Case Management

Transitioning Patients for Success

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Case Management Defined

"*Case Management in Hospital/Health Care Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient's right to self-determination.*"

- American Case Management Association

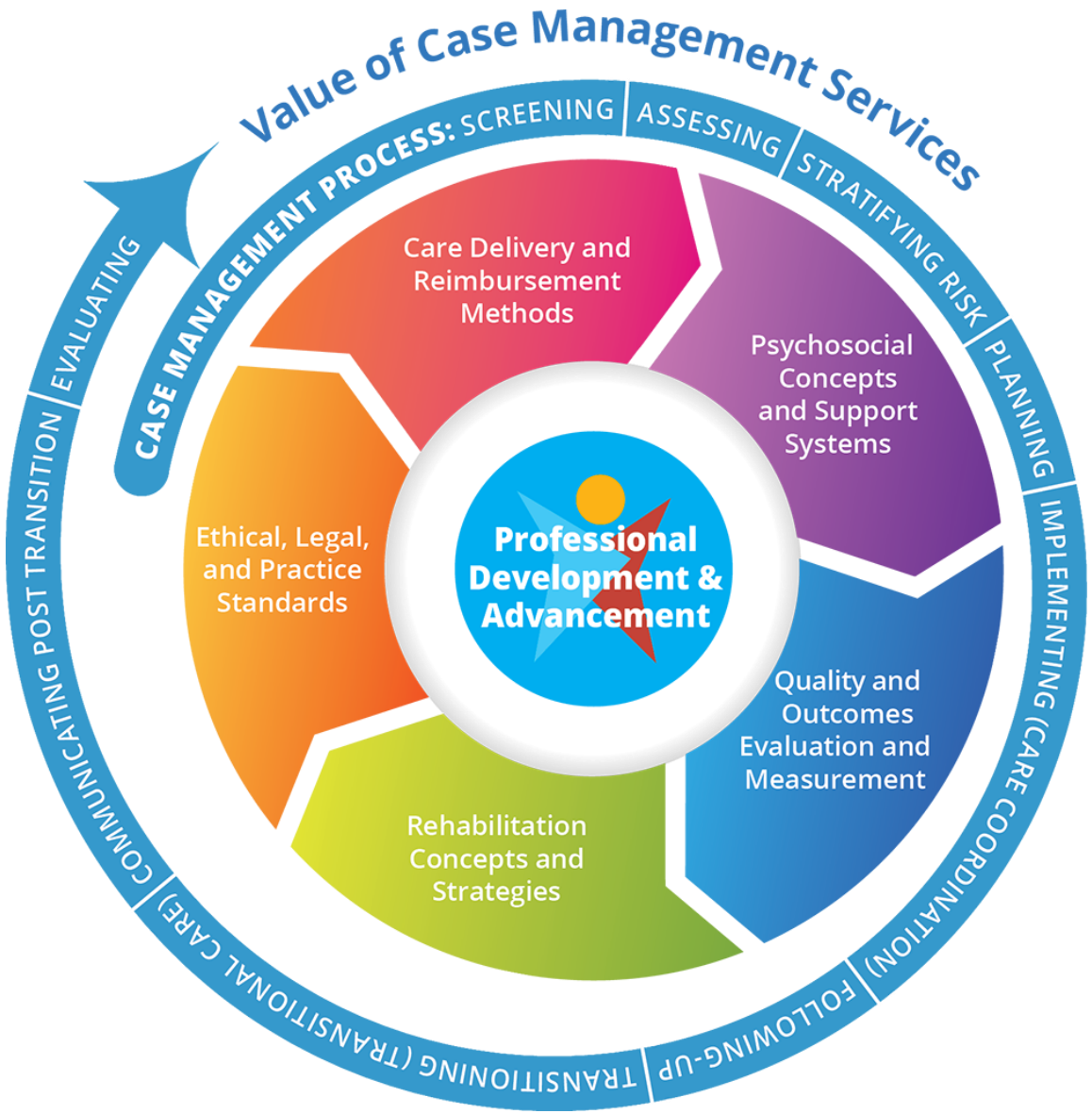
Care Management Defined

"Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes."

-Case Management Society of America

The Value of Case Management Services

- Case Management is the glue that keeps the plan of care together and on track.
- Acute Case Management is the collaborative process to identify patient's needs for success outside of the hospital, that starts from the moment a patient is admitted and continues until they are transitioned out of the hospital to the next level of care.
- Community case management follows the patient throughout their health journey.



Main 2 Branches of Case Management

- **Utilization Management**: a process that evaluates the efficiency, appropriateness, and medical necessity of the treatments, services, procedures, and facilities provided to patients on a case-by-case basis.

- **Care Management**: a team-based, patient-centered approach, designed to assist patients and their support systems in managing medical conditions more effectively. It includes identification and coordination of services necessary for successful disease management outside of the hospital.

Necessity of services Necessity of Service

Case managers work closely with physician advisors as liaisons who support case management with compliance issues, medical necessity, and correct utilization of resources. Case managers should understand how they can proactively prevent medical necessity denials in coordination with physician advisors, how transitions of care impact revenue, and how they can assist with cost containment, avoidable days, and medical necessity of one-day stays.

Barriers Case Managers Encounter

- Geographical location
- Limited Resources - Placement
- Lack of (Family) support
- Limited Funding-No benefits
- Behavioral Issues- Substance Abuse
- Mental Health
- Criminal Background- Sex Offender
- Care Givers lack of Support of Care Plan
- Inability to provide preference

Governing Rules for Case Management

Conditions of Participation (CoP) are developed and enforced by CMS.

- **§ 482.30 Condition of participation: Utilization review:**

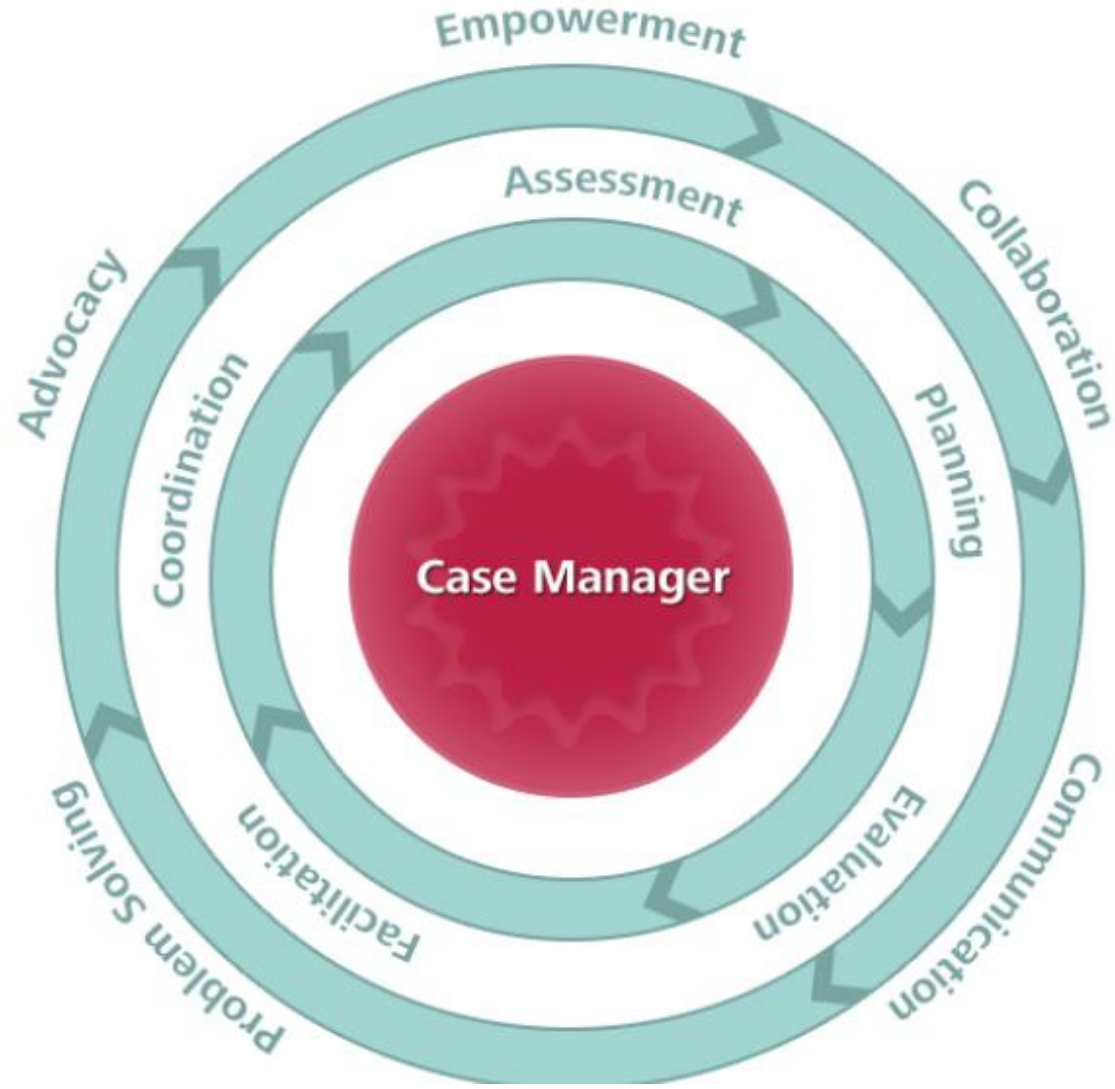
The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

- **§ 482.43 Condition of participation: Discharge planning:**

The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

A Day in the Life of Case Managers

- Utilization Review
- Discharge Planning
- Compliance with CoPs and State/Federal Regulation
- Documentation Improvement
- Advance Directives
- Involuntary Commitments
- Plan of Care Throughput
- Bed Placement
- Adoptions/Surrogacy
- Ethics Committee
- Protective Service Referrals
- Financial Planning/Counseling
- Palliative Care
- Readmission prevention
- SDoH assessments and interventions



Common Abbreviations use in Case Management

- 12X: Medicare penalty billing, resulting in payment of only ancillary charges
- 13X: Medicare penalty billing for outpatient services
- ADR: Additional Development Request
- ALF: Assisted-Living Facility
- CAH: Critical Access Hospital
- CC44: Condition Code 44
- CDI: Clinical Documentation Improvement
- CDS: Clinical Documentation Specialist
- CDMP: Compliant Documentation Management Program
- CERT: Comprehensive Error Rate Testing
- CM: Case Manager/Management
- CMI: Case Mix Index
- CMS: Centers for Medicare & Medicaid Services
- DME: Durable Medical Equipment
- DRG: Diagnosis-related group
- EMTALA: Emergency Medical Treatment and Labor Act
- FCSO: First Coast Services Options
- GMLOS: Geometric Mean Length of Stay
- HINN: Hospital-Issued Notice of Non-Coverage
- HHS: [U.S. Department of] Health and Human Services
- INPT: Inpatient
- IQ: InterQual
- IS: Intensity of Service
- JCAHO: Joint Commission on Accreditation of Healthcare Organizations
- LOS: Length of Stay
- LTAC: Long Term Acute Care Hospital
- MAC: Medicare Administrative Contractors
- MIC: Medicaid Integrity Contractor
- NH: Nursing Home
- OBS: Observation
- OIG: Office of Inspector General
- OP in a bed/OIAB: Outpatient in a bed
- PASRR: Pre-Admission Screening and Resident Review
- QIO: Quality Improvement Organizations
- RAC: Recovery Audit Contractor
- SI: Severity of Illness
- SNF: Skilled Nursing Facility
- SSI: Social Security's Supplemental Security Income
- SW: Social Worker
- Swing Bed: post-acute level SNF care bed
- UM: Utilization Management
- VA: Veteran's Administration

CMS Programs & Conditions of Participation

At an annual cost of $799 billion as of 2019, Medicare is one of the largest health insurance programs in the world. Providing nearly universal health insurance to the elderly as well as many disabled, Medicare accounts for almost 14% of U.S. health expenditures, one-eighth of the federal budget, and 2.9% of the GDP. Medicare has evolved over the past 50 years through its mandates and Conditions of Participation. With a significant percentage of the population covered by Medicare programs, it is imperative that case managers understand the program, its requirements of providers, and its requirements for individual eligibility and coverage.

Value-based Care

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. The Innovation Center also plays a critical role in implementing the Quality Payment Program in which clinicians may earn incentive payments by participating in Advanced Alternative Payment Models (APMs). In addition, the Medicare Shared Savings Program, Accountable Care Organizations, Hospital Readmissions Reduction Program are designed to improve quality of care while reducing expenditure. Case managers should be knowledgeable about value-based programs, ACOs, and APMs that will impact the beneficiary's plan of care, services available, and reimbursement policies.

Care Coordination Across the Continuum

- Care coordination begins before the patient ever presents to the hospital and is a strategic plan for transitions of care for patients within the healthcare system. It is the summation of daily activity for case managers. In the bigger picture, care coordination brings all aspects of patient care into orderly focus. It brings all resources, both medical and human, to the table to produce the optimal outcome for the patient. Case managers must understand the activities involved in effective care coordination and deploy effective patient-centered communication to streamline patient care across the continuum.

Medicare

Part A:

Case managers, as financial stewards to their organizations and liaisons to the transdisciplinary care teams and patients, must understand the Medicaid program so that they can appropriately serve their patient populations and assure appropriate reimbursement of services. Although Medicaid varies by state, it can be helpful for case managers to know the main tenets of the program

Part B:

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A.

Medicaid

Case managers, as financial stewards to their organizations and liaisons to the transdisciplinary care teams and patients, must understand the Medicaid program so that they can appropriately serve their patient populations and assure appropriate reimbursement of services. Although Medicaid varies by state, it can be helpful for case managers to know the main tenets of the program

Affordable Health Care Act

The Patient Protection and Affordable Care Act, often referred to as the Affordable Care Act (ACA) was enacted and signed into law in 2010. Since then, the US has implemented law and adapted to the regulatory overhaul and expansion of coverage. The political debate persists, but the ACA has a significant impact on how healthcare providers treat and manage patients. Case managers are obligated to examine the impact regulations have on patient care planning and track impending changes to legislation. Because the ACA also impacts all payers in healthcare, patient education is an important component of patient care.

Federal Reserve

Various resources exist through governmental funding for eligible individuals. Several of these resources have restrictions regarding citizenship, age, disability, income, or medical condition. Case managers should be aware of each program's eligibility requirements, and any changes to such.

Worker Compensation & Veteran's Health Administration

When an individual receives Workers' Compensation – a state mandated insurance for employees that have suffered injuries or illness as a result of their job — case managers must aid in coordinating care with adjusters related to the benefits they receive. Case managers should additionally be aware of eligibility specifications for veteran healthcare benefits and enhanced services through the Veteran's Health Administration.

ELOS and the DRG

- DRG: Diagnosis related group: classifying groups of patients together based on similar diagnoses, age and expected length of stay with a fixed reimbursement regardless of actual cost of care
- ELOS: Expected length of stay as determined by the DRG helps guide the Case Manager in utilization review and discharge planning
- ALOS: Actual length of stay
- GMLOS: Geometric mean length of stay

How we are paid

- DRG's
- Medicare and most payers focus explicitly on documentation to accurately reflect each patient’s severity of illness, complexity, and quality of care provided in order to justify the length of stay or service duration. As care costs are reimbursed based on the accuracy and specificity of such documentation and coding, it is important for case managers to understand the system and effectively evaluate reimbursement practices.

MS-DRG	TYPE	MS-DRG Title	Weights	Geometric mean LOS
001	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	25.3518	28.3
061	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	2.7316	5.8
062	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W CC	1.8561	4.2
063	MED	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W/O CC/MCC	1.4685	3.0
069	MED	TRANSIENT ISCHEMIA	0.6948	2.2
190	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1708	4.2
191	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9343	3.5
192	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7120	2.8
193	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.4550	5.0
194	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9771	3.8
195	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.6997	2.9
280	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.7431	4.7
281	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	1.0568	3.1
282	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7551	2.1
283	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.6885	3.0
284	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7614	1.8
285	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5227	1.4
291	MED	HEART FAILURE & SHOCK W MCC	1.5031	4.6
292	MED	HEART FAILURE & SHOCK W CC	0.9938	3.7
293	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6723	2.6
312	MED	SYNCOPE & COLLAPSE	0.7228	2.4
313	MED	CHEST PAIN	0.5992	1.8
391	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.1903	3.9
392	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7395	2.9
602	MED	CELLULITIS W MCC	1.4607	5.0
603	MED	CELLULITIS W/O MCC	0.8402	3.6

DRGs: Diagnostic Related Groups

- DRGs drive the Geometric Mean Length of Stay (GMLOS), which is a guide as to how many days a patient with that diagnosis normally stays in the hospital before transfer to the next level of care.
- This is what most payers, including Medicare, use to determine the amount of reimbursement a hospital receives for the patient's stay.
- Once you exceed that amount, the hospital eats the cost. Managing length of stay is vital.
- Physician documentation is KEY to getting the best DRG applied to the case.

Patient Status/Class:

OUTPATIENT

Ambulatory or same-day surgery

Labs, most diagnostic procedures

OBSERVATION

Typically < 48 hours in hospital

Monitoring, testing → often lower severity

INPATIENT

Need for acute care setting, typically > 48 hours

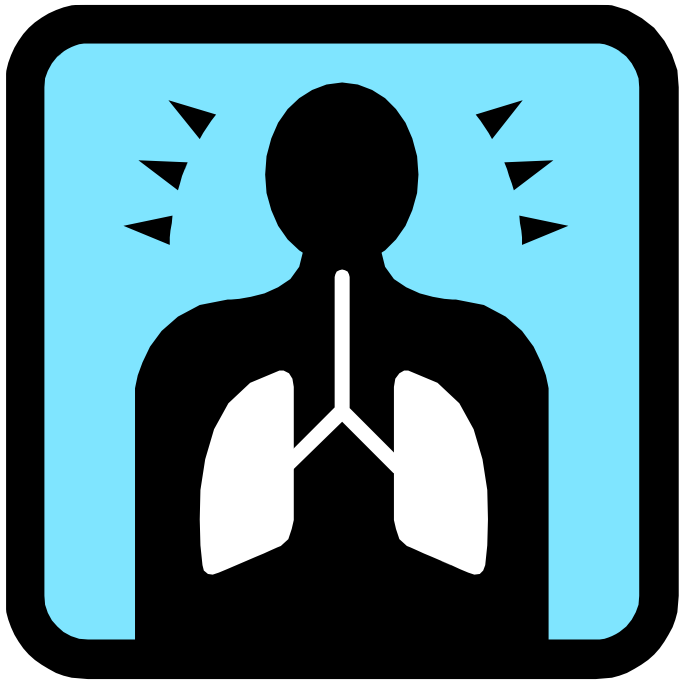
INPT-only procedures, new onset vent

Medicare Qualified Stay

- The beneficiary must have been an inpatient of a hospital for a **medically necessary stay** of at least 3 consecutive calendar days.
- Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay
- The beneficiary must also have been transferred to a participating SNF within 30 days after discharge from the hospital

Medicare 2 Midnight Rule: Inpatient

- Inpatient-Only procedures
- **OR**
- New onset mechanical ventilation
- **OR**
- Documentation of medical necessity, expected to cross at least two midnights
  - -Risk stratification, Plan of care, Expected length of stay, Anticipated discharge plan



Condition Code 44

- **WHAT:** Notification to Medicare patient that his/her status is changing from Inpatient to Observation. The pt will need to receive a copy of the MOON.
- **WHEN:** Must occur prior to discharge, and prior to billing, with attending & UR physicians' agreement
- **WHY:** Observation status could result in higher co-payments for the patient

The Emergency Medical Treatment and Labor Act (EMTALA)

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Social Security Act

Intended to provide protection to individuals coming to a hospital to seek care for an [emergent medical condition]

[A hospital] is obligated to provide [an individual with an emergent medical condition] with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur

A hospital [can] not escape liability under EMTALA by admitting an individual with no intention of treating the individual and then inappropriately transferring or discharging that individual without having met the stabilization requirement

[Receiving hospitals] specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, (…)) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual

Regulatory Notices Delivered by CM

Important Message from Medicare: Hospitals and CAHs are required to deliver the Important Message from Medicare to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. FFS & MA IM | CMS

Medicare Outpatient Observation Notice (MOON): Hospitals and CAHs are required to provide a MOON to Medicare beneficiaries (including Medicare Advantage health plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH). CMS.gov

Hospital Outpatient Observation Notice (HOON): This form is to be used to immediately (no later than 24 hours) notify a non-Medicare patient or the patient's representative when a patient is placed on observation status. The signed version must be incorporated into the patient's medical record and provided to the patient, patient's survivor, or legal guardian through discharge papers. AHCA: Hospital & Outpatient Services Unit - Hospitals (myflorida.com) This is for Florida only.

Hospital Issued Notice of Noncoverage (HINN) letter: Hospitals provide HINNs to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is not medically necessary, not delivered in the most appropriate setting, or is custodial in nature.

Detailed Notice of Discharge (DND): As under original Medicare, a hospital must issue to plan enrollees, within two days of admission, a notice describing their rights in an inpatient hospital setting, including the right to an expedited Quality Improvement Organization (QIO) review at their discharge. (In most cases, a hospital also issues a follow-up copy of this notice a day or two before discharge.) If an enrollee files an appeal, then the plan must deliver a detailed notice stating why services should end.

Thank you

Q & A