IMA Insights

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Prevent Losing Revenue by your Case Management Leadership

To Our Healthcare Clients and Friends:

Is your hospital losing money due to gaps in your case management program? A highly functioning case management program is the key to managing patient progression, avoidable days, care delivery delays and denials prevention. The key to a comprehensive and efficient case management department is to have a Director of Case Management with the requisite skill sets.

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BACKGROUND

Typically, when a seasoned Director of Case Management leaves or retires, the best case manager is promoted to the Director level position. While this may appear to be an immediate solution, the difference in required skill sets between a case manager position and a Director level position is vast. Further, without a structured transition plan and mentoring for a new Director, the effectiveness of the case management program and the impact on reimbursement is jeopardized. There are currently hundreds of Director of Case Management vacancies nationwide and appointing an experienced Director can take six to twelve months.

CHALLENGES

A Director of Case Management in an acute care organization has multiple responsibilities. First and foremost, the Director must ensure the organization's compliance with Medicare Conditions of Participation (CoPs) and regulations. The Director needs to monitor the effectiveness of the organization's Utilization Review Plan and Utilization Review Committee. Often, the Director is asked to provide data analysis with clinical insights and root cause analyses for the reports reviewed by the committee. The Medicare Program Evaluating Payment Patterns Electronic Report (PEPPER) is issued on a quarterly basis and requires analysis and review by the Utilization Review Committee in order to align clinical practice with regional, State and National benchmarks.

Additionally, the Director must monitor and evaluate the hospital's use and delivery of the Important Message from Medicare (IM), Advanced Beneficiary Notices (ABN), Hospital Issued Notices of Noncoverage (HINN), Condition Code 44, the Two-Midnight Rule and soon the Medicare Outpatient Observation Notice (MOON). All of these regulations require cross-functional communication and the ability to work across multiple hospital departments and disciplines to ensure compliance.

The Director is also responsible for ensuring compliance with Discharge Planning Conditions of Participation from Medicare and establishing a Readmissions Prevention Program. Discharge Planning regulations include offering and documenting that patient choice was offered for skilled nursing facility and home health agency referrals. Readmission prevention can be a full time job in itself. Medicare penalizes the hospital for these readmissions, although non-compliant patients are often the source of readmission.

Additionally, the Director needs to monitor several critical elements on an ongoing basis. The initial application of evidence-based criteria to ensure the appropriate level of care whether it is Observation, Inpatient or Outpatient is key to proper patient placement and reimbursement. Also, there needs to be a process in place for second level physician review to ascertain medical necessity if the patient does not meet inpatient criteria. Furthermore, length of stay, as defined by each organization, needs to be reviewed and monitored to ensure that patients are appropriately moved along the continuum of care in a timely manner and do not experience delays due to the lack of resource availability or barriers associated with the discharge process.

A Director needs to be able to evaluate key performance metrics and trends, as well as conduct root cause analyses to explain and address variances. A Director must be responsive to new initiatives to support the organization with value-based purchasing and resource management.

The Director must understand the revenue cycle process, denials and appeals activity and the growing number of auditing bodies that review records on a retrospective basis. A Director who is knowledgeable about the denial trends in an organization can provide education to case managers, utilization reviewers and physicians in an attempt to prevent the denials from occurring by focusing on activities such as improving clinical documentation.

INSIGHTS

An educated Director will ensure that the organization is compliant with Medicare Conditions of Participation, rules and regulations. The Director will maintain compliance and be prepared for visits by accrediting bodies and state Department of Health surveys. Additionally, an experienced Director will assist an organization to effectively negotiate commercial insurance contracts.

A new Director of Case Management requires the requisite skill sets achieved through formal education and knowledge in a wide variety of subjects in order to successfully manage a highly functioning case management department. The management of this department is critical in ensuring appropriate hospital reimbursement for services provided.

When appointing a novice leader, providing a seasoned mentor for a period of three to six months will enable the new leader to more successfully manage the department. A case manager that is promoted to a Director level position from within the organization or a new Director without case management experience will also benefit from mentorship. This will provide support and guidance to understand and learn the idiosyncrasies, rules and regulations in this vitally important function and to be successful in the Director role.

This investment in the new Director will result in major dividends when the leader is able to maintain or reduce length of stay, assist to increase the Case Mix Index, ensure appropriate patient statuses and assist case managers in efficiently managing patient progression, which when combined will influence the organization’s financial stability.

When an internal candidate or immediate replacement is not feasible, employing an experienced Interim Director of Case Management during the search should be considered. An experienced interim can provide the organization with a seasoned executive to assess current gaps in the program, provide a roadmap, lead change and a period of orientation and mentoring for the new Director once hired. Further, the interim can assist the organization with screening potential candidates to hire the best Director for the organization and provide mentoring to the new leader.

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SUMMARY

Acute care organizations with successful Case Management programs have leaders with the requisite skill sets and knowledge to lead and manage the challenges related to the numerous Medicare, State and insurance rules and regulations impacting case management.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance, please call me at IMA Consulting at 484-840-1984.

Truly yours,

Sue Erwin

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MEET THE AUTHOR - Sue Erwin

Sue possesses more than 30 years of progressive experience in healthcare with acute care organizations, home health agencies, as well as with the Centers for Medicaid and Medicare Services (CMS). Her care management experience spans more than 10 years. She provides expert consultation to ensure compliance with Medicare Conditions of Participation and Joint Commission standards, efficiency in workflows, resource management, and delivery of cost-effective patient care. Sue is adept at providing physician and provider education and developing systems to ensure patient progression and effective discharge planning. Additionally, she has the ability to implement first level review best practices, and key Case Management metrics evaluation and performance improvement.

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