OPTUM®

GROWING YOUR CASE MANAGEMENT CAREER

BEST PRACTICES AND INDUSTRY UPDATES

Optum Executive Health Resources

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SPEAK THE LANGUAGE YOUR CFO WANTS TO HEAR

When you ask your Chief Financial Officer (CFO) or another executive if they know what Case Management does or what value it provides, do you get blank stares?

Case Managers typically play a multifunctional role within their hospital, but their responsibilities are not often well understood by other departments in the organization. They wear many hats depending upon the model in use by their facility. Daily responsibilities may include medical necessity review; coordinating care; regularly evaluating a patient's mental, physical and financial barriers to successful discharge; and ensuring the clinical staff and patient are aligned about recovery and discharge plans.

Directors of Case Management (DCMs) need to speak the language their patients need one minute, and the language of a CFO the next. When leadership determines the success and value of a Case Management department, it often involves a set of metrics separate from these day-to-day patient touchpoints. Many of those measures, particularly those that interest your CFO, affect the financial integrity of the hospital. Responsibility lies with the DCM to effectively show how the department's efforts affect these key performance measures. After all, without sufficient funding to keep the lights on, no patients can be helped. Profitability also directly affects the resources available to hire new staff members, conduct continuing training and develop innovative solutions to improve overall efficiency, such as care management software with dashboard capabilities.

Fortunately, there are many ways to show the value Case Management provides. Below are some of these key measures and the ways you can demonstrate your success in influencing them:

CASE MIX INDEX (CMI)

CMI is a measure of the relative severity of your hospital's patients, compared to that of all of your hospital peers. CMI is based only upon inpatient admissions and is heavily influenced by the DRG assigned to each admission. CMS and other value-based care models are focused on CMI and are evaluating penalties for poor performance. To demonstrate a positive effect on CMI, a DCM can provide metrics on cases which failed inpatient first-level criteria, but are appropriately identified as inpatient during second-level review, or which had undocumented complications or comorbidities discovered during the Utilization Review (UR) process.

LENGTH OF STAY (LOS)

Length of stay is based upon what is documented in medical records. Since only inpatient cases are included within length-of-stay calculations, Case Management can contribute to LOS reduction efforts by helping inpatient/outpatient determinations be as accurate as possible. DCMs can show how their team's efforts contributed to reductions in measured LOS by reporting how many short-stay cases they identified and the LOS both before and after those short stays were included.

REIMBURSEMENT

While the quality of care provided doesn't change based on admission status, reimbursement differentials between inpatient and outpatient can be extreme. Identifying inpatient status during either the first- or second-level review can greatly affect a hospital's reimbursements from both Medicare and commercial payers. While the obvious revenue impact comes from cases that fail first-level criteria, but are appropriately identified as inpatient during second-level reviews, don't forget to consider the reverse. Cases incorrectly identified as inpatient will often result in denials, and a Case Management team that catches these issues before billing is effectively avoiding those denials and helping the hospital receive its proper reimbursement. Present both inpatient-to-outpatients and outpatient-to-inpatients as revenue generated by your team.

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REDUCING AVOIDABLE DAYS

Care coordinators help limit avoidable days by facilitating timely transfers and ensuring that therapies, tests and imaging are appropriate for the current stay or are rescheduled as outpatient and done post-discharge. Each of these factors can affect a hospital's finances. For example, certain tests may not be reimbursed if they could have been done more appropriately as an outpatient. Each of these measures can be reported to CFOs to demonstrate a positive revenue contribution.

How you respond to your CFO's questions can shift the way leadership views your team. Reporting your results in terms of impact on key performance indicators can shift the perception of your team from a budget line item consuming resources to an asset generating additional revenue for your facility. That, in turn, can help justify requests for new team members and funding to further amplify your results and operate more effectively.

HAVE YOU REASSESSED YOUR CASE MANAGEMENT RESOURCES RECENTLY?

Case Management teams face a wide range of responsibilities that pull them in many directions: multidisciplinary rounds, family and caregiver conferences, admission and continued stay reviews, medical necessity processes, obtaining authorizations, discharge planning and coordination, and continuing education, to name a few. Each of these responsibilities provides a critical service to patients, and leads to serious consequences if neglected.

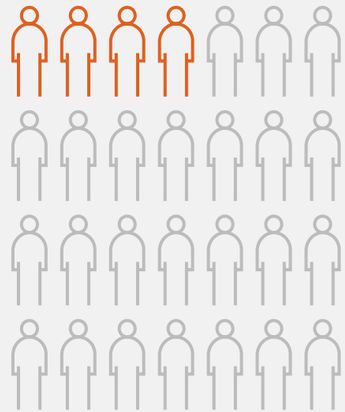
Determining whether you have sufficient resources to accomplish these critical tasks isn't simply a matter of hitting a certain CM-to-patient ratio. Don't forget to account for time your staff members are away from the hospital, including vacations, illnesses, family medical leaves, training or attending conference events. Up to 15% of your Case Managers' anticipated capacity can be lost as a result of these factors.

And, even if your Case Management team is sufficiently staffed, it's an ongoing challenge to maintain that state. Turnover, an unfortunate — but unavoidable — part of the business, hits Case Management departments twice: first through a reduced staff needing to pick up the additional workload, and then through additional focused time to recruit, interview, hire and train new team members. Your staffing model should always account for turnover within the department with an action plan to address a reduced staff and reallotment of job duties during this time.

Tight budgets can further hinder the process of attracting the best talent to fill vacancies. However, departments can ease the burden during understaffed periods by adding clerical staff to assist with Case Management tasks that do not require a clinician, such as tracking cases, inputting data and obtaining authorizations for patient transport. Typically, these tasks can consume several hours a week of a Case Manager's time — time that could be better spent managing other aspects of the role.

Additionally, Case Management teams can look to off-load time-consuming or technical tasks to third parties, who can often operate efficiently as a result of specializing in those tasks. Many of these organizations also provide free analytic services that can pinpoint ways to further streamline your operation and can provide reporting without your team having to crunch numbers manually.

The demand for the services of Case Managers continues regardless of staff disruptions. Properly accounting for this reality in your staffing model will set up your team to successfully deliver on its clinical responsibilities, enhance patient care and provide value to your facility.



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ARE YOU REALLY USING YOUR UTILIZATION REVIEW PLAN?

You remember it well: The project took an exhausting three months and involved dozens of meetings. You had to juggle schedules, manage deliverables and negotiate agreements between Compliance, Finance and Utilization Review (UR). At each step, you had to consult the Conditions of Participation and assess the structure of your hospital departments to make sure you could deliver on the strategy. But finally, after all that time, you had a UR plan that all parties agreed was practical, compliant and effective. It felt like you were finished at last.

Yet a UR plan is like any other plan: It's only valuable if the UR team continues to employ it in day-to-day operations.

Most UR plans begin with the Medicare Conditions of Participation, which state: "[T]he UR Plan must provide for the review of Medicare and Medicaid patients with respect to the medical necessity of admissions to the institution, the duration of stays, and professional services furnished." (Section 482.30(c)(1)). Yet weekend admissions, Case Manager medical emergencies, vacation time and turnover can cause some cases to slip through the cracks and go unreviewed. If this happens often enough, it can easily become a new standard to let certain cases pass without a review. Without regularly reviewing operations against the UR plan, it's easy for processes to gradually change in response to day-to-day challenges without being noticed.

Your UR plan shouldn't sit in a desk, but rather be the foundation for every decision you make.

The launch of a new UR plan often involves staff training to remind them about existing policies and introduce new policies. This training offers a snapshot of compliance, a single point in time when all team members are aware of and focused on following the UR plan. However, as new priorities emerge and employee turnover introduces new team members, awareness of and compliance with the UR plan often suffers. Reviewing your UR process on a regular basis and comparing it against your UR plan can identify training needs to improve the efficiency of your team.

When auditing your UR process, check whether you are supporting the plan with clear expectations and performance goals. For example, you may set a departmental goal of referring at least 90% of cases which fail first-level screening for a second-level Physician Advisor review. Reporting the results to the UR committee quarterly or monthly and following up with a performance improvement plan can help you address any inconsistencies internally, well in advance of any auditor activity or company-wide auditing efforts. When possible, analyze metrics and reports to quantify your assessments.

In addition to assessing performance, a regular review of the UR plan can provide clarity to your team members about their purpose and priorities. Should your staff prioritize utilization review or discharge planning? Are inappropriate transfers reported and tracked? If your individual team members' goals don't support — or, worse, run contrary to — the priorities laid out in the UR plan, your department will struggle to function successfully and efficiently.

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Reviewing the UR plan against departmental procedures isn't just a good practice to remain compliant and effective, but also a necessary requirement for effective management.

Ultimately, both internal and external parties will use your UR plan to verify that procedures are in place to comply with contractual and legal requirements. It isn't simply a strategy you developed; it needs to be a strategy you practice, update and verify regularly. It shouldn't sit in a desk, but rather be the foundation for every decision you make.

Consider these questions as you review your processes against your UR plan:

- If your UR plan requires that you apply an evidence-based methodology to second-level reviews, or a certain criteria set to every first-level review, how many cases did not undergo this review?
- How long has it been since your team underwent training on the UR plan? How frequently does the plan require training to occur?
- Do your results show that you're meeting all timelines or deadlines?
- Are you fully complying with requirements that reflect the Conditions of Participation?
- Is your team meeting the performance metrics outlined within the UR plan?

OPTIMIZING MEDICAL NECESSITY WITH A COMPREHENSIVE PROCESS

There is a phrase in carpentry, "Measure twice, cut once," that warns us to take the time to check our work before taking an irrevocable step. That same phrase packs a powerful lesson for Case Managers, as well. While hospitals typically have a first-level review process to help identify medical necessity, few have taken the next step and instituted a comprehensive second-level review.

What are the stakes? Hospital reimbursement certainly depends upon each case having a clear patient status that will withstand auditor scrutiny and payer review. Accurate patient status determinations are essential for helping leadership understand their patient mix, and can contribute to contract negotiations. But patient status doesn't only affect hospital and payer finances. Indeed, whether patients are inpatient or outpatient will dramatically affect their out-of-pocket costs from deductibles and copayments. Both your hospital and your patients rely on your professional expertise.

While hospitals typically conduct first-level reviews, some stop there. Yet the best way to serve each of these factors faithfully is to follow a Utilization Review (UR) process that includes both first-level and second-level reviews and regularly communicates with the Appeals team.

FIRST-LEVEL REVIEWS

CMS acknowledges that it isn't reasonable to expect physicians to screen all admissions. First-level reviews provide the foundation of all UR activity by providing an initial sorting of cases into inpatient or outpatient status based upon a criteria set, often InterQual or MCG. It's a challenging task, since it depends upon cases being completely and clearly documented. Sometimes, key information may be missing or unclear, which can confuse and slow down the process. Screening criteria also cannot take risk assessment or documentation of physician concerns into account, so even if a case looks appropriate from the Case Manager's point of view, it may not meet screening criteria. An effective first-level review process, therefore, is a vital first step, yet isn't always sufficient to correctly identify patient status.

Some cases are "gray cases," cases that don't immediately pass first-level criteria but are still appropriate for an inpatient level of care. Typically, gray cases have several comorbidities or physician-documented risks or concerns. While they don't pass first-level criteria, they do require further consideration; that's where second-level reviews come in.

SECOND-LEVEL REVIEWS

Conducted by physicians, second-level reviews provide a deeper dive into the case details by adding a Physician Advisor perspective to the case. Second-level reviews have become far more important in light of recent regulatory changes. The CMS 2016 Hospital Outpatient Prospective Payment System (OPPS) Final Rule allowed for payment on a case-by-case basis for inpatient short stays (less than two midnights) if the documentation supports the admitting physician's judgment that the patient requires inpatient hospital care. Likewise, commercial insurers continue to press hospitals on their determinations and are denying both inpatient and outpatient cases that don't include sufficient support for them within the documentation. Acuity and physician judgment are more important than ever.

> A strong UR process should send all cases that fail first-level screening for a second-level review.

A strong UR process should send all cases that fail first-level screening for a second-level review. If a case fails first-level screening, it isn't necessarily outpatient. Did the documentation clearly point toward outpatient status, or was some information missing? First-level reviews don't always provide that clarity. Remember, only a physician can make a decision to admit.

Through the combination of first- and second-level reviews, hospitals can provide a defensible medical necessity determination to help billing departments properly submit every case for reimbursement. Equally important, the due diligence and hard work done by Case Management through this two-level process ensures that patients receive the right status and accompanying financial obligations.

> Whether patients are inpatient or outpatient will dramatically affect their out-of-pocket costs from deductibles and copayments. Both your hospital and your patients rely on your professional expertise.

PARTNERING WITH APPEALS

Case Management should continually evaluate opportunities to improve the process. The Appeals team can provide feedback about the UR process by sharing payer trends that emerge from the types of and reasons for denials. When armed with that information, Case Management teams can help prevent denials by proactively ensuring sufficient support prior to submission.

A robust UR process — involving first- and second-level reviews and best-practice sharing with Appeals — affects not only the financial integrity of the hospital but also the personal finances of patients, whose medical costs are affected by the decision to admit.

A BEST-PRACTICE APPROACH

DENIAL PREVENTION

Develop and operate a proactive, consistent, accurate utilization management process

Use Physician Advisors to perform concurrent peer-to-peer appeals to reduce retrospective denials

Perform routine and continuing documentation, education and training

COMPLETE DOCUMENTATION

Clearly articulate clinician concerns

Clearly articulate why inpatient care is reasonably anticipated

DENIAL MANAGEMENT

Ensure that Case Management and the business office understand key contractual elements for payers

Hold health plans accountable by exercising all appeal rights

Simplify denial management process when possible

Have physicians contribute to and/or write appeal letters for complex and difficult cases

TRADITIONAL MEDICARE APPEALS

Prepare all appeals as if presenting to the Administrative Law Judge (ALJ)

Address clinical, compliance and regulatory issues

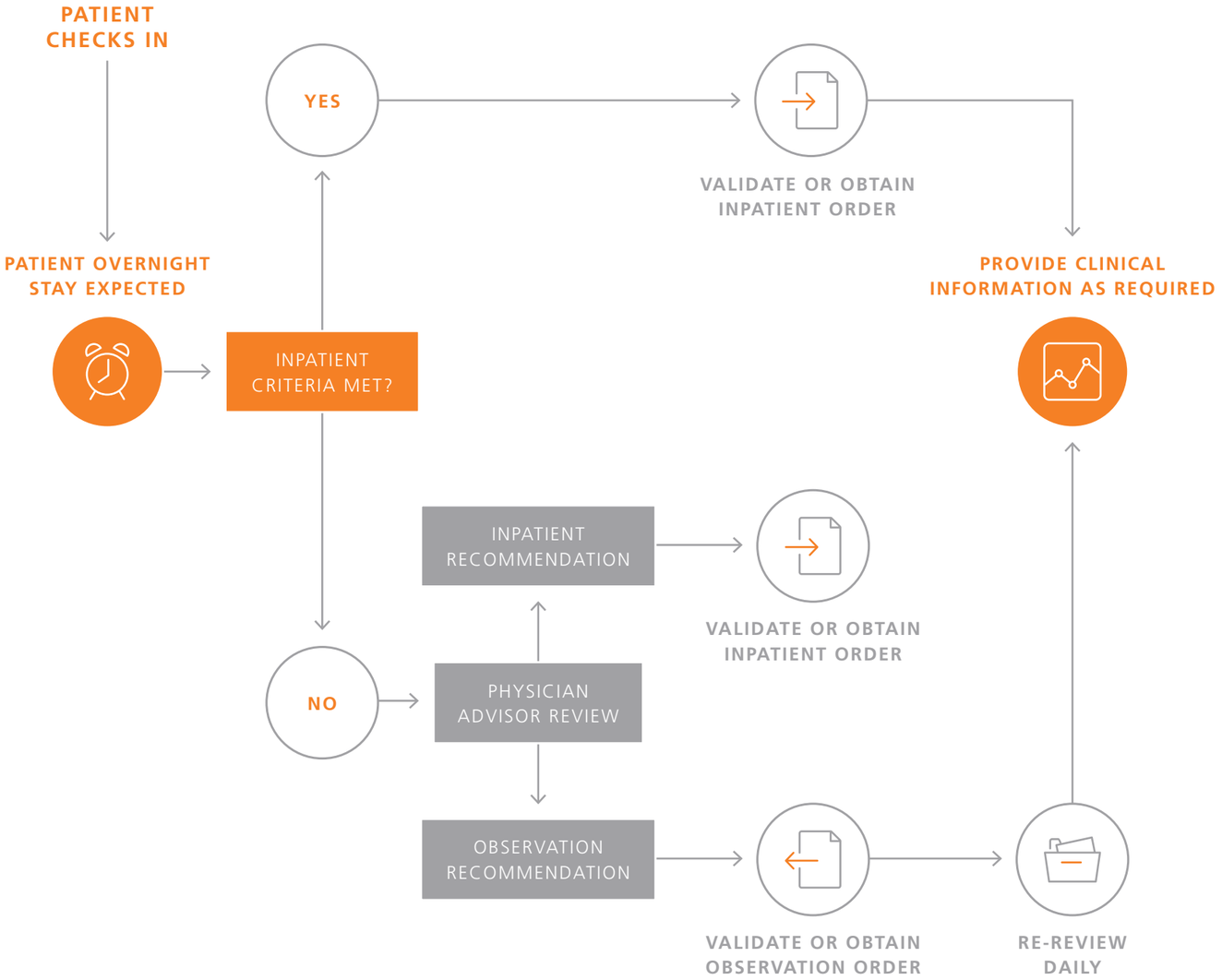
QUESTIONS TO EVALUATE YOUR ADMISSION REVIEW PROGRAM

The following questions assist in evaluating current medical necessity admission review programs and provide a checklist for ongoing evaluation of program effectiveness.

- ☐ Does the Utilization Review (UR) plan reflect a consistent process that is compliant with the UR standards as outlined in the Medicare Conditions of Participation?
- ☐ Does Case/Utilization Management follow a process of strict application of inpatient screening criteria for all Medicare beneficiaries as directed by the Hospital Payment Monitoring Program (HPMP) Compliance Workbook to ensure a two-level medical necessity admission review process?
- ☐ Are expert Physician Advisor reviews completed for all Medicare cases that do not meet first-level UR screening criteria for an inpatient admission?
- ☐ Is Case/Utilization Management using the most updated version of inpatient UR screening criteria?
- ☐ Is the medical necessity admission review process in effect 7 days per week, 365 days per year?
- ☐ Is there ongoing training and education available for Case/Utilization Management and Physician Advisor teams?
- ☐ Is there inter-rater reliability testing and quality assurance of Case/Utilization Management?
- ☐ Do the Physician Advisors remain up to date on ongoing regulatory guidance changes and the latest evidence-based care guidelines and outcomes?
- ☐ Is there inter-rater reliability testing and quality assurance of Physician Advisor teams?
- ☐ Are there processes in place to ensure ongoing communication between Case Management, Physician Advisors and treating physicians?
- ☐ Does the UR process ensure the creation of an enduring and auditable document for each Medicare case that provides permanent evidence of your UR process?
- ☐ Are the treating physicians at the hospital educated regularly on the importance of complete documentation, the need to work closely with Case/Utilization Management and Physician Advisors, and the role they play in ensuring both hospital and physician regulatory compliance?
- ☐ Is a regular analysis of the hospital's Probe & Educate outcomes, PEPPER and other benchmarking data completed to look critically at observation rates to identify areas that may require more attention to meet medical necessity admission criteria?
- ☐ Is there a process to ensure that the treating physician order is concordant with the admission status determination?
- ☐ Is there a process to ensure that the treating physician, hospital and beneficiary are aware of final claim status before patient discharge?

UTILIZATION REVIEW WORKFLOW

Below is the recommended workflow to help your facility elevate the consistency of your concurrent medical necessity review processes.



UNDERSTANDING THE TWO-MIDNIGHT RULE

When CMS implemented the Two-Midnight Rule (CMS-1599-F), its effects reverberated throughout the community of Medicare stakeholders. Though intended to provide clarity to the inpatient admission decision-making process, the resulting waves of confusion continue to be felt. Two years after its implementation, the Two-Midnight Rule was significantly modified by the 2016 OPPS Final Rule (CMS-1633-FC).

Understanding the importance of the Two-Midnight Rule — and how it got to where it is today — isn't only critical for physicians and hospital administrators. For Case Management, recognizing the medical necessity of an inpatient versus an outpatient determination and ensuring that the proper documentation is included in the medical record help to achieve compliance and provide defensibility against denials.

It is fair to ask whether the Two-Midnight Rule has achieved its objective of providing clarity, and to what extent the modification to allow for short inpatient hospital stays on a case-by-case basis promotes understanding of what constitutes an appropriate inpatient admission. The answer is elusive since enforcement has been severely lacking since its implementation. Though Recovery Auditors (RAs) are able to conduct patient status reviews if a provider is referred to them by the QIOs, to date no referrals have been made.

The only actual guidance hospitals can rely upon are the "Probe and Educate" reviews conducted by the Medicare Administrative Contractors (MACs) and QIO reviews of inpatient short stays that began on October 1, 2015, but remain in a holding pattern. Probe and Educate denial rates varied among MACs from 33% to 75% of all claims reviewed, results which scream misunderstanding and regulatory noncompliance from providers and contractors alike.

It is safe to say that the factor of time is important with the advent of the Two-Midnight Rule, but it is medical necessity, rightfully, that reigns supreme.

A few short months after the QIO assumed the responsibility for performing short-stay inpatient reviews, 38% of hospitals fell into the major concern category (error rate greater than 20%). But it wasn't just the providers getting confused; in May 2016, CMS halted the QIO's performance of patient status reviews "in an effort to promote consistent application of the medical review of patient status for short hospital stays." CMS temporarily suspended short-stay reviews to retrain the QIOs on the Two-Midnight policy and in order for the QIOs to complete a re-review of claims previously denied by the QIOs. After an approximately four-month pause, CMS has approved the resumption of patient status reviews by the QIO effective September 12, 2016.

It's not surprising that CMS, providers and medical reviewers are experiencing difficulty. The guidance for making appropriate inpatient admissions is confusing, and at times contradictory. The Two-Midnight benchmark instructs physicians to admit patients based on a reasonable expectation that the patient needs hospital care lasting two midnights or greater. OPPS 2016 allows for Medicare Part A payment for inpatient admissions that do not satisfy the Two-Midnight benchmark if the admitting physician determines that the patient requires inpatient hospital care. Administering dissimilar guidance for admissions with an expected length of stay less than two midnights and for admissions with an expected length of stay greater than two midnights is confusing for hospitals and physicians, unenforceable by medical reviewers and inconsistent with regulatory guidance.

The key role of medical necessity provides a thread of continuity, however. From the Two-Midnight Rule's inception, CMS and its representatives noted that the time factor was merely an overlay on existing medical necessity requirements. This is the main reason why it was not uncommon to routinely see inpatient admissions with lengths of stay greater than two midnights denied under the "Probe and Educate" program.

While CMS's choice to distinguish between the need for "hospital care" in meeting the Two-Midnight benchmark and "inpatient hospital care" for short inpatient hospital stays appears confusing, it's a distinction without much of a difference. Claims that meet the benchmark are "generally appropriate" for payment because, generally, though not absolutely, a patient whose condition requires a hospital stay meeting or exceeding two midnights in the hospital will meet inpatient medical necessity criteria. Conversely, a hospital outpatient receiving observation services does not rise to the level of an inpatient based solely on the passage of time.

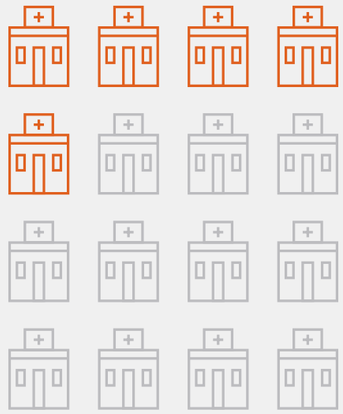
If we have learned anything in the little time that the QIOs were performing short-stay inpatient reviews, it is this: Medicare, consistent with OPPS 2016, will pay for less-than-two-midnight inpatient hospital stays.

The decision whether to admit or discharge a patient can usually be made in less than 24 hours, and in only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. Therefore, while it may be uncommon, existing guidance permits for the payment of reasonable and necessary observation services that span greater than two midnights. While it may be permissible, at no time has CMS articulated or presented guidance to suggest that an appropriate outpatient stay automatically converts to an appropriate inpatient admission when the clock strikes midnight on the second day.

If we have learned anything in the little time that the QIOs were performing short-stay inpatient reviews, it is this: Medicare, consistent with OPPS 2016, will pay for less-than-two-midnight inpatient hospital stays. It's a welcome revelation, but should not come as a surprise, since CMS did not define inpatient hospital admissions with expected lengths of stay less than two midnights as "rare and unusual."

Regardless of the length-of-stay expectation and consistent with CMS longstanding policy, all admissions must be medically necessary and the documentation in the patient's medical record should clearly support the admitting physician's decision that the patient requires inpatient hospital care. With the advent of the Two-Midnight Rule, it is safe to say that the factor of time is important, but it is medical necessity, rightfully, that reigns supreme.

Whether or not the Two-Midnight Rule has clarified or further confused clinicians in determining patient stays is certainly up for debate, but for Case Management, recognizing how the rule applies can help maintain consistency and compliance in regard to the inpatient/outpatient decision.



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