

# Case Management Monthly

Best Practices  
and Practical Solutions

## Patients deserve a choice in the discharge plan



### Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ Document that patients were given postacute choices
- ▶ Create and maintain a list of postacute choices

When it comes to discharge planning, Medicare rules require hospitals to involve the patient in the process.

More specifically, hospitals must give patients a choice between the available and appropriate postacute services (e.g., home health agencies [HHA] and SNFs).

According to the *Conditions of Participation for Hospitals* in Section 482.43(7):

*The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of posthospital care services and must, when possible, respect patient and family preferences when they are expressed.*

### IN THIS ISSUE

#### p. 3 Important Message from Medicare

The American Case Management Association's public policy committee examines whether the second Important Message from Medicare is necessary.

#### p. 4 Case-mix index

Your hospital's case-mix index says a lot about the facility. Find out what you and your department can do to make it the best it can be.

#### p. 6 Readmissions

Learn about a tool that identifies readmissions before they happen.

#### From the Director's Desk

Paul Arias, RN, BSN, MIS, explains how to execute denial prevention.

#### Complex case

A case manager takes on a patient's high-profile spouse.

## Documenting patient choice

Hospitals do have options when it comes to documenting that the patient was given a choice of post-acute facilities, including:

- ▶ A form that a patient or significant other must sign.
- ▶ A staff-written narrative note in the medical record.
- ▶ Discharge technology that automatically generates a choice letter given to

**"Medicare doesn't tell hospitals how to document choice—although some wish that it would."**

—Jackie Birmingham, RN, MS

patients and their families. The letter is a function of the software that allows its inclusion in patients' medical records.

The *Conditions of Participation for Discharge Planning* and the *Interpretive Guidelines for Hospitals* (p. 293) include references to the rules.

"Medicare doesn't tell hospitals how to document choice—although some wish that it would—because of the varied nature of hospitals," writes **Jackie Birmingham, RN, MS**, vice president of Curaspan Health Group in Newton, MA.

Hospitals can either give patients a form to sign or ask for verbal communication. If the hospital provides patients with a postdischarge choice verbally, you should document that conversation in the patients' records, says Birmingham.

Medicare allows hospitals to develop policies based upon what will best meet the needs of their patient population.

To improve documentation of postacute choice, Birmingham offers the following tips:

- ▶ **Review your hospital policy.** Many case managers are unaware of their facilities' choice policy. Include

> *continued on p. 2*

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## Patient choice

< continued from p. 1

how to inform patients if the hospital has a financial relationship with the postacute provider.

- **Audit your current practice.** Ask staff members who perform discharge planning how they satisfy the choice requirement. Perform peer reviews.
- **Set up role-playing.** Conduct role-playing for situations that may cause a delay in discharge. For example, a patient only wants a particular facility and there are no beds available. If you spend only 10 minutes, the results will be worthwhile.
- **Automate the discharge planning process.** This will ensure valid evidence that:
  - Appropriate and available HHAs, SNFs, and hospices are on the list
  - The patient received a list from which to choose
  - Both the final choice and level of care were documented and are a permanent part of the medical record

## Creating and maintaining a list

Regardless of method, hospitals should document that the patient reviewed a list of appropriate and available hospice providers, SNFs, or HHAs. The lists of Medicare-certified SNFs and HHAs are available at one of CMS' Compare Web sites.

There is one site dedicated to HHAs ([www.medicare.gov/HHCompare/Home.asp](http://www.medicare.gov/HHCompare/Home.asp)) and one specific to nursing homes ([www.medicare.gov/NHCompare/home.asp](http://www.medicare.gov/NHCompare/home.asp)). Information for hospice providers can be found at [www.cms.hhs.gov/center/hospice.asp](http://www.cms.hhs.gov/center/hospice.asp). Names of providers of durable medical equipment, prosthetics, orthotics, and supplies are also available on the Medicare Web site ([www.medicare.gov/Supplier/Home.asp](http://www.medicare.gov/Supplier/Home.asp)).

To decide which facilities to include on your organization's list, you must facilitate proactive discharge planning to identify what level of care meets the patient's needs, Birmingham says.

The types and levels of postacute care providers are generally based on the patient's functional status and medical needs, but you won't know what the patient needs until you start discharge planning. Be proactive in providing choices, and patients will be more satisfied. Follow the rules, but be patient-focused, Birmingham says. ■

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Illustration by  
David Harbaugh



*“The doctor says you can be discharged to the cafeteria by noon—the lunch menu features filet mignon.”*

## Is the second Important Message from Medicare important?



### Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ Identify problems case managers have with the second Important Message from Medicare

The American Case Management Association (ACMA) Public Policy Committee is in communication with CMS to change the requirements for the second Important Message from Medicare (IM).

“The IM is such a hot issue,” says **Ann Michie, RN, MS, MPA, CCM**, former chair of the ACMA Public Policy Committee and consultant in Huntsville, AL. “Everyone complains about it.”

### Survey results

To get a better idea of how hospitals handle the second IM, the Public Policy Committee members developed an online survey.

The committee received 389 responses. The results of the survey include the following:

- ▶ 84% say case management is responsible for issuing the second IM
- ▶ Nearly 40% of respondents say the issuance of each IM takes more than 10 minutes
- ▶ Of those who track IM compliance, 40% report a compliance rate between 76% and 100%
- ▶ 38% of respondents report increased numbers of discharge appeals
- ▶ 96% say less than 25% of patient appeals are successful
- ▶ Respondents generally feel the second IM adds little value to patient care and adds to patient confusion and frustration

The survey’s results reinforced what the committee members had already known about the second IM through anecdotal evidence—the process is burdensome, redundant, and ineffective.

“It definitely supported our thoughts when they told us that there was an increase in appeals for facilities,” says **Christy Whetsell, BSN, RN, MBA, ACM**, chair of the Public Policy Committee and director of care management at West Virginia University Hospital in Morgantown.

However, very few of those appeals are successful, and some case managers feel patients use the appeal to stay an extra day while waiting for a response.

### Additional comments

ACMA CEO L. Greg Cunningham took the survey results to CMS, and according to ACMA, the agency was receptive. CMS requested that ACMA poll its membership and return with a prioritized list of concerns with the second IM.

The Public Policy Committee held a special breakfast session during the National Institute for Case Management/ACMA national conference in San Antonio to allow the membership to contribute their thoughts. Case managers filled the ballroom—a testament to the fact that they are passionate about the issue, says Whetsell.

Case managers from across the country lined up behind microphones and offered their solutions to the second IM process.

One commenter suggested the IM be included in the Medicare manual. She stated that most Medicare beneficiaries know the manual cover to cover. The solution would inform patients about their rights and encourage increased collaborative efforts around patient transitional planning.

Most agreed that patients must understand their appeal rights, but how that information is delivered needs to be improved.

“We aren’t saying get rid of [the IM] totally, but let’s do it once and not twice,” says Michie.

“What I got from the session is that everyone is still very passionate about the issue,” Whetsell says. “We got a lot of good ideas that I will take to the next public policy meeting, and we will work on next steps.” ■

# What does case-mix index mean to you?

## Continuing Education | Learning Objectives

After reading this article, you will be able to:

- Calculate your facility's case-mix index
- Identify factors that affect case-mix index

"Hospital fortunes rise and fall based on what the CMI is doing," says **Lynne Spryszak, RN, CCDS, CPC-A**, clinical documentation improvement (CDI) education director at HCPro, Inc., in Marblehead, MA.

The financial department monitors case-mix index (CMI), and in an ideal world, the hospital's CMI would be as high as possible. A high CMI means the hospital performs big-ticket services and therefore receives more money per patient. Case managers can do their part to make sure that number is as high as possible.

### Calculate and analyze CMI

To calculate CMI, choose a time period (e.g., one month) to examine. Within that time, take all the DRGs your hospital billed and add up the relative weights (RW). Now, divide that number by the total number of DRGs. What you are left with is your hospital's CMI for that month.

Finance departments consider CMI when determining the hospital's budget. If the hospital's actual CMI is

less than what the finance department predicted, the hospital may experience a loss in revenue.

Even seemingly small changes in CMI have a large effect on the hospital's bottom line. The table on p. 5 shows how a 0.10 change in CMI affects a hospital with a hospital specific rate of \$4,500. CMS determines hospital-specific rates based on geographic location and overhead costs, graduate medical education costs, and indigent patients served.

Case management departments can use CMI like a barometer of change within an organization, Spryszak says. If your CMI drops, it could be a sign of change in surgical or medical volumes, for example. Similarly, if your hospital's CMI is lower than hospitals in your area, it could be a sign that the hospital is not capturing the complications and comorbidities (CC) and major CCs (MCC) that group those accounts into a higher-weighted DRG.

**Loretta Olsen, MSN, RN**, director of revenue cycle at Jennie Edmundson Hospital in Council Bluffs, IA, monitors CMI monthly to make sure the hospital meets its CMI goal.

### Influence and improve CMI

A hospital can't perform unnecessary services for the sake of improving CMI. However, there are ways that the case management department can improve

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a hospital's CMI. The first is to work with physicians to improve documentation. If patients have CCs and MCCs that reflect a higher level of complexity, the hospital can bill for a higher-weighted DRG. However, coders can only report what the physician documents in the patient's record.

A strong CDI program will help physicians understand the importance of documentation. A strong CDI process supports opportunities to query physicians for a more specific diagnosis.

Beyond documentation, improper admissions can also drive down a hospital's CMI. Remember, CMI is only concerned with the hospital's inpatients.

The DRG for an inpatient that could have been treated in the outpatient setting will have a low RW (e.g., 0.5 or 0.6). If this happens once or twice, it shouldn't be an issue, but if a significant number of those patients are included in the inpatient equation, it will drive down the CMI, Spryszak says.

To solve the problem of improper inpatient admissions, Jennie Edmundson took level of care decisions out of the physicians' hands. Before admitting a patient, physicians write an order to "admit to case management protocol." A case manager then applies InterQual criteria to the physician's documentation, and the physician signs off on the decision.

"Physicians don't base level of care on any criteria; they base it on length of stay, and that's incorrect," Olsen says.

Case managers at Jennie Edmundson also conduct concurrent assessments daily to ensure that each day is medically necessary.

After implementing the case management protocol, Olsen saw the hospital's CMI increase, in addition to seeing more appropriate inpatient admissions.

"In this day and age, case management departments should be paying attention to case-mix index, because it does affect reimbursement," says Olsen. ■

### Beware when you compare

Comparing case-mix indexes (CMI) is not an exact science, says **Lynne Spryszak, RN, CCDS, CPC-A**, clinical documentation improvement education director at HCPro, Inc., in Marblehead, MA.. Factors that can artificially influence CMI include:

- ▶ **A rare high-weighted DRG.** If a patient suffers a car accident and requires a tracheostomy and more than 96 hours of mechanical ventilation services, that patient will group to a DRG with a relative weight (RW) of more than 18. Patients who require that level of care are infrequent and can significantly increase CMI in one month.
- ▶ **Different seasons.** Comparing the CMI from one season to another can be problematic. Your hospital may see more broken hips in the winter because more people are slipping on the ice. That could make the first quarter CMI higher than the second. That's why Spryszak recommends comparing quarters year to year.
- ▶ **Department absence.** If your cardiac surgeon attends a weeklong conference, there will be no scheduled surgeries performed during that time. This could cause a dip in the CMI because scheduled surgeries have high RW, and if the surgery volume is down, this will cause a temporary decrease in CMI. That is why it is important to measure your CMI over a 12-month period. Hospitals with high surgery volumes are more likely to have a higher CMI because of the higher RW and normally lower LOS, says **Loretta Olsen, MSN, RN**.

Eliminate these factors when calculating changes in the CMI. This will give you a more accurate representation of your average CMI, Spryszak says.

"You have to look at it like ice-skating scores. You need to throw out the high and the low scores to get the actual median," she says.

### Sample CMI analysis

<b>CMI FY 2009</b> = 1.567
<b>CMI FY 2010</b> = 1.457
<b>CMI difference</b> = 0.10
<b>Hospital-specific rate</b> = \$4,500
<b>Number of discharges</b> = 5,000
<b>Decrease in reimbursement per discharge</b> = \$450 (0.10 × \$4,500)
<b>Reduced reimbursement</b> = \$2,250,000 (\$450 × 5000)

## Checklist tool helps staff evaluate the entire patient, identify readmissions



### Continuing Education | Learning Objectives

After reading this article, you will be able to:

- ▶ Use the Discharge Planning for Social Work Referral tool

Case managers tend to focus on the reason patients present to the hospital and sometimes ignore other patient characteristics.

For example, if a patient presents with pneumonia, the case manager might not consider other comorbidities (e.g., wounds or the patient's living situation) that do not directly relate to the diagnosis.

Failure to address these underlying issues can lead to unplanned, preventable readmissions—a target area for recovery audit contractors (RAC), CMS, and third-party payers. An examination of the patient's entire medical condition helps improve patient care, thereby preventing readmissions and potential RAC recoupment.

The case management department at Jennie Edmondson Hospital in Council Bluffs, IA, developed a tool that helps case managers do just that, says **Loretta Olsen, MSN, RN**, senior director of revenue cycle at Jennie Edmondson.

### Readmission assessment tool

Before implementing the Discharge Planning for Social Work Referral tool, Jennie Edmondson had a readmission rate of 8%. Despite its already low rate, increased regulatory focus on readmissions prompted **Lorrie J. Reddish, RN**, the hospital's lead case manager, to

reevaluate the case management department's understanding of readmissions.

Reddish began by speaking with her staff.

"When I started talking to our case managers, everybody had a different idea of what was important to refer a patient to home health or a lower level of care," she says.

The differing opinions had a lot to do with which area of the hospital the case manager worked. New case managers also had different ideas of what factors could be a warning sign of a possible readmission.

Reddish created the Discharge Planning for Social Work Referral tool using information from those conversations as well as information that was published in "Identifying Potentially Preventable Readmissions" in *Health Care Financing Review*, fall 2008.

As the tool's name suggests, patients identified as re-admission risks are referred to a social worker, who then arranges for necessary postacute services (e.g., home health, skilled nursing, insurance applications).

The result is a tool that helps case managers at Jennie Edmondson identify a patient's readmission risk at the time the patient admits to the hospital and throughout his or her stay.

### The assessment tool in action

The following is an example of how the Jennie Edmondson case managers use the tool:

*A patient receives news that she is diabetic. The case manager reviews the patient's record and sees that the patient weighs more than 300 lb. The physician has prescribed insulin. The case manager conducts a screening interview with the patient and discovers that she lives alone.*

Based on this information, this patient would receive four checks:

- ▶ One check for the diabetes diagnosis
- ▶ One check for her weight

### Questions? Comments? Ideas?

Contact Associate Editor  
**Ben Amirault, CPC-A**

Telephone **781/639-1872, Ext. 3934**

E-mail **bamirault@hcpro.com**

- One check for her living situation
- One check for the insulin

This patient is at moderate risk for readmission, according to the Discharge Planning for Social Work Referral tool. Case managers do not refer patients to social workers based solely on the number of checks. The intention of the tool is to allow case managers to focus their efforts on the patients who need more attention, Reddish says.

Based on the research Reddish conducted, characteristics that would trigger an automatic referral to social work include a patient who:

- Is a nursing home or assisted living resident
- Readmitted within the past 30 days
- Has transportation difficulties
- Exhibits noncompliant behavior
- Has a new diagnosis of cancer
- Has a new diagnosis of cerebrovascular accident
- Has a new diagnosis of congestive heart failure or atrial fibrillation
- Has a new diagnosis of pulmonary embolism or deep vein thrombosis
- Has an altered mental status
- Has new ostomies/trach/drains/wounds to care for at home
- Is prescribed Lovenox/Arixtra (other than venous thromboembolism prophylaxis)
- Is prescribed home IV antibiotics/total parenteral nutrition
- Is paying for the stay
- Has limited or no coverage for prescriptions

“Specific diseases are at higher risk for readmission, with the top ones being heart failure, [chronic obstructive pulmonary disease], and pneumonia,” says Olsen.

For example, patients newly diagnosed with cancer, cerebrovascular accident (i.e., CVA) or pulmonary embolism/deep vein thrombosis (i.e., PE/DVT) will potentially go home on medications that require home health intervention.

A patient discharged on IV antibiotics or other IV fluids will also need home healthcare or SNF placement.

Patients who are self-pay and/or have limited prescription coverage trigger an automatic referral so the social worker can attempt to find resources that will help them maintain their healthcare after discharge.

Currently, case managers use the tool more as a guide and an educational tool than actual documentation, but Reddish hopes to improve the tool and possibly use it to document the need for a social work referral. ■

### Part of a bigger whole

The Discharge Planning for Social Work Referral tool is just one part of the overall commitment to discharge planning at Jennie Edmundson Hospital in Council Bluffs, IA.

Discharge planning starts at admission and, in some cases, extends after the patient has gone home.

Upon admission to the hospital, patients receive a discharge flyer that includes the patient’s estimated LOS and information about what they can expect during their stay.

“[This flyer] ensures a patient feels confident about their healthcare at discharge,” says **Loretta Olsen, MSN, RN**, the hospital’s director of revenue cycle.

Case managers also discuss the LOS with other members of the healthcare team so they can initiate the appropriate discharge planning.

Case managers engage patients throughout the discharge planning process, encouraging them to take notes about discharge instructions and other education they receive about their condition.

Before patients leave the hospital, they must fill out a checklist that includes the following questions:

- Do you understand your activity expectations?
- Do you understand your medications and when you should take them?
- Do you understand when your follow-up visits are?
- Do you have the financial resources available to obtain necessary medications and medical equipment?

The checklist ensures that patients know what to expect after their hospital stay and encourages them to ask any questions they may have.

## Discharge Planning Guidelines for Social Worker Referral

Patient characteristic		Checks	Comments
<b>Factors that affect discharge</b>			
Male/female > 75 years old		√	
Nursing home/assisted living resident		Automatic referral	
Lives alone		√	
Dependent care, lives with family		√	
Weight > 300 lb.		√	
Hospitalized > 5 days		√	
Readmitted within past 30 days		Automatic referral	
Transportation difficulties (to and from PCP office, to get medications, groceries, ride home, etc.)		Automatic referral	
Noncompliant behavior		Automatic referral	
<b>Illnesses</b>			
New diagnosis of cancer		Automatic referral	
New CVA diagnosis		Automatic referral	
New diagnosis of CHF/AFIB		√	CM to assess need for HHC
New diagnosis of diabetes		√	CM/DM ED to assess need for HHC
COPD/pneumonia diagnosis		√	CM to assess need for HHC
Surgical patient—dressing changes		√	CM to assess need for HHC
Altered mental status		Automatic referral	
New ostomies/trach/drains/wounds to care for at home		Automatic referral	
<b>High-risk medications</b>			
New Lovenox/Arixtra		Automatic referral	
New Coumadin		√	CM to assess need for HHC
New insulin		√	CM/DM ED to assess need for HHC
New diuretic		√	CM to assess need for HHC
Takes 5 or meds at home		√	CM to assess need for HHC
Home IV antibiotics/TPN		Automatic referral	
Financial			
Self-pay		Automatic referral	
No/limited coverage for prescriptions		Automatic referral	
<b>Risk level for readmission</b>			
Risk level	Checks	Risk class	
Low	0–5	I	Home health or services are not offered to patient according to the number of checks, but the more checks a patient had, the higher probability of readmission.
Moderate	6–13	II	
High	Automatic referral	III	

Source: Jennie Edmundson Hospital, an affiliate of Methodist Health System, Council Bluffs, IA.