Case Management Practice: Examining the Past and Preparing for the Future
L. Greg Cunningham, MHA

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“Case management in hospital and 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.”

Approved by ACMA membership, November 2002
This year’s national conference in Chicago marked ACMA’s fifteenth anniversary. For nearly two decades, ACMA has supported the practice of case management and provided innovative education, tools and resources to help practitioners provide effective and efficient patient care.

In this issue of Collaborative Case Management, we reflect on the past 15 years of ACMA and the evolution of case management. We also look ahead and discuss the future of our practice and its increasing importance in this ever-changing health care landscape. In his article, “Case Management Practice: Examining the Past and Preparing for the Future,” ACMA CEO, L. Greg Cunningham, examines national research-based trends regarding historical and future case management practice, and correlates and compares individual and organizational preparation for future practice issues.

Health care is serious business, but in his article, “What’s Your Discharge Plan?” speaker, humorist, and author, Ron Culberson takes a light-hearted approach to asking what we as care providers are doing to prepare for “our discharge from this world at the end of our lives.” Culberson, who spent the first part of his career working as a clinical social worker, explores some of the common diagnoses seen among case management professionals, including “Hyper-earnestism” and “Acronymitis,” and provides practical suggestions and “treatment.”

Mahatma Gandhi is famously quoted as saying, “Be the change that you wish to see in the world.” The last 15 years have seen significant changes both within the practice of case management and the health care system as a whole. I look forward to serving you as President over the next two years and it is my hope that in the midst of a changing care system, we as a community of case management professionals will be the change we wish to see in health care – not simply reacting to change, but affecting change in order to protect the interests of providers and ensure optimal outcomes for patients.

Christy Whetsell, BSN, RN, MBA, ACM

President, ACMA
The last ten years have seen significant health care delivery changes. As the U.S. health care system evolves, the role of case managers has become increasingly important. Finding the solutions to discharge, level of care, transitions and utilization of resources have been within case management’s purview for some time. But, strategically hospital/health system leaders recognize case management as the nexus of managing patient populations and avoiding readmissions — creating a much broader scope of responsibility and expanding into the patient’s community, physician’s office and their home.
to learn from the past and forecast what will happen next. The same is true for case management – in order to properly speculate and examine the future of the practice; one must first gain a better understanding of the past. This can be achieved by exploring how case management came into existence and how it has changed since its inception, as well as examining several key trends from the last ten years of ACMA’s National Hospital Case Management Survey.

CASE MANAGEMENT: A LOOK BACK
Case management is a profession rooted in constant change and adaptation based on scientific advancements, evolving societal values and increased awareness of unmet needs. The late 1980s and 1990s were formative years for hospital/health system case management. During this time, organizations began to combine utilization review, discharge planning and social work to create an early version of the practice now recognized as case management.

In the early 2000s, case management evolved further. During this time, integrated models of case management including both nurses and social workers became more common. Case management’s scope of service also began to increase. Practitioners were faced with significant challenges and barriers to effective and efficient care such as denials, staffing/resource scrutiny and Medicare Recovery Audit Contractors (RACs).

CASE MANAGEMENT TODAY
As provisions of the Patient Protection and Affordable Care Act (ACA) continue to roll out, case management struggles to meet the increased needs of health systems. The Centers for Medicare and Medicaid Services (CMS) have increased scrutiny of hospital readmissions and have issued fines to those organizations deemed to have “excess” readmissions. Readmissions are one of the key factors that have given birth to transitions of care/transitional care models.

ACMA defines the process referred to as “transitions of care” as “effective care coordination across different health care settings to ensure implementation of the patient’s established plan of care. Patients and families must be empowered and expected to be active participants in Transitions of Care. Such participation includes: comprehension of available options for care, informed decision making, and commitment to the planned transitions.”

PREDICT AND ANTICIPATE
In order to predict the course of health care and the future of case management practice and prepare accordingly, case management leaders should ask themselves five strategic questions:

1. Where are the reimbursement and funding opportunities?
2. What are the organization’s expectations for case management in this new health care/reimbursement environment?
   • How can case management realign or reorganize to ensure that expectations are met, while ensuring growth opportunities for the department?
3. Who are the power brokers?
   • With whom should case management closely align to ensure that (a.) the department’s contributions are valued and (b.) opportunities for growth are aligned with the case management scope of practice?
4. What are case management’s greatest weaknesses?
5. What are the areas of concern/scrutiny for leadership?
   • CFO and staffing
   • CEO and outcomes
   • CNO and overlapping roles

WHAT DOES THE DATA SAY?
Through the National Hospital Case Management Survey, ACMA has collected data for more than 10 years by performing a biennial, randomized study of over 400 hospitals and their case management departments. The survey shows the changing nature of the profession of case management, as well as changes within health care as a whole. This information is valuable in noting relevant trends that require the attention of case management leaders as they plan for the future. The survey produces 95% confidence level data, which speaks to key issues such as performance measures, top challenges, staffing, budgets and salaries.

The flagship project of ACMA practice research in hospital case management, the survey produces 95% confidence level data on over 75 elements of the practice.

To view graphs and charts providing further detail on these data points, go to www.acmaweb.org/FutureofCM.

• Key Performance Measures - Length of stay (LOS) has maintained its position as the most important measure, however, other key performance measures have changed significantly in the last 10 years. Readmissions started the decade as the second most important measure before falling off compared to avoidable days/delays, denials and observations in the middle of the decade. However, now readmissions have risen in importance and respondents report it as the second most important measure. Overall, LOS and readmissions are by far the most important measures according to respondents. It is interesting to note that quality issues, physician practice patterns and cost per case have all fallen significantly in the last 10 years while denials, avoidable days and observations have all dramatically increased in importance. A future prediction is that quality will resurge as outcomes are scrutinized and challenges are made regarding patient outcomes.

• Top Challenges - Discharge barriers and physician buy-in were once by far the top challenges reported by respondents, but now they have fallen below scope of responsibilities and staffing. Managing readmissions appeared on the list of top challenges for the first time in 2013, and it is already listed among the top five challenges. Scope of responsibilities, level of care issues and staffing have all been rising as concerns since 2007. A future prediction is that scope is going to continue to increase, creating the necessity for case management to have outcome achievement and other data to support additional resource allocations.

• Days of On-Site Coverage - Almost all hospitals now provide seven days a week of on-site coverage, whereas at the beginning of the decade this number was less than half. Case management is no longer a Monday to Friday, eight-hour day role. Progressive Case Management services made these changes earlier than others, and in the future the notion of “on-site” coverage will become a misnomer as acute care is inheriting multiple sites of coverage beyond the hospital.

• Hours of Coverage - Similarly to days of coverage, the number of hours covered has increased, especially for Saturday and Sunday. There was a slight anomaly from 2007 to 2011 with Monday to Friday hours holding steady
and Saturday and Sunday hours decreasing.\textsuperscript{5} Anecdotally, this may be attributed to the economic recession, which spanned 18 months between December 2007 and June 2009.\textsuperscript{4} This pattern has since reversed and it is predicted that an upward trend will continue.

**Department Funding** - Case management department budgets have increased since 2009, the first year that ACMA asked about budgets in the survey. Budgets should have increased if they were simply growing according to the rate of inflation, however, ACMA data clearly demonstrates that budgets are growing at a much faster pace than inflation. From 2009 to 2011, case management department budgets increased 6%, and from 2011 to 2013, budgets increased by almost 17%.\textsuperscript{7}

**FTEs** - ACMA data shows that in the average number of FTEs for case management departments, there are slight decreases from 2003 to 2005 and from 2009 to 2011. These are most likely recession-related, but overall FTEs are growing quickly. In 2011, case management departments had an average of 21.6 FTEs, but that number has increased by 25% to an average of 27 FTEs in 2013.\textsuperscript{8} A future prediction is case management professionals will continue to be a high-demand commodity for health care systems; however, more scrutiny is anticipated with respect to their competencies and individual outcome achievement.

**FTE Breakdowns** - Case management departments are becoming more diverse. Departments are less dominated by nurse case managers, and the number of other staff such as documentation specialists, utilization management (UM)/utilization review (UR) specialists and discharge specialists is increasing. This changed dramatically from 2007 to 2009, but this increase has continued at a more gradual pace since then.\textsuperscript{9} ACMA anticipates the continued use of allied health professionals and unlicensed lay staff to complement the case management model and required functions.

**Salaries** - Since the 2009 survey, salaries for all staff types—director, nurse and social worker—continue to increase:
- Director increase: 16.9%
- RN increase: 9.2%
- SW increase: 8.66%
- CPI inflation: 8.39%\textsuperscript{10}

**Nurse Case Manager Salary vs. Staff**

**Nurse Salary** - ACMA did not gather information on difference in salary between nurse case managers and staff nurses prior to 2013, but based on the 2013 survey there is a trend toward nurse case managers earning more than staff nurses.\textsuperscript{1} The competency requirements and job demands will continue to create demand for elite professionals in the field of case management. Finding those who have balanced clinical assessment, communication, analytical and problem resolution skills will require competitive salaries and it is predicted nurse case manager salaries will continue to rise.

**Average Readmissions Penalty Costs** - The maximum penalty of 1% for readmissions in 2012 is equivalent to the national average salaries of seven nurse case managers or almost nine social work case managers (see Figure A). As shown in Figure A, this number only increases together with the increased maximum penalties of 2% and 3% in 2013 and 2014 respectively. This information provides incentive for hospitals to apply resources to reduce readmissions. This data should be used to demonstrate how additional case management FTEs can help reduce risk exposure and/or prevent readmissions penalties. Out of necessity, case management will become savvier in the use of data – fueling its ability to achieve needed resource allocations and validate operational trends and needed changes. Readmissions will force organizations to depend on case management to assess/influence care, manage levels of care/transitions, ensure compliance with discharge instructions and monitor health indicators for preventive interventions.

**FTEs Devoted to RAC, Readmissions, Observation, and Transitions of Care**

<table>
<thead>
<tr>
<th>AREA</th>
<th>PCT. TOTAL FTE’S DEVOTED</th>
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<tr>
<td>Observation</td>
<td>20%</td>
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<tr>
<td>Transitions of Care</td>
<td>18%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>15%</td>
</tr>
<tr>
<td>RAC and/or Government Denials</td>
<td>4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>57%</td>
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2013 ACMA National Hospital Case Management Survey • This data and information is the property of the American Case Management Association (ACMA). Use of this data without ACMA permission is prohibited.

**Plan for the Future**

**Workplace**

The most logical starting point in planning for the future of one’s professional practice is the workplace. What is going on at the hospital or health system, in the department, on the patient units?

Budget constraints are an important consideration in planning for the future. Even though the aforementioned data show that case management budgets are increasing, case management professionals still struggle to fund many of the programs they believe should exist in order to effectively care for patients’ medical, psychosocial, discharge and transitional needs. Furthermore, administration must balance case management among other priorities. Hospital administrators need data and cause and effect analyses to support case management maturation, staffing or funding for effective care solutions.

Integrating more non-nurse and non-social work staff is another important consideration. The changing health care system demands a greater workforce and non-clinically trained staff provide
a more cost-effective solution in certain roles. However, it is important to consider that these individuals’ scope of practice must not include independent or autonomous accountabilities for patient clinical outcomes – an area for which they are not trained.

With these considerations in mind, the next logical question is, “how do I plan for the future?  
1. **Documentation.** Track the effectiveness of programs, efforts and FTEs. Ensure information and data are on file in order to quickly substantiate for administration the return on investment (ROI). Positive effects on resources can strengthen requests for additional staff and funding. Years ago, several hospitals had community-based care programs, but these programs were not well-documented, and in the mid to late 1990s, their budgets and staffs were eliminated because the supporting data lacked evidence of ROI – “where the money flows, so shall the resources.” This fate of these hospitals is unfortunate, as these programs would have positioned their systems well for today’s transitions of care and readmissions requirements.

Even if programs are cut, be sure to leave clear descriptions of what was done, how it was done and the results, because many services of the past have a tendency to become new again. There was a time in case management when most hospitals began cutting their social work FTEs, but now organizations are increasing social work staff, as well as investing in increased salaries for social workers. Those departments who maintained good records of how their models operated with adequate social work staff are at an advantage because they have an existing foundation to build upon.

2. **Create a back-up plan.** By preparing for worst case scenarios – urgent budget cuts, recessions, etc. – one is able to ease the transition and address challenges calmly and logically.

3. **Implement a transitions of care model.** One can create models with varying skill sets applied and track results. In existing models, there are various degrees of support for advanced practice nurses, physicians and nurse case managers. Social work case managers, allied health professionals and lay individuals all have roles in transitions of care, but required skill set and financial feasibility should drive the model. As a back-up plan, one may test the efficacy of various skill sets applied and keep the results on file for recovery or challenging financial times. The plan should draw attention to the skill mix and costs associated while measuring outcomes. It is easier to develop such a plan when not in the midst of a “storm” or financial cutbacks, and given case management’s history, plans must be made to account for these occurrences.

4. **Pursue certification.** History shows that health care and other industries rely on certification to ensure levels of service are provided by well-trained and competent professionals. Case management is no exception – certification validates the competency of case management professionals, offering a unique indicator to enhance credibility and recognition within the field, as well as career and organizational advancement.

Data from the 2013 ACMA National Hospital Case Management Survey shows that case management certification has at least some influence 88% of the time in hiring decisions, with it playing a significant role in 67% of hiring decisions. Nearly half (47%) of case management departments prefer the ACM certification. Organizations are increasingly requiring certification and this trend is likely to increase. In 2013, ACMA released its case management certification position statement, which states “Nurses and social workers with two or more years of health care system experience should have their Accredited Case Manager (ACM) credential by December 31, 2016 to practice health care system case management. Thereafter, because new case managers need 24 months of health care system case management experience to be eligible to take the ACM exam, certification should be achieved by the 36th month of practice.”

Furthermore, many organizations have begun to offer incentives such as salary increases and bonuses to staff who earn case management certification. In 2013, 42% of survey respondents indicated that their organization offers incentives for case management certification.

**COMMUNITY**

Once a plan has been established for internal case management and transitions of care, case management leaders should look to expand their planning to include the community. The ACA focuses on keeping people well, rather than “fixing” them when they become sick, so hospitals must reach into the community in order to meet certain mandates of the ACA. One of the ACA’s key provisions ties reimbursements to readmission rates – this should motivate hospitals to keep the residents of their communities healthy in order to minimize admissions. To achieve this, hospital case managers must expand their scope of duties “outside the walls” of the hospital. In many ways, case management has always reached beyond the walls, but now the care process must physically exit the hospital.

By partnering with community resources, specialists and primary care physicians, hospital case managers can implement strategies to help patients seek treatment before their condition escalates and requires treatment in the emergency department (ED). Proactively educating patients and families in regards to disease processes through community programs will be a key component to partnerships that are successful in keeping communities healthy and reducing admissions and readmissions. Partnerships will also allow case managers to identify gaps in care and communication that previously led to unnecessary admissions and preventable readmissions.

Developments in technology are making it easier to educate patients and maintain awareness. Case managers should stay abreast of technological advancements that facilitate patient/family engagement and seek to integrate such technology in order to meet patient needs and ensure job security in an increasingly “wired” world.

Social media and mobile technology specifically have created an easy, instantaneous way to communicate, and case managers can take advantage of these resources by using social media and health apps to connect with patients. This integration of social media, technology and health data collection is known as Mobile Health (mHealth). Currently there are more than 5,000 health apps designed for smartphones. Case managers can implement mHealth in their discharge plans by encouraging patients to track or detect conditions using specific health apps. But case managers must be sure to check the validity of the information provided by these apps before recommending them to patients as currently there is little governance or oversight of app developers.
ON CAPITOL HILL

It is important to monitor developments in Washington, D.C., in order to create plans that adjust as legislation changes the practice of case management. The ACA has already caused significant changes to the U.S. health care system – affecting reimbursements and establishing new standards of care.

Also affecting reimbursement is sequestration. These sweeping cuts mean that programs that once helped underinsured patients may no longer exist or may have severely limited resources, so discharge planning and health management within the community setting will become more challenging. Thus, it is important to proactively plan and develop creative solutions to overcome these barriers – partner with other organizations and agencies to discover low-cost solutions that meet patients’ needs and apply for grants to cover expenditures.

Immigration reform is another issue that has significant implications for health care. It is estimated that in 2012, 11.7 million people were living illegally in the U.S.11 If these individuals are granted amnesty or some other path to citizenship; they will gain access to Medicaid and Medicare if needed. With insurance either provided privately or through CMS, these individuals will be more likely to seek treatment when they need it rather than avoiding documentation. It is imperative that case management creates a plan that outlines how the department will address this increase in new patients. To support this plan, it is important to outline the benefits to the hospital of additional funding and FTEs.

CREATE THE FUTURE: THIS IS THE TIME

Influencing the future of case management requires dedication and perseverance. Case management professionals must be resourceful, creative and confident in order to secure resources, time and manpower in a changing and challenging health care environment.

It is often easy to blame administration, physician advisors or the director as they “don’t understand our department’s needs.” Those who “do not understand” should be educated – take the lead in arranging and initiating meetings to ensure these individuals are aware of the value and savings the department provides. Key data should be presented in these meetings that clearly demonstrate the value and ROI of case management. Fostering these relationships and educating key decision makers is the equivalent of purchasing life insurance for the department and its programs. It is much easier to secure funding and FTEs if a positive working relationship exists in which information and knowledge is regularly shared. It is important to the health of the case management department that its leaders are seen as practitioners who have authority and knowledge, rather than people who only interact with key decision makers when they need a favor.

Case managers should also communicate with members of Congress on a regular basis to discuss case management’s impact within the community and share how the work of case management helps them keep their promises and commitments to the community. Awareness breeds recognition, and recognition breeds influence.

Senators and Representatives want to please their constituents, so share concerns and ideas with them. When legislators see that by helping case managers, they are helping themselves and the community, they are more likely to advocate for legislation that will help case management achieve its goals.

“If you’re not at the table, you’re on the menu,” is a popular adage in politics. The actions one takes today will impact their future. Case managers who boldly step-up to challenges and act as an impetus for change will find themselves at the table, convening with hospital administrators and key health care leaders in shaping the future.

ABOUT THE AUTHOR

L. Greg Cunningham, MHA, is the founder of ACMA and currently serves as its CEO. Prior to founding ACMA and serving as its first national president, Mr. Cunningham held positions as the Governor’s assistant to the Department of Health and Human Services for former Arkansas Governor Bill Clinton, vice president of a 750-bed medical center, corporate vice president for a six-hospital system, and served as a national health care consultant working in more than 100 U.S. hospitals. He earned bachelor’s degrees in biology and business administration from the University of Central Arkansas, and his master’s degree in hospital/health administration from Duke University. He completed his residency in hospital/health administration with Carolinas Healthcare System.

REFERENCES


3 Id.

4 Id.

5 Id.


8 Id. 10 Id. 12 Id.

9 Id. 11 Id. 13 Id.


Part A inpatient hospital claims with dates of admission between October 1, 2013 and March
Hospitals Must Continue Implementation of Controversial 2-Midnight Rule

Jessica L. Gustafson, Esq., Abby Pendleton, Esq.
These authors have no financial relationships with commercial interests to disclose.

On August 2, 2013, the Centers for Medicare & Medicaid Services (“CMS”) released its 2014 Inpatient Prospective Payment System Final Rule (the “2014 IPPS Final Rule”), which became effective on October 1, 2013. Amid a flurry of controversy, the 2014 IPPS Final Rule revised CMS’s reimbursement criteria for Part A inpatient hospital claims, creating new guidelines to establish the medical necessity of inpatient hospital admissions (i.e., instituting the “2-midnight rule”), clarifying CMS’s documentation requirements and creating conditions of Medicare Part A Payment related to physician inpatient admission orders and certifications. Following the effective date of the 2014 IPPS Final Rule, CMS delayed many post-payment audits of hospital claims for the purposes of determining hospitals’ compliance with the 2-midnight rule. Instead of allowing post-payment audits, CMS established a pre-payment medical review program, known as the “probe and educate” medical review program, designed to identify and correct claims improperly billed and to provide education to hospitals implementing the requirements of the 2014 IPPS Final Rule.

LEARNING OBJECTIVES
1. Discuss the current status of the 2-midnight rule
2. Gain a better understanding of the rule and its implications for hospitals
3. Discuss the future of the 2-midnight rule, including pending legislation

PROBE AND EDUCATE MEDICAL REVIEWS
The probe and educate medical review program was announced on November 4, 2013 and was initially planned to cover Medicare Part A inpatient hospital claims with dates of admission between October 1, 2013 and
March 31, 2014. Thereafter, on January 31, 2014, the probe and educate medical review program was extended for an additional six months to cover claims with admission dates through September 30, 2014. On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law, which allowed CMS to continue its probe and educate medical review program through March 31, 2015 (and prohibited Recovery Auditors from conducting patient status reviews on claims with dates of admission between October 1, 2013 and March 13, 2015). CMS has expressed its intent to continue the probe and educate medical review program through March 31, 2015.

Despite ongoing misleading industry guidance to the contrary, by extending its probe and educate medical review program, CMS did not delay the effective date of the 2-midnight rule. In fact, for dates of admission between October 1, 2013 and March 31, 2015, Medicare Administrative Contractors (“MACs”) are specifically tasked to conduct pre-payment medical reviews of a sample of each hospital’s Medicare Part A inpatient claims (i.e., between 10 and 25 claims, depending on hospital size), for hospital stays crossing 0-1 midnight, for the purpose of determining a hospital’s compliance with the provisions of the 2014 IPPS Final Rule. If a hospital is out of compliance, additional reviews will take place. Medical review will focus on hospitals’ compliance with following three requirements contained in the 2014 IPPS Final Rule: (1) order, (2) certification, and (3) the 2-midnight benchmark (i.e., whether the patient was appropriately admitted as an inpatient (“patient status review(s)”).

During the probe and educate medical review time period (i.e., for Part A inpatient hospital claims covering admissions between October 1, 2013 and March 31, 2015), Medicare review contractors (including Recovery Auditors and SMRCs) generally are prohibited from conducting post-payment patient status reviews. However, Medicare review contractors may continue other types of post-payment inpatient hospital medical reviews for claims with admission dates within this time period (e.g., coding reviews, reviews for the medical necessity of a procedure). Additionally, Medicare review contractors may continue to conduct patient status reviews for dates of admission prior to October 1, 2013.

As of May 12, 2014, “MACs have completed most first probe reviews, of 10 (or 25) claims, for providers within their jurisdiction, and are beginning to provide educational information related to the first probe period findings.” The steps the MACs will take following initial probe and educate medical reviews will depend on the audit findings. If the MACs identify “concerns” related to hospitals’ compliance with the 2014 IPPS Final Rule, additional auditing will take place. MACs also may “conduct a limited number of additional reviews if provider billing trends or variances are indicative of abuse, gaming or systematic delays in the submission of claims for the purpose of avoiding the MAC prepayment probe audits during the probe and educate period.”

On February 24, 2014, CMS published initial results of the MACs’ probe and educate reviews. The examples CMS shared include only denials based on clear failures to implement the requirements of the 2014 IPPS Final Rule. As a result, the educational value of this publication is limited. “Grey areas” of compliance or non-compliance are not addressed by the document. Cited examples of common denials include the following:

- Missing or flawed inpatient admission orders;
- Admissions for procedures where the expectation of a 2-midnight stay for hospital care was not supported (e.g., a patient discharged 10 hours following a pre-procedure inpatient admission);
- Admissions for medical conditions where the expectation of a 2-midnight stay for hospital care was not supported (e.g., documentation reflects an expectation to discharge after “monitoring overnight” – clearly reflecting an expectation for a hospital stay crossing 1 midnight); and
- Records containing physician attestation statements of an expectation of a hospital stay crossing 2 midnights without any supporting documentation of this expectation in the records.

**SUB-REGULATORY GUIDANCE**

Following publication of the 2014 IPPS Final Rule, CMS published several sub-regulatory guidance documents in an effort to clarify its expectations. The sub-regulatory guidance has not altered the basic requirements set forth in the 2014 IPPS Final Rule related to inpatient admissions. However, certain details with respect to the core requirements have changed over the course of the various publications.

The evolving sub-regulatory guidance has created confusion among hospitals attempting to comply with the 2014 IPPS Final Rule requirements. For example, in certain circumstances (e.g., authorized practitioners to complete inpatient admission orders, content of inpatient admission orders), the sub-regulatory guidance has been internally inconsistent. Additionally, the evolving sub-regulatory guidance appears to have created confusion for (or at the very least, inconsistencies among) the MACs enforcing the 2014 IPPS Final Rule. Therefore, at the same time it published updated sub-regulatory guidance on February 24, 2014, CMS directed the MACs to re-review all claim denials made as part of the probe and educate medical review program prior to January 30, 2014 to ensure that the reviews (and any corresponding denials or education) were consistent with current sub-regulatory guidance. CMS authorized the MACs to reverse any previous denials outside of the Medicare appeals process; additionally, CMS waived the 120-day timeframe for filing redetermination requests for denials made as part of probe and educate medical review prior to January 30, 2014, provided that such appeal is submitted before September 30, 2014.

**THE FUTURE OF THE 2-MIDNIGHT RULE: PENDING LEGISLATION**

On March 5, 2014, U.S. Senators Robert Menendez (D-NJ) and Deb Fischer (R-NE) introduced the Two-Midnight Rule Coordination and Improvement Act of 2014 (S. 2082) to the U.S. Senate. If enacted, this legislation would require the following:

- CMS, in consultation with interested stakeholders, to develop criteria for coverage of short inpatient hospital stays, accounting for the medical necessity and appropriateness of an inpatient stay crossing less than 2 midnights;
- CMS to develop a payment methodology for short inpatient hospital stays;
- CMS to develop a crosswalk of ICD-10 codes and CPT codes as well as a crosswalk of DRG and CPT codes to permit hospitals to compare inpatient hospital services and outpatient services;
- A delay in enforcement of the 2-midnight rule (with the exception of probe and educate reviews, which are permitted under the legislation);
The Senate bill has been referred to the U.S. Senate Committee on Finance.

In its 2015 IPPS Proposed Rule, CMS requested public comments regarding an alternative payment methodology for short inpatient hospital stays (consistent with the proposal contained in the Two-Midnight Rule Coordination and Improvement Act of 2014).

In particular, CMS requested comments regarding the way such payment methodology would be designed, including:

- The way to define short or low cost inpatient hospital stays; and
- The way to determine an appropriate payment amount.

In addition, in its 2015 IPPS Proposed Rule, CMS solicited comments regarding additional possible exceptions to its 2-midnight rule, beyond inpatient-only procedures and unexpected mechanical ventilation.

CONCLUSION

It is essential that physicians are educated regarding the documentation requirements for which they are responsible under the 2014 IPPS Final Rule. CMS guidelines are evolving. Hospitals must devote resources to closely monitor the CMS “Inpatient Hospital Review” website as CMS works to finalize its guidance related to the 2014 IPPS Final Rule.

ABOUT THE AUTHORS

Jessica L. Gustafson, Esq. and Abby Pendleton, Esq. are founding shareholders with the health care law firm, The Health Law Partners, P.C. The firm represents hospitals, physicians, and other healthcare providers and suppliers with respect to their healthcare legal needs. Ms. Gustafson and Ms. Pendleton co-lead the firm’s Recovery Audit and Medicare appeals practice group, and specialize in a number of areas, including Medicare, Medicaid and other payor audit defense and appeals; healthcare regulatory matters; compliance; HIPAA privacy and security compliance matters; overpayment refunds; reimbursement and contracting matters; and payor de-participation matters.

REFERENCES

2 See 42 C.F.R. § 412.3 (e) (1): Except as specified in paragraph (e)(2) of this section, when a patient enters a hospital for a surgical procedure not specified by Medicare as inpatient only under § 419.22(f) of this chapter, a diagnostic test, or any other treatment, and the physician expects to keep the patient in the hospital for only a limited period of time that does not cross 2 midnights, the services are generally inappropriate for inpatient admission and inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed. Surgical procedures, diagnostic tests, and other treatment are generally appropriate for inpatient admission and inpatient hospital payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights...

3 Emphasis added.

4 42 C.F.R. § 412.3.

5 42 C.F.R. § 424.11.


7 CMS has directed the MACs to apply the 2-midnight “presumption” in conducting patient status reviews: “CMS will direct MACs NOT to focus their medical review efforts on stays spanning at least 2 midnights after admission absent evidence of systematic gaming, abuse, or delays in the provision of care...” See Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013 (Last Updated: 02/24/2014), available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/tingHospitalClaimsForAdmissionsForPosting2242014.pdf.


9 Id.

10 The 2-Midnight benchmark is summarized as follows: Medical reviewers will consider the fact that the beneficiary was in the hospital for greater than 2 midnights following the onset of care when making the determination of whether the inpatient stay was reasonable and necessary. For those admissions in which the basis for the physician expectation of care surpassing 2 midnights is reasonable and well-documented, reviewers may apply the 2-midnight benchmark to incorporate all time receiving care in the hospital.

11 Id.

12 Medicare “review contractors” include all of the following:

• Comprehensive Error Rate Testing (“CERT”) auditors, tasked to measure improper payments in the Medicare fee for service (“FFS”) program (see http://www.cms.gov/CERT);
• Medicare Administrative Contractor (“MAC”) medical reviewers;
• Recovery auditors (formerly known as Recovery Audit Contractors (“RAC”)), tasked to identify and correct improper payments in the Medicare program (see http://www.cms.gov/RAC);
• Program Safeguard Contractors (“PSCs”) and Zone Program Integrity Contractors (“ZPICs”), tasked to prevent, detect and deter incidences of fraud and abuse in the Medicare program (See Medicare Program Integrity Manual (CMS Pub. 100-08), Ch. 4, § 4.2.2.2), which soon will be rolled into the forthcoming Unified Program Integrity Contractors (“UPICs”); and
• Supplemental Medical Review Contractors (“SMRCs”), responsible for “perform[ing] and/or provid[ing] support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid Programs” (See http://www.strategichs.com/about-smrc/).


html. This delay in post-payment audit activity presumably is the fact supporting the extensive misinformation released referencing a delay in the effective date of the 2014 IPPS Final Rule (in particular, the 2-midnight rule).

- See http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Medicare-FFS-Compliance-Programs/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Programs/Medicare-FFS-Compliance-Programs/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.

- The sub-regulatory guidance documents include the following:
  - Hospital Inpatient Admission Order and Certification dated September 5, 2013;
  - Hospital Inpatient Admission Order and Certification dated January 30, 2014;
  - Frequently Asked Questions: 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013 (last updated 03/12/2014);
  - Selecting Hospital Claims for Patient Status Reviews: Admissions on or after October 1, 2013 (last updated02/24/2014);
  - Reviewing Hospital Claims for Patient Status: Admissions on or after October 1, 2013 (last updated 03/12/2014); and
  - Medicare Inpatient Hospital Probe and Educate Status Update, February 24, 2014.

Each of the sub-regulatory guidance documents is available from the CMS Inpatient Hospital Review website: http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.


- After the introduction of S. 2082, on March 12, 2014, U.S. Senator Sharrod Brown (D-OH), and on March 13, 2014, U.S. Senators Kirsten E. Gillibrand (D-NY) and Charles E. Schumer (D-NY) joined in co-sponsorship of the Two Midnight Rule Coordination and Improvement Act of 2014. See http://thomas.loc.gov/cgi-bin/bdquery/z?d113:SN02082:@@@P.

- See Section 2 (a) of S. 2082, available at https://www.govtrack.us/congress/bills/113/s2082/text.
- See Section 2 (b) of S. 2082, available at https://www.govtrack.us/congress/bills/113/s2082/text.
- See Section 2 (c) of S. 2082, available at https://www.govtrack.us/congress/bills/113/s2082/text.
- See Section 2 (d) of S. 2082, available at https://www.govtrack.us/congress/bills/113/s2082/text.
- See http://thomas.loc.gov/cgi-bin/bdquery/z?d113:S.2082:

  Notably, on December 11, 2013, a substantially similar piece of legislation was introduced to the U.S. House of Representatives. On December 11, 2013, U.S. Representative Jim Gerlach (R-PA6), along with 120 bipartisan co-sponsors, introduced H.R. 3698, the “Two-Midnight Rule Delay Act of 2013.” H.R. 3698 was referred to the U.S. House of Representatives Committee on Ways and Means.

  The two pieces of legislation are similar: (1) Both S. 2082 and H.R. 3698 would provide for a delay in enforcement of the 2-midnight rule (except for probe and educate medical reviews, which are permitted to continue under both bills); (2) Both S. 2082 and H.R. 3698 would require CMS to develop a payment methodology for short stay inpatient hospital admissions; and (3) Both S. 2082 and H.R. 3698 would mandate CMS to develop crosswalks between ICD-10 Codes and CPT codes and DRG and CPT codes.

  One key difference between S. 2082 and H.R. 3698 is that the U.S. Senate bill, S. 2082, includes a mandate for CMS to develop criteria for coverage of short inpatient hospital stays, accounting for the medical necessity and appropriateness of inpatient stays crossing less than 2 midnights.
What’s Your Discharge Plan?

Ron Culberson, MSW, CSP

THIS AUTHOR HAS NO FINANCIAL RELATIONSHIPS WITH COMMERCIAL INTERESTS TO DISCLOSE.

Do you want to go out in a blaze of glory during a family meeting right after you gave them the best follow-up care advice they’ve ever heard?

Or, do you want to go quietly while completing the last piece of documentation on the most challenging patient of the month?

Or, do you want to go suddenly after a hearty round of laughter while watching the movie, Patch Adams Tackles Case Management?

When it comes down to it, I suspect most of us would simply prefer to go contently. And when I say “go,” I’m referring to the ultimate of all discharges, our discharge from this world at the end of our lives.

As a case manager who understands discharge planning, you must realize that going contently starts long before the discharge itself. So I ask, what are you doing to prepare for your own contented discharge? It requires an individualized plan based on your needs and desired outcomes. That being said, let me suggest the following discharge plan:

LEARNING OBJECTIVES
1. Discuss the importance of a “discharge plan” for case management professionals
2. Develop an individualized plan based on needs and desired outcomes
3. Learn from patients and incorporate that learning into both personal and professional life.

THE ULTIMATE DISCHARGE PLAN

Diagnosis #1: Hyper-earnestism
Symptoms: Common among professional caregivers is an elevated level of earnestness. Since the work you are doing is important and often affects the quality of life of patients and their families, there is a tendency to see the work as more critical than it may actually be. Additionally, friends and family who may have less important jobs such as teachers, civil servants, and most assuredly, corporate executives, are scorned.

The result is an imbalance in worldview, especially when it comes to self-importance and self-care. Work is often prioritized over personal relationships, health, spiritual care, and keeping up with American Idol.

Treatment: Lighten up. Your work is important but not more important than balance. Pay equal attention to your personal relationships, your health and your spirituality. The only person you harm by taking your work too seriously is yourself. If you are going to be good to anyone else, you must first be good to yourself.

Diagnosis #2: Acronymitis
Symptoms: This is an affliction of both the brain and the mouth. That autonomic nervous system blocks interpretive explanations before acronyms are spewed out in large doses. A case manager may refer to BP, BID, D/C, ED, and PPO before realizing that the patient and/or family member have already glazed over and stopped listening. This leads to miscommunication, a lack of connection, and in some cases a patient getting treatment for ED instead of an OD.

Treatment: The most effective treatment for Acronymitis is twofold. The first is empathy. The more you empathize with a patient, the more likely you will choose words instead of acronyms. As Stephen Covey said, “Seek first to understand before being understood.” The second treatment is thinking. Because of the automatic nature of Acronymitis, sharp cognitive activity is a truly effective cure. Thinking about the choice of each word will often lead to better communication and case management plans. Practice each of these techniques QID.
Diagnosis #3: Turf Nose

Symptoms: With this diagnosis, a case management team member gets his or her nose out of joint when he or she feels that another discipline does not understand his or her role and are constantly impinging on his or her responsibilities. The problem leads to animosity, defensiveness, and the stealing of other team members’ food from the staff refrigerator.

Treatment: The treatment for Turf Nose is to understand both the complimentary and the overlapping roles within any multidisciplinary team. No one “nose” everything, and that is the beauty of the many different members of the team. The better each team member gets to know the different roles of the other disciplines and seeks to work in partnership instead of opposition, the less out of joint the nose will be.

Diagnosis #4: AC Acid Indigestion

Symptoms: This epidemic disorder leads to a daily knot in the stomach which eventually works its way around to a royal pain in the buttocks. Each day, a new policy-induced pain occurs and historical treatments become less effective. Then, just when a case manager thinks that her body can’t take any more, the government releases a new reflux medication in the form of a reform of the reform and the pain subsides — temporarily, of course.

Treatment: The most effective treatment for AC Acid Indigestion is to stop listening to the news, senior leaders, and anyone who believes that the ACA is toxic. Word travels fast but AC Acid Indigestion travels faster. Instead of filling one’s head with unpredictable predictions, indescribable fears, and anticipatory anxiety, simply focus on today and what you can do with what you’ve got. And as an added form of protection, avoid Thai food when possible.

Diagnosis #5: Denial

Symptoms: This is a diagnosis that not only affects our patients and families but most of us as professionals. The symptoms include denying that time is marching on, denying that our clothes do make us look fat, denying that we may succumb to serious illness, and denying that we may ultimately die. The result is a lack of awareness of the present moment and the richness that accompanies it. Additionally, there is an avoidance of taking care of ourselves, resolving damaged relationships and, most importantly, the preparation of our resources for the needs we may have in the future. Essentially, we pretend that we might be the first person to outsmart death.

Treatment: The treatment for this disorder is simple. Live in the moment with an appreciation for the future. Tell those closest to you that you love them. Make healthy choices. Monitor and manage your savings so that you won’t be a burden on your children — unless, of course, you cherish the thought of being a burden on your children. And most importantly, live a life of significance so that when you die, you have made a positive impact on those who you’ve encountered.

Discharge Summary: Case management is important. But it should not be so important that you lose sight of the proper life perspective. Learn from your patients. You must pay attention to this moment in time and to the people around you as a way to solidify relationships and leave a lasting impact. And most importantly, you must realize that your time on this planet is limited but that it should not limit your value.

Final Discharge Status: Alive and Thriving.

ABOUT THE AUTHOR

Ron Culberson, MSW, CSP, spent the first part of his career working in a large hospice organization as a clinical social worker, middle manager, and senior leader. As a speaker, humorist, and author of “Do it Well. Make it Fun. The Key to Success in Life, Death, and Almost Everything in Between,” he has delivered more than 1,000 presentations to associations, government agencies, non-profit organizations, and corporations. Ron’s mission is to change the workplace culture so that organizations are more productive and staff are more content.

If you are going to be good to anyone else, you must first be good to yourself
The DMEPOS Competitive Bidding Process: Is It Working?

Angela D. Ciotto, JD

LEARNING OBJECTIVES
1. Discuss issues surrounding Medicare’s Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.
2. Describe DMEPOS Competitive Bidding Regulations.
3. Identify access issues, share concerns and submit complaints related to the program.

Medicare’s Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program was enacted by Congress as a cost and fraud protection measure. From its inception, there have been questions about the program’s complexity and fairness, and whether it would hinder beneficiary access to necessary DMEPOS items and services.

Over the past several years, the Center for Medicare Advocacy (the Center) has shared testimony and publications on DMEPOS and its implementation. In Connecticut, the Center has received caller complaints indicating that some Competitive Bid Winners may not be fulfilling their contracts, thus compromising beneficiaries’ access to DMEPOS products and services. The Center is concerned that beneficiary access to necessary services may be a nationwide problem.

DMEPOS COMPETITIVE BIDDING REGULATIONS PROVIDE GUIDANCE TO SUPPLIERS

Pursuant to Federal Regulation, the Competitive Bid Winners are required to deliver the DMEPOS items directly to the beneficiaries. See 42 C.F.R. 414.422(e)(1), 414.422(g), and 424.57(c)(12).

The relevant portion of 42 C.F.R. 414.422 (Terms of Contracts) provides:
(e) Furnishing of items.
Except as otherwise prohibited under section 1877 of the Act, or any other applicable law or regulation:
(1) A contract supplier must agree to furnish items under its contract to any beneficiary who maintains a permanent residence in, or who visits, the CBA [competitive bidding area] and who requests those items from that contract supplier.

42 CFR 424.57(c)(12)(Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges) states:
(12) Must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery. (The supplier must...
document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively).

**DMEPOS COMPETITIVE BIDDING CONCERNS: ARE THE COMPETITIVE BID WINNERS LIVING UP TO THEIR CONTRACTS?**

The effectiveness of the competitive bidding process and the capacity of various suppliers to provide and service beneficiaries’ DMEPOS are in question. Various potential breaches and issues have come to the Center’s attention including:

- Failure of the contract supplier to deliver walkers to a Skilled Nursing Facility upon the beneficiary’s discharge, thereby causing the beneficiary to pay out of pocket from a non-bid winning supplier;
- Failure of the contract supplier to deliver CPAP machines to beneficiaries, requiring them to pick the item up (many beneficiaries do not drive);
- Failure of the contract supplier to facilitate repairs of the DMEPOS items, instituting confusing processes for beneficiaries with broken DMEPOS items;
- Insufficient number of suppliers for specific geographic areas; and
- Lack of a meaningful process to address access issues to DMEPOS products and services.

As the DMEPOS Competitive Bidding Program impacts more areas of the country, it is important to remain attentive to access and delivery concerns. Suppliers are complaining about the bidding process and the capacity of various Competitive Bid Winners to provide and service the DMEPOS items under an artificially low contract bid price awarded. These concerns seem to be borne out by complaints received by the Center thus far. It appears that at least some beneficiaries are having difficulty obtaining the DMEPOS products and services they need.

**USE THE CMS COMPLAINT PROCESS TO REPORT PROBLEMS TO MEDICARE**

In addition to sharing your access issues with the Center at DMEPOS@medicareadvocacy.org, the Centers for Medicare & Medicaid Services (CMS) has a complaint process set up to address concerns about the program. Advocates are concerned that beneficiaries might be unnecessarily confused or harmed by the program, and wish to ensure that beneficiaries have access to necessary DMEPOS and services. Complaints can be made directly to the Competitive Acquisition Ombudsman via e-mail at CompetitiveAcquisitionOmbudsman@cms.hhs.gov or by regular mail at the following address:

**Tangita Adams Daramola**
Competitive Acquisition Ombudsman
Center for Medicare and Medicaid Services
7500 Security Boulevard, Baltimore MD 21244

**CONCLUSION**

CMS, encouraged by advocates, must ensure that the DMEPOS Competitive Bidding program is implemented efficiently, effectively, and assures beneficiaries’ continued access to necessary DMEPOS and services. Beneficiary stories about problems are essential to understanding whether the program is working as intended and whether beneficiaries are getting necessary DMEPOS items and services.

**ABOUT THE AUTHOR**

*Angela D. Ciottone* is an attorney in the Center for Medicare Advocacy’s Connecticut office. Ms. Ciottone prosecutes appeals on behalf of Medicare recipients and dually eligible Medicare/Medicaid recipients. Prior to joining the Center, Ms. Ciottone was a civil trial attorney in the private sector. Ms. Ciottone graduated from the University of Connecticut with a degree in the Biological Sciences, and worked in the pharmaceutical industry prior to receiving her law degree from Western New England University School of Law. She is a member of the Connecticut Bar Association, has been a volunteer in the Connecticut Pro Bono Network, and is licensed to practice in multiple jurisdictions.

This article adapted from the Center for Medicare Advocacy’s June 26, 2014 Weekly Alert. For more information, visit www.medicareadvocacy.org.
Leader, Advocate and Caregiver: Honoring Dr. Sharon Mass

In the summer of 2013, Sharon Mass, PhD, ACM, retired from her role as Director of Case Management and Palliative Care at Cedars-Sinai Medical Center after 23 years of service. In April, Dr. Mass completed her term as National President of ACMA, an exclamation point on her 14 years of service to ACMA and the National Board of Directors. Dr. Mass was one of nine founding board members of ACMA and since its inception she has dedicated countless hours to help grow ACMA into a national association now nearly 5,000 strong providing education, resources and networking to those who daily serve as advocates on behalf of patients, families and their hospital/health systems.

The following are quotes from just a few of the people who have worked with Dr. Mass throughout her career, and as a result, have been touched by her commitment to patient care, kindness and dedication.

On behalf of ACMA and its members, thank you, Dr. Mass, for all you have done for ACMA and all your efforts to advance the practice of case management.

It is a true privilege to call Dr. Mass a colleague, mentor, and friend. She has been a tremendous leader in the field of case management for many years. As one of the visionary, founding board members of ACMA, she has contributed her knowledge, leadership, skills, and passion to our industry like few others. Dr. Mass’s contributions to the field have helped lead us to where we are today and will have a considerable presence far into the future. I thank her for all she has done to advance the practice and science of case management.

Pam Foster, MSW, LCSW, MBA/HCM, ACM
Director, Care Coordination
Mayo Clinic Health System
Eau Claire, WI

Throughout her career at Cedars-Sinai, Sharon had a singular focus—assuring that the needs and interests of our patients came first and that our obligation to serve our patients did not end at the hospital’s doors. Over the years, her creativity and energy was instrumental in contributing to Cedars-Sinai’s leadership position for high-quality patient care. I am sure she brought that same dedication, passion and intellect to the work of the ACM.

Thomas M. Priselac, MPH
President and CEO
Cedars-Sinai Health System
Los Angeles, CA

Sharon was the first person I called to establish a founding board for ACMA. She accepted without hesitation and from that day forward has been nothing short of a champion for ACMA and the practice of case management. Being a social worker, Sharon brought an element of true concern and empathy for any member of our association or any initiative we considered—she has always recognized that people, in our case “members,” are the most important aspect of our personal and professional journeys. In her many years on the ACMA board of directors and throughout her tenure as president, she has always taken time for anyone who wished to speak with her—they may have been surprised by her candid responses as she also believed in being a realist, but her commitment to helping people with their issues is unwavering and her ability to encourage and praise surpasses anyone I have met in my career. Dr. Mass has certainly left her mark on ACMA and established a standard that we strive to maintain—keep people first and lift them higher than yourself.

L. Greg Cunningham, MHA
CEO
American Case Management Association
Little Rock, AR
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