

Case Management Monthly

BEST PRACTICES AND PRACTICAL SOLUTIONS

Manage your fear of the RAC Create a defense against RAC denials

CMS' Recovery Audit Contractor (RAC) program elicits feelings of fear, but **Brenda Keeling, RN, CPHQ, CPUR**, president and owner of Patient Response in Milburn, OK, says fear is the last thing you should feel when faced with a RAC audit.

"Fear won't get you anywhere," says Keeling. "When people are fearful, they tend to practice avoidance. Avoidance won't get you anywhere—the RAC is here to stay."

And RACs may actually help your facility adopt good practices for the future, she adds.

By setting up strategies for defense, Keeling says, your facility will be better able to defend itself against denials and recoupments—not only from RACs, but from other payers as well.

"The last thing anyone wants to hear is 'The RAC is a good thing,' but if it helps case managers argue their point for vigilant documentation, then something good can come out of it," she says.

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Learn how one facility adopted a clinical model to improve documentation and decrease denials.

From the Director's Desk

This month's installment discusses strategies for managing LOS before patients enter the hospital.

Complex case

One case manager involves Homeland Security with a difficult patient discharge.

Weapons of defense

You can defend yourself against a negative RAC audit, but to do so, certain processes must be in place. You can never be too prepared for RACs, regardless of when they come to your facility, says Keeling. She suggests the following four steps to get your facility "RAC ready":

1. Look at your admission process. Are you looking at every point of entry? A common practice is to review cases 24

hours after admission, but if you wait 24 hours to review a patient who might have been better off

"When you appeal back to the RAC, you need to show that a patient warranted the treatment and length of stay that was given to them."

—Paul Arias, RN, BSN, MIS

in observation status, the damage may already be done, and you may already have a denial on your hands. Make it your process to have a case manager review and approve every case in which a bed may be assigned.

2. Scrutinize short-stay admissions. The bulk of denied claims are from inpatient admissions. Medicare places increased scrutiny on one- to three-day stays for medical necessity. Therefore, it would behoove facilities to assess current admission processes for determining medical necessity for admission. Keeling suggests you review all admissions for medical necessity and appropriateness despite financial classification.

3. Have at least one outside audit. Keeling recommends hiring an outside contractor to conduct a mock audit and to bring to light areas of weakness in your facility.

"A self-audit is a terrific idea, but internal staff tends to become comfortable in their day-to-day environment, so the staff might not be able to see things as clearly as a fresh set of eyes will," she says.

4. Implement teamwork. Work as a team with utilization review, documentation specialists, admitting

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RAC denials

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personnel, finance, and coding; have this team review the results of the chart audit findings. You'll be amazed at how your team will brainstorm for areas of improvement.

As a director of care coordination at Crouse Hospital in Syracuse, NY, **Paul Arias, RN, BSN, MIS**, has already been through a RAC audit. He says going through the process taught him that preparation was essential.

"We were lucky; our auditors found very few problem areas, but that is because we have strong patient review processes in place," says Arias. "Still, we're continually finding room for improvement. If you are open to self-review and have good processes in place to reduce denials, you'll help yourself tenfold."

Educate physicians on how to collaborate with case management to admit and discharge patients to their proper level of care, Arias says, adding that having a physician involved is a hospital's best defense in the

appeals process. "I see facilities looking for templates for appeals," he says. "I really believe that is the worst approach they can take. Patients aren't cookie-cutter; each has different circumstances. When you appeal back to the RAC, you need to show that a patient warranted the treatment and length of stay that was given to them. Having a physician in on that argument has been worth its weight in gold."

Know your rights

Remember that RACs cannot randomly select claims or target one "solely because it is a high-dollar claim," according to the draft *Statement of Work*. A RAC can only "target a claim because it is a high-dollar claim and contains other information that leads the RAC to believe it is likely to contain an [over- or underpayment]."

Nancy Hirschl, BS, CCS, president of Hirschl & Associates in Laguna Niguel, CA, and an HCPro *RAC Report* advisory board member, says the "other information" could include:

- Diagnosis codes that may be incorrectly coded based on RAC experience in the private health insurance arena
- Diagnoses that often present physician documentation insufficiencies
- Procedure codes that do not correlate with diagnosis codes
- Procedure codes that may indicate inappropriate site of service/inpatient status
- Incongruent charge to payment comparison
- The belief that the claim payment was not consistent with Medicare payment policy

Hirschl says you should identify areas the RAC may target before the RAC arrives, develop strategies to defend your data, and improve case management protocols.

"The RAC may deny your claims, but you can and should defend your original coding, billing, and patient status if documentation and clinical evidence supports it," says Hirschl. ■

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Make advocacy and quality the focus of a comprehensive case management program



Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ List the three stages involved in hospital patient care management
- ▶ Explain the structure of a physician-based case management model

If your case management program is like most, it focuses mainly on utilization review and discharge planning. **Stefani Daniels, RN, MSNA, CMAC, ACM**, says many case managers are getting bogged down by these duties and losing focus of what case management is really about: patient advocacy.

“The heart of hospital case management must be advocacy. It’s a case manager’s No. 1 ethical obligation,” says Daniels. “The problem is it’s often a challenge to translate advocacy into day-to-day practical operational terms.”

Although some facilities—such as Clinton Memorial Hospital (CMH) in Wilmington, OH—use models to help case managers spend more time with patients and less time on paperwork, many don’t.

Daniels says that case managers often focus only on the end of a patient’s stay, the transition period. However, she says case managers should be advocates for all three stages involved in hospital care:

- ▶ **Access**—how the patient gets to the hospital
- ▶ **Throughput or care management**—the care the patient receives while in the hospital
- ▶ **Transition or discharge planning**—how and when the patient will leave the hospital and the level of care he or she will require at that time

“Everything that a case manager does as a patient navigator to help that patient get through the system as quickly and safely as possible is in the name of advocacy and quality,” Daniels says.

Make sure only the right patients are admitted

Daniels points out that hospitals are dangerous places. “Every day you’re in the hospital, your risk of an adverse event goes up 6%,” she says. Therefore, advocacy begins by making sure only those patients whose benefits outweigh the risks are admitted into the acute care setting. Daniels says facilities should prevent denials instead of managing them. This begins with gatekeeping.

A good gatekeeping system means identifying all your facility’s access points and asking the right questions to prevent unnecessary admissions. Direct admits, transfers, and patients who are scheduled for outpatient surgery but end up in a bed overnight are often the toughest to handle. “Clearly, gatekeeping is essential, especially with the recovery audit contractors. If you admit [an unnecessary patient] and try to fix them, look at the energy you’re wasting,” Daniels says.

Daniels provides an example: A family taking care of a mother with Alzheimer’s disease feels as though they can’t take care of her anymore. They take her to the ER. As an advocate for this patient, a case manager knows that if admitted, this elderly woman will lose function within the first 24 hours of being in a bed. Additionally, the chances are great that the hospital will not get reimbursed by Medicare. Therefore, as patient and hospital advocate, the case manager will immediately begin to look for available nursing homes or Alzheimer’s units and figure out how to get her there immediately. “Even if the hospital has to underwrite some of the costs of the stay, it will most likely be cheaper than the costs of admitting her as an inpatient,” Daniels says.

Move the patient through the continuum

The second part of patient advocacy comes in after patients have already been admitted. At this stage, the main function of the case manager is to be sure the patient is re-

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Patient advocacy

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ceiving the right level of care for his or her condition.

Daniels says the appropriate questions to ask are:

- Does this treatment plan meet the immediate acute care needs of the patient? If not, unnecessary risks are being taken, adding cost to the patient's bill.
- Is the treatment plan related to the diagnosis? If not,

"The director of case management must educate others about how advocacy in case management translates into those practical strategies that, in the end, will benefit the hospital and the organization."

—Stefani Daniels,
RN, MSNA, CMAC, ACM

the admission diagnosis is wrong or the treatment plan is not appropriate for that admission diagnosis.

See "Progression of care chart" on p. 5 for additional questions.

Daniels provides an example: A patient comes in for a cardiac problem, is treated, and is otherwise ready for discharge, but the physician is ordering a barrage of bone tests. The case manager asks the physician why he is ordering these tests, and the physician responds, "He was complaining of pain, so I thought I'd order them." Getting the tests performed is admirable, but getting them done in a hospital setting adds risk to the patient and costs the hospital money. As the case manager, arranging for the patient to get these tests filled as an outpatient—even if it means paying for a taxi to get the patient from his house—is the best option. Getting discretionary tests done in an inpatient setting is adding risk to the patient and adding to the LOS.

Plan for a timely and safe transition

Transitioning the patient out of the hospital, or discharge planning, is the part of patient care on which many case managers focus, Daniels says.

Important questions to ask at this stage are:

- What milestones will indicate readiness for a lower level of care?

- Are resources in place for access to postacute services, products, or treatment?

Daniels provides an example: A patient is getting ready to be discharged home. The doctor writes a prescription for a sophisticated, costly antibiotic. A good advocate is going to say, "This patient is not going to fill that prescription. He can't afford it. Is there any acceptable alternative that the patient will more likely fill?"

Putting it into practice

Executing advocacy may be a difficult concept for some case managers and hospital administrators to understand, Daniels says.

"To simply tell a CEO, 'You've got to start thinking about your case management as an advocacy program,' they're going to say, 'I can't afford it. I cannot afford to provide an advocate,'" she says. "The director of case management must educate others about how advocacy in case management translates into those practical strategies that, in the end, will benefit the hospital and the

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organization.” Daniels says these strategies involve working closely with physicians on behalf of your facility’s most important stakeholders—the patient and the organization.

At CMH, **Pam Daniel, RN, MSN**, director of continuum of care, oversees a physician-based case management model that allows case managers to be patient- and physician-focused so they never have to worry about utilization review.

“The case manager’s job is to advocate for both the patient and the facility,” Daniel says, adding that the facility’s model helps case managers build functional relationships with physicians.

Each case manager at CMH is assigned a specific group of physicians, based on the utilization of the physician. The case managers discuss the plan of care with the physician in terms of which resources are available to the patient. For example, a patient with insurance will have more options available than one without it.

CMH, like any other facility, struggles with different payer rules and changing Medicare regulations.

“We have a dedicated person who does our utilization review,” Daniel says. “She works closely with the case managers to let them know what the payers’ requirements are, how many days have been approved, when we’re going to need our next review.”

This helps the case managers keep physicians in the loop.

“Prior to that, we were having our case managers do their own utilization review, which was then taking away from being there to round with their physician and actually being able to see their patients,” she says.

Daniel says the case management program is respected and valued by the hospital administrators, and the case management staff members love their jobs. “These are the coveted jobs, and no one leaves unless they’re moving out of the area,” she says. “We haven’t replaced a case manager in about four years now.” ■

Progression of care chart

Access	Throughput, care management, progression of care	Transition
Does the patient require an acute level of care?	Is the treatment plan related to the reason for acute admission?	What milestones will indicate readiness a for lower level of care?
Does the treatment plan meet the immediate acute care needs?	Does the ongoing treatment plan contribute to the desired outcome?	Are transition plans confirmed by the team?
Is the treatment plan related to the admission diagnosis?	Does intensity of service correlate with severity of illness?	Do plans require a case manager? A social worker?
Does the patient need case management intervention?	Do the prescribed services add value to acute care needs?	What contingency plans are being considered?
Would another level-of-care venue be less risky?	Has a targeted transition been identified?	Is the patient/family in accord with the transition?
Are community services available?	Are the prescribed services being delivered efficiently?	Are resources in place for access to postacute services, products, or treatment?
What postacute needs are anticipated?	Do new barriers signal a need for a social worker?	

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Ask June

How can my facility's hospitalist program help improve case management goals?

by June Stark, RN, BSN, MEd

Hospitalists, who specialize in the management of hospitalized patients, take over for PCPs when it's time to admit patients. Hospitalists work on fast-paced, intensely focused, and streamlined schedules and have been known to shave days off the average stay at a facility.

Because of the efficiency and cost-effectiveness they can bring to facilities, hospitalist programs are quickly gaining traction. The American College of Physicians estimates that more than 2,000 new hospitalist programs have popped up across the nation in the 10 years since the concept was born.

As we witness a boom of hospitalist programs, it has become clear that hospitalists have much in common with case managers. They share the same strategic goals, which include LOS reduction, appropriate utilization of clinical resources, core measure achievement, quality of care management, and customer satisfaction.

The achievement of these goals is dependent on the close collaboration between hospitalists and case managers, and on the structure, organization, and composition of the hospitalist program.

To ensure the success of your hospitalist program, take the following steps:

- **Assign hospitalists by unit.** When hospitalists are unit-based, LOS reduction goals are easier to achieve. This is because continuity is built into a geographic-based assignment. The hospitalist is visible and easily located, and time is gained, as traveling from one patient care area to another is avoided.
- **Establish morning hospitalist/case manager rounds.** Start every day with rounds to plan the day and the stay. Daily rounds open the lines of communication and clarify the direction and goals for the day. It ensures that all caregivers are on the same page.
- **Consider hiring experienced physicians.** A hospitalist program that is staffed with experienced

physicians has an edge over those that are not. A physician who has been part of an established practice has likely developed organizational skills and clinical expertise that are easily transferable to managing a hospital-based practice. An experienced physician is more likely to have LOS management skills and the ability to coordinate care in a cost-effective manner.

- **Expect a learning curve.** Just like a new case manager, a new hospitalist will face a learning curve. Budgetary goals may not be easily achieved during this period. Expect an experienced physician to take two weeks to one month to get up to speed, whereas an inexperienced physician may take as long as three to six months to learn the ropes.
- **Establish guidelines promoting communication between hospitalists and PCPs.** The satisfaction of the referring physician or PCP is essential to the success of your hospitalist program. Frequent, clear, and effective communication, which meets the needs of the PCP, will ensure future referrals and utilization of your hospitalist program.
- **Monitor patient/family satisfaction.** Survey patients and their families to determine the effectiveness of your hospitalist program and the customer satisfaction it garners. Ask patients to identify the name of their physician caregiver in the hospital to allow for follow-up.

Above all, it is important to create a clear, shared vision for success and encourage communication between hospitalists and case managers.

Although hospitalist programs vary, the ability to develop strategies to work with hospitalists will help case managers meet their goals. Supporting the hospitalists and acknowledging the unique contribution each individual physician can give will help foster a collaborative, effective case management team. ■

Transforming the elective precertification process

One hospital system uses care management to improve its prearrival process



Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ Discuss the value of having a clinical basis for elective preadmission review for all in-hospital procedures
- ▶ Differentiate between a clinical and nonclinical review process for elective surgical admissions

The corporate care management staff at the University of Pittsburgh Medical Center (UPMC) knew its system of using nonclinical staff members to review plans for elective surgical admissions begged for restructuring. Communication was poor, LOS was up, and denials were difficult and time-consuming to appeal.

Laura D'Andrea, RN, BS, manager of prearrival nurse liaisons for the corporate care department at UPMC, says it all came down to communication.

Even in a best-case scenario, nonclinical staff members lacked the expertise required to determine whether there were gaps in the documentation that needed to be addressed.

"We knew it was important to create a model that allowed the clinical staff to have a hand in the precertification process," says D'Andrea. "We needed their clinical background so the right questions could be asked up front."

In the beginning

UPMC saw that having nonclinical staff members review elective surgeries hadn't been working for some time. Patients stayed beyond their planned and approved LOS, and there was a lack of communication surrounding a patient's discharge plan. In the late 1990s, UPMC decided to try out a pilot program in which three nurse liaisons at Presbyterian University Hospital in Pittsburgh reviewed elective and urgent hospital visits.

The nurse liaisons were charged with:

- ▶ Improving communication and documentation

- ▶ Ensuring that the correct level of care was requested from physicians
- ▶ Making sure the planned procedure was appropriate for the diagnoses listed
- ▶ Ensuring that precertification requirements were met and in place prior to the date of service

"These aren't issues that UPMC has grappled with exclusively," says D'Andrea. "These issues are far-reaching; we just felt there had to be a logical solution."

Some of the problem areas the facility thought could benefit from clinical review were:

- ▶ **Insurance verification.** Inaccuracies meant care management

"It all comes down to communication. If all you have is someone pushing paper, then you're not going to see results."

—Laura D'Andrea, RN, BS

had to backtrack to provide third-party payers the appropriate information for reimbursement.

- ▶ **Delayed work lists.** This meant patients had unnecessary days tacked on to their LOS.
- ▶ **Difficulty assessing procedure documentation.** Lack of communication created unnecessary extra work for in-house care managers. It also meant it was difficult to capture and trend information to help prevent denials.

The shift to care management

At the time, the nurse liaisons worked on the patient access team and were responsible for keeping an eye on how each stay affected hospital finances.

But it was soon apparent these nurse liaisons needed to be under the umbrella of care management, says D'Andrea. In February 2006, the prearrival nurse liaisons were transitioned from patient access to care management.

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Precertification

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“In order to have an effective prearrival program, we needed to have people review prearrivals with an eye to the entire continuum of patient care, so it was really a care management function. They needed to look at precertification and know if a projected length of stay and discharge plan were going to work,” she says.

The shift from patient access to care management allowed the nurses to review accounts with an eye toward:

- **Improving documentation.** The nurse liaisons were charged with reviewing the prearrival plans for patients and making suggestions prior to patient arrival.
- **Managing LOS.** By being involved from the get-go, the nurse liaisons were better able to verify the validity of a physician’s authorization for a patient’s hospital stay and argue it before they were faced with a denial.
- **Preventing denials.** By ensuring that the correct authorization has been made for each case, care management has been able to plan ahead for the appropriate level of care.

Kristy Porter, BS, project manager of UPMC’s corporate care department, says slight adjustments made a world of difference.

“UPMC has successfully developed a prearrival clinical model by realigning the nurse liaison under the care management umbrella. This has provided a much-needed clinical basis for our elective admission review,” says Porter.

A successful switch

Porter and D’Andrea say the prearrival nurse liaisons have proven vital to the fiscal well-being of UPMC. The nurse liaisons not only ensure that the correct level of care is requested prior to patient admission; they police all cases prior to admission to ensure there is an appropriate plan for the diagnosis listed.

By implementing this system, UPMC has seen a drop in denial rates, and LOS has decreased. Additionally, care management has found that it’s more capable of tracking and trending areas in need of improvement.

“It all comes down to communication,” D’Andrea says. “If all you have is someone pushing paper, then you’re not going to see results. By utilizing our staff’s clinical expertise, we’ve managed to create a streamlined program, which has a model the rest of [the hospitals in] our system will hopefully follow.” ■

Questions? Comments? Ideas?

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Preadmission interventions can help improve LOS

by Christy Whetsell, RN, MBA, ACM

Case management department employees will hear the familiar phrase “We need to decrease LOS” many times in their careers. Frontline case managers have many hurdles before them as they try to manage LOS; creating a model that breaks your facility’s LOS plan into achievable, smaller goals can be a helpful and proactive solution.

When thinking about how to break down your LOS plan, a good place to start is with preadmission interventions. Preadmission interventions include:

- ▶ **Partnering with surgery clinics to assist patients in preplanning for their discharge from scheduled surgeries.** Collaborate with your orthopedic clinics to create handouts for patients that help them think about their anticipated discharge needs, discuss how to evaluate or choose postdischarge services, and encourage them to visit and choose postacute facilities prior to admission.
- ▶ **Collaborating with your perioperative services.** For example, most hip-surgery patients are evaluated by the physical therapy staff immediately following surgery. If your physical therapists don’t work on weekends, it makes sense to avoid doing these surgeries on Fridays because it would mean the patient would not be seen until Monday.
- ▶ **Identifying high-risk patients and implementing preadmission patient education.** Patients identified as a home discharge that reveals they have no social support systems should be referred to the medical social worker for presurgery intervention.
- ▶ **Providing education to the community about the healthcare system.** Set up information clinics in the community that promote proactive health-care decision-making. Inform the community about

how to manage care. Such discussions can trigger preplanning thoughts that will be beneficial to the patient and hospitals.

Breaking down LOS

There are many ways you can dramatically improve LOS, including:

- ▶ Making sure all patients are screened within 24 hours of admission. Identify potential discharge concerns and implement plans to address any issues a patient may have immediately.
- ▶ Coordinating daily communication with the healthcare team, patient, and family regarding the patient’s treatment plan and progression toward discharge.
- ▶ Establishing a process to identify patients who have many complicated needs and are going to require the “whole village” to move through the continuum of care. Use medical directors, physician advisors, and discharge support team members to implement an individualized plan of care and transitional/discharge plan.
- ▶ Tracking and trending avoidable delays/days, discharge time, and capacity management. Analysis of the data by unit, service, and physician may identify specific areas that may benefit from individualized interventions.

Preadmission interventions can play a strong role in effective LOS transformation. Keep in mind that, just like pennies you save for vacation, saving a quarter, a half, or a whole day per patient can add up to a lot in the end. ■

Editor’s note: Whetsell is on the board of ACMA and is the director of care management at West Virginia University Hospital in Morgantown.



Complex case

Case manager calls upon Homeland Security to aid in patient discharge

Omar is an illegal immigrant from Saudi Arabia. He is unconscious upon his admission to the ICU as the result of a serious narcotic overdose. Omar, a known substance abuser in his community, was rescued by paramedics, who report he had approximately two minutes of anoxia before resuscitation measures were able to be implemented.

The neurologist determines that Omar has experienced a degree of permanent brain damage, which will leave him with impaired decision-making capabilities, approximately equal to those of a 16-year-old. Although the neurologists agree that Omar can still live somewhat independently, he will require a sustained level of daily supervision to support him in his routine activities. His case manager realizes his condition has created complex discharge needs. She begins planning for the discharge early in his stay, even though he is still acutely ill. Omar refuses to offer the hospital staff any identifying information, so the case manager must search for his family members or a significant other without his help.

By thoroughly searching through medical records of similar admissions, the case manager finds one containing Omar's full name and the names of relatives. The case manager also learns that Omar arrived in the United States more than 12 years ago with a green card and never returned to his country of origin when the card expired.

The case manager calls the nearest listed relative, Omar's brother, who says Omar's long-standing substance abuse has been a terrible strain on the family, and that they can no longer offer him support. However, the brother provides the phone number of Omar's parents in Saudi Arabia. The case manager calls the family and receives a curt response that the

family will offer no help. After the first call, the family never answers the phone again.

At this point in the case, nearly two weeks after being admitted, Omar is improving and will soon be ready for discharge. With limited resources to assist him, and the knowledge that Omar is in this country illegally, the case manager decides to contact the Saudi Arabian consulate. The case manager hopes the consulate will fly Omar to his home country; however, it will not take on the cost of flying him home.

The case manager continues to check Omar's background. She discovers he has a criminal record in several states. With this information, the case manager feels she has no alternative other than to contact the Immigration and Customs Enforcement (ICE) division of the U.S. Department of Homeland Security. ICE tells her it is aware of Omar's history and wants to start work to deport him once he is healthy enough for discharge.

With the support of her hospital's social worker, the case manager establishes a safe discharge plan for Omar while she is waiting for ICE to take action. The case manager refers him to a halfway house for patients with his level of mental abilities. The halfway house offers a work rehabilitation program and 24-hour supervision. This transition plan offers Omar the neurological and occupational rehabilitation he needs. As a result, ICE allows him to remain at the halfway house until he is fully rehabilitated and in the best condition to return to his native county.

The case manager does not hear from ICE or Omar after he transitions to the halfway house and assumes he returned to his home country. It is difficult for her because she's unsure of the final outcome, but she knows she made the best discharge plan possible. ■