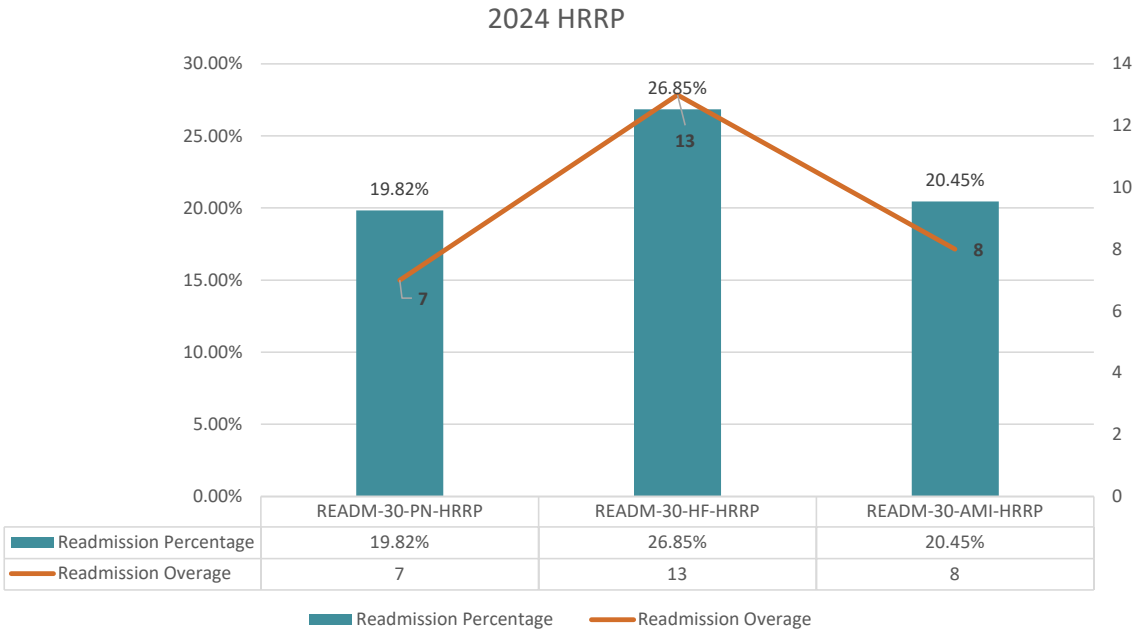
# Quality & Readmissions

Case Management can impact financial outcomes



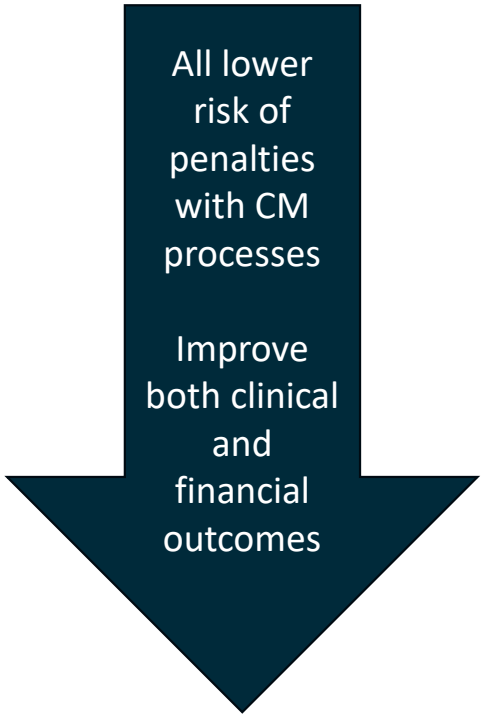
# Hospital Readmission Reduction Program (HRRP)- Opportunity Example



# Readmission Reduction Strategies

- Step 1- Starts with discharge planning
  - Coordinated plan with the clinical team
  - Patient education and include the caregivers
- Step 2- Hospital follow-up appointment
  - Best practice is to leave with an appointment scheduled
  - Appointment reminders
  - Transitional Care visit (Goal within 7 days)
- Step 3- Post discharge phone calls- Care Management
  - Phone calls for the 30-day period (Frequency based on readmit risk)
- Step 4- Community partners
  - Develop partnerships and expectations
  - Partnership and shared risk



# Transfer DRGs- Understand the Financial Impact

- Based on the Post-Acute Transfer (PACT) Rule
  - 275 DRG's affected by transfer DRG rule
  - Transfer DRG's account for approximately 40% of all Medicare D/C's
  - Medicare was concerned with patients being moved too fast from acute setting
    - This resulted in acute and post-acute getting full payments
  - Transfer DRG Calculations for transfer payments
    - Hospital reimbursement is based on the GLOS
    - **First day** of care is paid at **double the per diem rate**
    - Additional days are paid at the per diem rate
  - **GLOS + 1 day is best practice to avoid transfer DRG penalties**
  - Discharge dispositions affected by the Transfer DRG rule
    - Skilled Nursing Facility
    - Children's/ Cancer Hospital
    - Home Health
      - Condition code 43 should be added on claim if services started 3 days after d/c
      - Condition code 42 should be reported for HH unrelated to hospital stay
    - Inpatient Rehab
    - LTACH
    - Psychiatric Hospital
    - Hospice- NEW

To qualify as a Transfer DRG- Services must start within 3 days after discharge

# Example of Transfer DRG Audit


* 6-month transfer DRG audit

# Building the Structure for Positive ROI Reporting

# Steps to Start ROI Reporting

**1**

**Set KPIs**

Align organizational goals with CM metrics- determine what will be tracked

**2**

**Develop Dashboard**

Create standardized dashboard for tracking KPIs for reporting

**3**

**Data and Reporting**

Review available reports and/or create reports for data elements- Often multiple reports are required and is dependent on system capabilities

**4**

**Outcomes Reporting**

Share information at hospital committees and team level- Track and trend by physician and service line where available

# VIRTUAL CARE PROGRAMS TO DRIVE REVENUE WITH CARE MANAGEMENT IN THE AMBULATORY SETTING

# VIRTUAL POPULATION HEALTH SOLUTIONS

## Chronic Care Management

- Monthly billable services
- Population identification
- Monthly outreach
- Medication reconciliation
- Care coordination needs
- Patient enrollment
- Care planning
- Multi-disciplinary approach
- Patient education
- Documentation completion

## Transitional Care Management

- Outreach post-discharge
- Validation of follow-up appointment
- Medication reconciliation
- Care coordination needs
- Completion of documentation to prepare for in person visit
- Weekly follow-up
- Appointment reminders
- Reduction in readmissions
- Patient education

## Psychiatric Collaborative Care

- Monthly billable services
- Population identification
- Patient registry
- Care coordination needs
- Weekly case review with psychiatric consultant provider
- Patient education
- Additional support
- Outreach and enrollment
- Documentation completion
- Medication reconciliation
- Monthly outreach

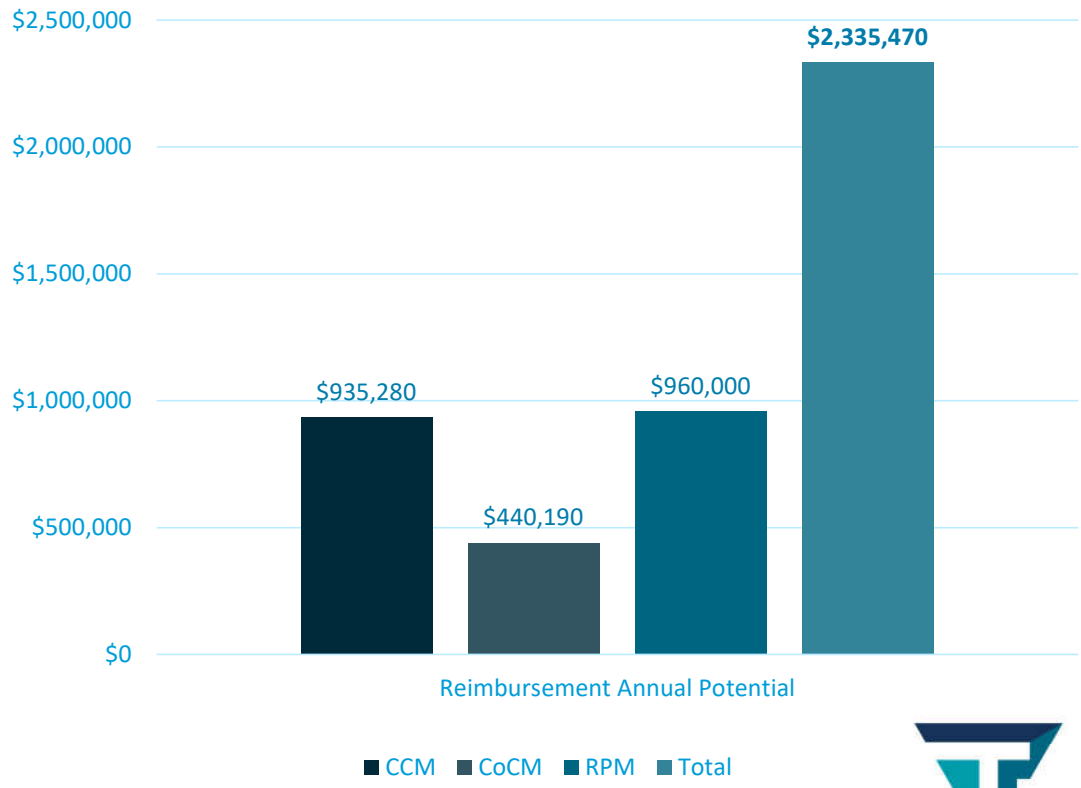
## Remote Patient Monitoring

- Monthly billable service
- Population identification
- Monthly outreach
- Patient enrollment and outreach
- Care coordination needs
- Devices provided (B/P, Glucometer, Pulse Ox, Scale)
- Monitoring of biometrics
- Patient clinical monitoring coverage 365 days/year
- Clinical pathway driven care
- Patient education
- Multi-disciplinary team

# Annual Reimbursement Potential for CMS Billable Care Management Programs

Estimated:
1,000 CCM lives
250 CoCM lives
500 RPM lives

Investing in Care Management results in positive ROI



# Summary of Driving ROI with Case Management

**Determine Goals**
Align organizational goals with KPI targets

**Analysis**
Determine reporting structure and trend KPIs to demonstrate outcomes


**Strategy**
Determine possible strategies for improvements that have the biggest impact on the organization

**Revenue Growth**
Evaluate missed opportunities that impact reimbursement and new revenue growth for virtual Care Management services

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