



**AUDIT DEPARTMENT**

**UNIVERSITY MEDICAL CENTER CASE MANAGEMENT AUDIT**

**for the period July 1, 2008 through June 30, 2009**

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March 29, 2011

Kathy Silver, Chief Executive Officer  
University Medical Center  
1800 W. Charleston Boulevard  
Las Vegas, Nevada 89102

Dear Ms. Silver:

As provided by our annual audit plan, we have conducted an audit of Case Management at University Medical Center (UMC). Our procedures considered transactions for the period July 1, 2008, through June 30, 2009. We examined and tested transactions, controls, and compliance for these periods.

The objectives of the audit were to determine whether:

- Procedures over observation activity are sufficient and in compliance with payer terms.
- Observation to admittance transactions are adequately justified and documented using Interqual criteria.
- Re-admittance activity is reasonable and handled properly.

Our examination revealed that internal control weaknesses exist in the current case management process at UMC. In addition, we noted that procedures covering patient care and back-end processes could be strengthened to help improve operational integrity and efficiency.

A draft report was provided to the Case Management Director. The department's management response is attached along with the final report. The assistance and cooperation of the case management staff are greatly appreciated.

Sincerely,

/s/ Jeremiah P. Carroll II

Jeremiah P. Carroll II, CPA  
Audit Director

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**UNIVERSITY MEDICAL CENTER  
CASE MANAGEMENT AUDIT  
for the period July 1, 2008 through June 30, 2009**

**BACKGROUND**

Case Management/Utilization Review (CM/UR) is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health and social needs through appropriate utilization of resources resulting in quality outcomes. CM/UR encourages a consistent direction in the care of patients. One of its primary responsibilities is to ensure that patients being admitted to University Medical Center (UMC) have met appropriate admissions criteria set by the American Medical Association (AMA), and utilized by Interqual (UMC's admission criterion software). Interqual's criteria, an industry standard, is a product of McKesson Corporation (a health care services company), and can be found on-line or in manuals purchased by the Case Management department.

Case Management is located on the 1st floor of the University Medical Center Patient Placement Center (PPC), 1800 West Charleston Boulevard, Las Vegas, Nevada 89102. The department is comprised of approximately 30 case managers, a department manager and an office assistant. All the case managers (including the department manager and director) are trained and experienced registered nurses (RNs).

Prior to April 2009, case managers were assigned to specific floors (i.e., 1300, 1400, 1500), and admitting nurses and utilization review nurses were assigned to insurance payers (i.e., Medicare, Medicaid, Commercial, etc.). Beginning April 2009, each case manager is now assigned to a certain area in the hospital (i.e., Emergency Room "ER", Intensive Care Unit "ICU", Intermediate Care "IMC", etc.). As a result, most of the case managers in the department experienced a learning curve as they became more familiar with the other insurance carriers (that they had not previously worked with).

**Before Inpatient Admission**

When a patient presents at UMC, the admitting specialist will create an account. The patient is seen by a physician and a nurse. If the patient does not meet the criteria for admission but is not stable enough to be discharged, he may be kept onsite for observation. In certain cases, the attending physician will determine that a patient's condition warrants admission to the hospital. The attending nurse will begin a chart for the patient (using the physician's information) documenting the patient's status and diagnosis (if known).

A case manager will print a daily report from MedSeries 4 called "Census Report for Case Management" for her assigned area. The census report shows all the patients currently occupying the rooms in her area (in room number order). It also displays a patient's status (I=inpatient, V=observation), admit date, gender, age, insurance type, attending physician and length of stay (LOS). The case manager uses this report to monitor the cases in her area.

## Observation/Admittance

Occasionally, a patient will be placed on observation status. This designation was designed to last no longer than 24 hours. The purpose is to allow a physician time to evaluate a patient's medical condition. Based on the condition or clinical picture, the doctor (along with Case Management) will decide if a patient should be discharged after observation expires, or admitted to inpatient status.

When a patient is admitted as either observation or inpatient status, a case manager will review the patient's chart. Using Interqual, she will make a determination as to whether a patient meets "Interqual" criteria for admission. Interqual is a nationally recognized admission criteria tool made by McKesson and used to qualify a patient's admission status. Interqual criteria are segregated into two sections; severity of illness (SI) and intensity of service (IS). A patient must meet one or more of the measures in each of the sections in order to satisfy admission requirements. If Interqual standards are met, the case manager will note this on the patient's chart and discuss this matter with the attending physician. The attending physician will note (in his physician's orders) the course of action for each patient.

Each case manager averages approximately 30 patients on any given day. Because of the volume of patients and the timeline criteria for the different insurance payers, case managers prioritize patients in the following order:

- 1) Observation – As previously stated, case managers have less than 24 hours to determine the status and ultimate decision of each patient. As such, cases with patients under observation are the highest priority.
- 2) Medicaid – Case Management must communicate with Medicaid within the first 24 hours of a patient's admittance (per Medicaid's guidelines). With this criterion, Medicaid patient cases are the second highest priority.
- 3) Managed Care Contracts – Insurance payers such as AETNA and Culinary have slightly longer processing guidelines. They are a medium priority and are third on the priority list.
- 4) Medicare – Case management is required to make contact with Medicare patients within 48 hours of a patient's admittance to provide the Important Notice from Medicare. They also are a medium priority, and fourth on the list.
- 5) Self pay – As no payers are identified for self pay patients, there are no timeline requirements yet identified. Therefore, self pay cases are classified as a lower priority. Self pay cases are identified by the Eligibility Department which provides assistance in finding a pay source for the patient.



UMC Eligibility Financial Services (EFS) aggressively attempts to qualify self pay patients for Medicare, Medicaid or Clark County Social Services resources. If EFS is successful, and once Medicaid is awarded, the case is then classified as “concurrent eligible” Medicaid. UMC is then given five days to submit initial review, supporting documentation and justification of the services and supplies that a patient received during his stay (i.e., radiology, laboratory, medication, etc.).

As mentioned earlier, Medicaid could approve or deny all or portions of the claim. UMC has an appeals process in place should a claim be denied. Medicaid will review appeals and make a determination on each claim.

### **Concurrent Review**

Once patients are admitted, case managers will monitor a patient’s stay at the hospital by reviewing charts and communicating with the nurses and physicians regarding the patients in their assigned units. In addition, case managers continue to communicate with applicable insurance carriers regarding a patient’s status and progress. Once or twice a week, a core group in each area (usually consisting of a case manager, chief nurse, social worker and physical therapist) will meet and discuss the patients in each of the rooms that occupy that area. This core group’s objective is to coordinate the care of each patient, perform concurrent (ongoing) review, consider safe transitioning options and discuss discharge plans. Each participant prints out a copy of the “census” report as a referencing tool (each taking notes on what course(s) of action have been decided regarding each patient). This process is important in order to help ensure the proper level of care is provided to each patient, and may assist in monitoring lengths of stay (LOS).

### **Discharge Planning**

Discharge planning begins almost immediately once a patient presents for observation or admittance. Although it is a physician’s ultimate responsibility to determine discharge planning, the social worker, case manager and other members of the health care team also have input. While the case manager is performing concurrent review, the social worker is exploring discharge options (i.e., home health care, skilled nursing facility, etc.) once discharge occurs. Coordination between the case manager, social worker and attending physician is required for a patient to be discharged.

The appropriate discharge orders are important for a patient’s safe recovery. In addition, UMC is subject to RAC reviews (Recovery Audit Contractors). Among the items included in the RAC audits are reviews for medically necessary admissions and properly coded discharges. The reviews are being performed by Health Data Insights (HDI) on behalf of the Centers of Medicare & Medicaid Services (CMS). HDI is tasked with identifying overpayments to providers as they relate to various diagnostic related groups (DRG). In addition to overpayments to providers, HDI is also reviewing re-admissions, specifically those that occur less than seven days and within thirty days from discharge. If UMC incorrectly discharges a Medicare/Medicaid



recipient, the current and previous admission may be denied as an “improper” admission and/or discharge.

### **Utilization Review (UR)**

Utilization Review had previously been a separate role carried out by a distinct group within the Case Management Department. Since the reclassification, all case managers are now responsible for utilization review. Utilization review involves the analyzing of a case (patient’s care) to assess whether resources were appropriately and properly used. Insurance carriers mandate that clinical review (or updates) be provided throughout a patient’s dates of service. The case manager shares this clinical information with the insurance carrier at prescribed intervals throughout a patient’s stay. UR conditions are covered under the Centers for Medicare & Medicaid Services, HHS CFR Ch. IV Section 482.30. Per this CMS regulation, UMC should have a utilization review committee consisting of at least two or more practitioners. This committee is tasked with reviewing individual cases to determine the appropriateness of admissions and/or continued stays.

### **Departmental Issues**

Management discussed some of the challenges the department is facing relating to information technology and training.

*IT* – The majority of work performed by Case Management is manual in nature. An IT assessment should be considered to help identify the areas where automation may improve their current processes.

*Training* – Due to the changes in Case Management, training each case manager on her new responsibilities is required and on-going. In summary, UR employees are being trained on case management processes, and CM employees are being trained on utilization review procedures. In addition, case managers are being trained on processing cases utilizing any and all the various insurance payers. As previously stated, a learning curve is to be expected while each case manager becomes more familiar with her new responsibilities.

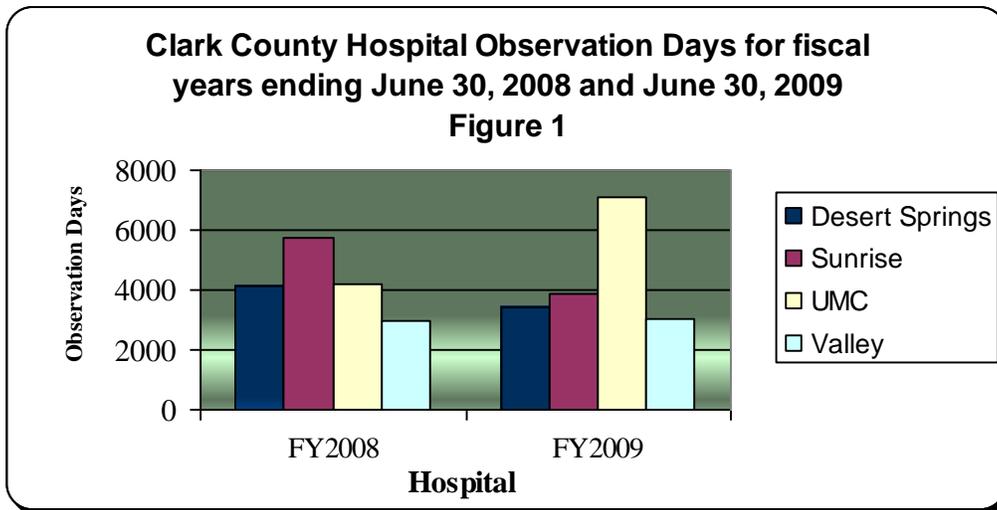
### **Statistical Information**

Various data was gathered externally from the University of Nevada, Las Vegas (UNLV) Center for Health Information Analysis website. This site contains information for all the hospitals in the state of Nevada. This data was compared with information obtained internally to determine trends. Observation days, inpatient days and length of stay (LOS) data were compiled.

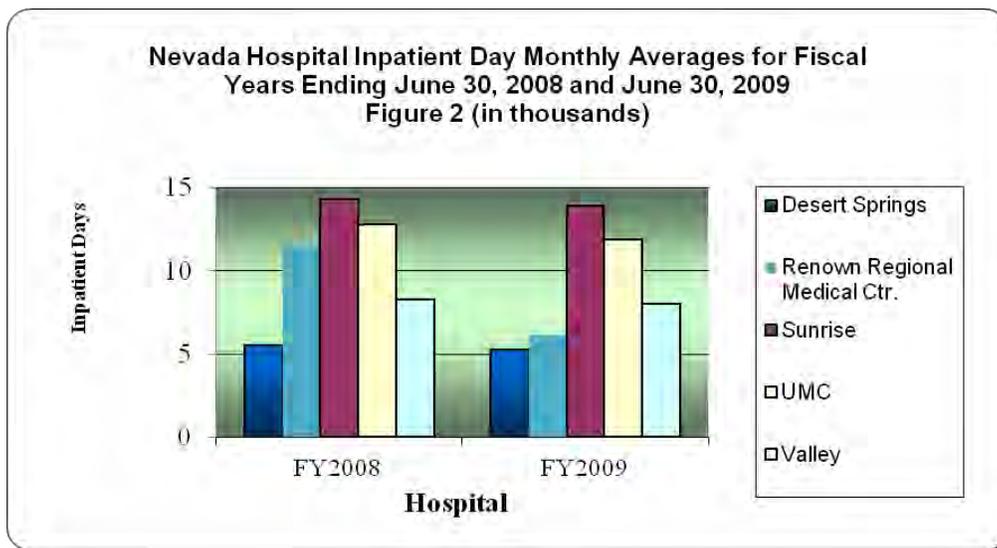
The following chart (Figure 1) shows Medicare observation day information for several Clark County hospitals for fiscal years ending June 30, 2008 and 2009. The graph shows that in comparing observation days between the two periods, UMC’s observation days have increased approximately 70 percent from 4,200 to 7,100. During the same period, observation days at both



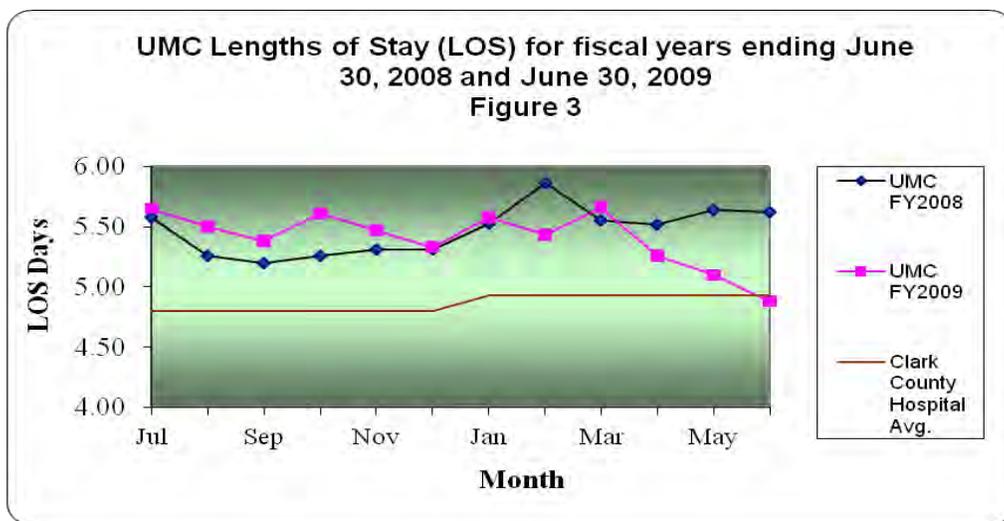
Sunrise and Desert Springs Hospital decreased 33 and 17 percent respectively. Observation days at Valley Hospital and overall observation days remained flat with a slight increase of two percent between years. The sharp increase in observation days at UMC can be partially attributable to the downward trend in inpatient days, which is discussed later. In addition, delays in patient transfers, procedural delays and an increase in dialysis observation patients have affected this significant increase in observation days. Note that data reported in Figures 1-3 are unaudited and included for informational purposes only.



The following graph (Figure 2) illustrates the hospital’s monthly inpatient day average for fiscal years 2008 and 2009 respectively (compared with other large hospitals in Nevada). In contrast to the observation days, inpatient days are showing a downward trend. Specifically, UMC’s inpatient day monthly average has decreased seven percent from approximately 12,800 in FY2008 to 11,900 in FY2009. This trend appears consistent with other hospitals in the state.



In addition to analyzing inpatient and observation days, we compiled the length of stay (LOS) periods at UMC for fiscal years 2008 and 2009 and found them to be 5.48 and 5.40 days respectively. The average of other Clark County hospitals over the same two year period increased from 4.80 to 4.93 days. Although UMC's LOS days are higher than the other hospital averages, it has decreased during a period when the overall average increased. In fact, UMC's LOS day average for June 2009 of 4.88 was below the Clark County average. This is a favorable trend for UMC and is consistent with the favorable trend in inpatient days. See figure 3 below.



## OBJECTIVES

The objectives of our audit were to determine whether:

- Procedures over observation activity are sufficient and in compliance with payer terms.
- Observation to admittance transactions are adequately justified and documented using Interqual criteria.
- Re-admittance activity is reasonable and handled properly.

## SCOPE AND METHODOLOGY

To accomplish our objectives, we conducted a preliminary survey that included a review of Nevada Revised Statutes (NRS), UMC Fiscal Directives, and policies and procedures. Audit examined specific accounts from documentation in MedSeries 4. We reviewed reports and randomly selected observation, admission and re-admission cases, analyzing notes from documentation in each patient's chart, interviewing management and staff, and examining other related documentation. We also selected a random sample of one particular physician's admissions based on information received during the preliminary survey. We conducted this



performance audit in accordance with generally accepted government auditing standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on those audit objectives.

The scope of this engagement covers the period from July 1, 2008, through June 30, 2009. The last day of fieldwork was July 1, 2010.

## **SUMMARY AND CONCLUSION**

Case Management, as explained earlier in the background section, is a series of processes consisting of four components: observation/admitting, concurrent review, discharge planning and utilization review (UR). In performing these processes, Case Management must operate within the guidelines of various regulated entities, as well as the requirements of numerous insurance carriers. To complicate this matter, there are various departments within UMC that contribute to or affect the process. Case Management works directly with Social Services, nurses, physicians, and insurance carriers in performing its responsibilities. In addition, the procedures that Case Management performs directly affect the Revenue Cycle. It is, therefore, especially important that Case Management maintain good working relations and open lines of communications with these various departments to ensure that its tasks are reasonably performed and in a timely manner.

Although UMC has policies and procedures addressing the responsibilities of each of these areas, there appears to be issues in the various functions as discussed in this report.

## **RESULTS IN BRIEF**

Based upon our preliminary testing, we determined that several weaknesses exist in the Case Management process at UMC.

In reviewing observation activity for the fiscal year ending June 30, 2009, we noted over 300 cases where observation stays exceeded the allowable hours per stay. These excess stays amounted to approximately 9,500 hours and \$527,000 of additional billing to insurance carriers. Based on the sample tested, these excess hours and dollars billed were largely due to patients awaiting transfers to mental health or skill nursing facilities.

There were also concerns surrounding the change in status or “observation to admitting” process. Patient information was not always complete and Medicaid authorization was not consistently obtained.

Case Management performs concurrent reviews with the nurses in their assigned areas, as well as works with Social Services on discharge planning. Several issues in these areas were



encountered. We found that Case Management did not have the appropriate amount of Interqual manuals to effectively perform their tasks. These manuals are used by case managers to determine if patients meet the criteria for observation or inpatient stay. We also noted, in reviewing patient charts, numerous occasions where case manager and/or social service notes were either missing or not regularly updated. Similarly, we found gaps in physician orders and procedural delays (which contributed to a lengthened patient's stay). These control lapses may result in discharge delays and/or charges being denied as medically unnecessary.

As mentioned earlier, utilization review entails a case manager's consistent and continual monitoring of a patient's case to help ensure that appropriate resources are utilized in that patient's care. Because these assessments are regularly provided to insurance carriers, it is essential that patient files are kept up to date.

We noted the disparity between the short utilization review timeframe that UMC operates within when compared to the amount of time that Medicaid has to perform a review. We also found that UMC's utilization review process was manual in nature. Additionally, it was noted that UMC does not have a utilization review committee, which is a CMS requirement.

Other issues were also noted in the coding, billing and medical records areas. Additionally, information technology concerns were discovered and are addressed in more detail in this report.

## **DETAILS OF FINDINGS**

### **Internal Controls**

#### *Claim Write-Offs*

There appears to be on going issues with claims being written off as was noted previously in the Revenue Cycle Audit. During detail testing on this engagement, we found a claim amounting to \$143,000 that is due to be written off due to untimely follow-up. We found a second claim for over \$45,000 that should be written off because prior authorization was not obtained from Medicaid. This "no prior authorization" denial resulted from a retro-eligibility account. Specifically, this account was approved for Medicaid benefits retroactively to cover the period of stay. However, Medicaid then denied the charges, as no authorization was obtained. In this case, the patient had already been discharged. When a patient is no longer in the hospital, UMC has 30 days from the date of eligibility to obtain authorization. UMC relies on Magellan to gain authorization on its behalf. Therefore, Medical Records should make sure that it provides Magellan with the information it needs (on a timely basis) to achieve this timeline. Alternatively, if a patient has not been discharged, Case Management has five days to perform a concurrent review seeking authorization.

All claims should be processed in a timely manner and all other processes (such as authorizations and follow-ups) should be handled appropriately to help ensure that proper claims are being created and remitted.



The Business Office should ensure that claim follow-ups are being handled judiciously. It should also amend its Medicaid authorization procedures to help ensure that patient stays are approved. In addition, Case Management should discuss and resolve denials resulting from retro-eligibility accounts with the State. These process changes may result in an increase in fees collected and a decrease in claim denials and account write-offs.

#### *Status Change to Observation After Discharge*

According to Medicare guidelines, Condition 44 states that charges for a patient's observation stay are reimbursable if the patient's status is changed from inpatient to observation prior to the patient being discharged. Specifically, Medicare's four criteria for meeting condition 44 guidelines include the following:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital.
- The hospital has not submitted a claim to Medicare for the inpatient admission.
- A physician concurs with the utilization review committee's decision.
- The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

During detail testing of patient charts, we noted five instances where a patient's status was changed on the chart from inpatient to observation after being discharged. When this occurs, UMC will be denied reimbursement for charges incurred during the patient's stay.

UMC should have specific procedures in place instructing physicians, nurses and case managers the importance of ensuring that any inpatient customers not meeting Interqual criteria for inpatient status be changed to observation by the physician prior to the patient being discharged. Case managers and nurses should immediately communicate with physicians when they determine that a patient does not meet Interqual criteria, as it is the physician's order that must reflect the status change. This will help ensure that related observation charges satisfy Condition 44 guidelines and are reimbursed by Medicare.

### **Case Management Process Issues**

#### *Manual Utilization Review Process*

Utilization Review, which is performed by every case manager, involves the assessment of a case to ensure that resources were appropriately and properly used in the treatment of the patient. Insurance carriers will periodically question level of care and request supporting documentation justifying services (or additional stays) that a patient receives. Currently, this process is handled manually and appears inefficient. The case worker may retrieve hard copies of information from a patient's chart, from MedSeries 4 and/or from a program called CQuence. CQuence is a database that contains physician documents relating to a patient's history and physical state.

In addition, a case manager prepares a Utilization Management form noting a patient's symptom(s) and plan of care. Once a case manager gathers the supporting documentation, she faxes the information to the requesting insurance carrier. This current process is time consuming and labor intensive. Having information available on-line would make retrieving information to



respond to information request from insurance carriers and all other entities more efficient and effective.

We recommend that Case Management review its existing operations and address areas where manual processes could be improved and/or automated. Case Management should participate in the design of a new electronic medical record when the decision is made by UMC to explore that venture. This may help improve the efficiency in data processing, retrieving and sharing for Case Management.

#### *No Utilization Review Committee*

UMC does not have a formal Utilization Review Committee. Rather, they rely on the “contracted” services of a physician for his expert opinion on patient cases. The physician has been on contract for numerous years. In addition, utilization review issues are periodically discussed at Performance Improvement (PI) monthly meetings. However, these PI discussions are confidential and not available for review.

Per the Centers for Medicare & Medicaid Services (CMS), UMC must have a Utilization Review (UR) Committee. Specifically, per 42 CFR Ch.IV Section 482.30, a UR committee should consist of at least two or more doctors of medicine or osteopathy. In addition, the regulation requires that a UR plan be created which provides for review of Medicaid and Medicare patients with respect to the medical necessity of:

- Admission to the institution.
- The duration of stays.
- Professional services (including drugs and biological).

Additionally, violations of hospital Conditions of Participation could result in UMC being excluded from participation in federally funded healthcare programs, such as Medicare and Medicaid. UMC appears to have processes in place to pass joint commission. The lack of a UR committee, however, may result in increased length of stay and unsupported admissions, resulting in a negative impact to revenue.

Although UMC contracts with a physician to review patient cases and utilization review issues are periodically discussed at PI monthly meetings, we recommend that the UMC Chief Operating Officer create a formal utilization review committee to regularly review patient cases. This will help satisfy the guidelines per CMS, may have a favorable affect on patient revenue, and may provide better oversight on patient cases.

#### *Case Management/Social Services Notes Not in Charts*

The UMC Case Management Department runs daily census reports from MedSeries 4 showing (by area) the rooms that are being occupied and information for each respective patient. Each case manager uses this report when performing rounds to check the status of patients. In reviewing patient charts, we noted in over 25 of the 81 charts that case manager/social services notes were either missing or had gaps of up to 35 days. In accordance to UMC Administrative Policy and Procedure #I-1.1.D, Case Management and Social Services should perform an initial



assessment within 24 hours of a patient's admission, order or referral. Per the policy, Case Management should perform re-assessments every 48 hours/and or as indicated by the patient treatment plan. Social Services should be performing re-assessments every five working days or as indicated by the treatment plan. These notes are important to help show active progression of a patient's care and the associated discharge planning. It is also helpful in ensuring that hospital resources are being utilized appropriately. Missing notes may negatively affect utilization review and ultimately result in claims being denied by insurance carriers

The Directors of Case Management and Social Services Departments should ensure that applicable notes are logged into a patient's chart on a regular basis and in conformance with admin policy # I-1.1.D. Gaps between notes should adhere to the guidelines set by the policy. This will help ensure that patient discharge planning is being handled adequately and timely. It may also help provide supporting documentation when insurance carriers request information to conduct a utilization review on a patient's hospital stay.

### **Patient Care Process Issues**

#### *Incomplete Patient Charts*

In reviewing discharged patient charts, we found several instances of gaps in documentation indicating pages were either missing or the documentation was incomplete. There was one instance where the patient's demographic information was not complete. There were also charts where the nurse's notes or doctor's discharge order was missing. In addition, there was one instance where the nurse's notes conflicted with the ER records. The nurse's notes showed that the patient arrived in 2 South at 7:00am on September 26, 2008. However, ER noted that the same patient was not discharged from ER until 20:40 that evening.

UMC should take the appropriate steps to make sure that patient charts are complete and accurate. Missing, incorrect or incomplete information on a patient's chart has several potential ramifications. First and foremost, these occurrences could affect patient safety and the proper and efficient medical attention the patient may need. This may affect a patient's length of stay (LOS) and result in the over or inappropriate utilization of UMC's resources. In addition, billing (and reimbursement) for charges and services provided a patient may be denied if appropriate information and documentation does not exist. Lastly, charts with complete and correct information may help reduce the risk of potential false claims filed.

Individuals in various departments contribute to the creation of a patient's chart. Upon discharge, it is Health Information Management's responsibility to ensure that the chart is complete or to notify the responsible individuals when part(s) of the chart are missing or incomplete. However, gaps and omissions should be corrected by the unit before the chart is ever forwarded to Medical Records. Therefore, we recommend the Chief Nursing Officer require departments put the chart in date order to identify missing documentation prior to forwarding the chart to Medical Records. We further recommend the Director of Health Information Management improve their self monitoring activity to help better identify missing pages. The process should include notifying responsible individuals to locate or recreate the missing documentation. Additionally, we recommend the Director of Health Information



Management implement a method to report missing pages or utilize existing tools, such as the Patient Safety Network system (used to monitor patient issues). This will provide a mechanism to trend issues and identify root causes so that they can be assured all charts are complete.

### *Procedural Delays*

Several individuals in numerous departments contribute to a patient's care. Each of these individuals performs his/her necessary tasks to ensure that a patient receives the medical services required to stabilize and improve the patient's condition, and prepare the patient for discharge or transfer to another facility. Each of these individual tasks should be performed on a timely basis to help ensure the efficient progression of a patient's stay. However, in reviewing patient charts, we noted several instances where procedural delays occurred. We found one patient who was ready for discharge, but waited an extra day for a discharge summary to be dictated by the physician. We also discovered five instances where form Legal 2000 "Application, Certification and Medical Clearance for Emergency Admission of an Allegedly Mentally Ill Person to a Mental Facility" expired and needed to be renewed in order for a patient to be transferred to a Mental Health Facility resulting in delays of varying timeframes. Another chart revealed that a patient waited an extra day for a hospice evaluation as part of discharge planning.

Coordinated efforts between physicians, nurses, Case Management, Social Services and other areas within the hospital should be improved to help ensure that the processes and procedures relating to a patient's care are being performed in a timelier manner, which may have a positive effect on patient safety. It might also result in reducing overall medical charges and, specifically, un-reimbursed charges by insurance carriers. Furthermore, efficient patient progression and discharges will help free up bed space at UMC for more acute patients requiring medical treatment. UMC should re-evaluate its policy on the progression of patient care. We recommend the Associate Administrator of Clinical Intervention and Quality Management establish escalation procedures for any delays in patient discharges over 24 hours. In addition, Social Services should reassess and amend its current procedures covering the monitoring and timely completion of Legal 2000 documentation. Established procedures should result in providing prompt and reasonable patient care in order to improve patient safety and efficiency in discharge planning.

### *Gaps in Physician's Orders*

Physician's orders (POs) are a vital component of a patient's care. They are used and referenced by all other hospital staff in carrying out necessary procedures in caring for a patient (from ordering or performing tests to filling patient prescriptions). To help ensure continuity and quality of a patient's stay, physician orders should always be kept current. However, in reviewing half a dozen charts for one physician's patients, we found two instances where the emergency room (ER) orders expired and the attending physician's orders were not created until several hours later. In one case, the gap was almost 13 hours. In the second case, there was a gap of four and half hours between the ER physician's order and the treating physician's order.

A third case revealed that the physician's order simply stated to continue ER orders even after the patient had been assigned. Typically, a physician will perform an assessment of a patient



transferred to his care, and prepare a specific physician's order to ensure a patient's continued quality of care.

Physicians should be assessing their patients per the guidelines set forth in UMC's Provision of Care policy number I-1.1.D. In accordance with this policy, physicians should perform an initial assessment on critical and adult intermediate care patients within a half hour and two hours of admission respectively. In addition, physician's orders should be completed appropriately and in a timely manner.

A lapse in a physician's order or having orders prepared without a doctor's assessment could pose several problems. Most importantly, these events may affect patient safety and the quality of care a patient receives. In addition, billing for (and reimbursement of) charges and services provided a patient may be denied if appropriate information and documentation does not exist. Lastly, providing proper and efficient medical attention to a patient may assist in the timely progression of a patient's visit. This may result in bed space freeing up in a more efficient manner.

The UMC Chief of Staff should enforce and monitor its administrative policy on the Provision of Care (provided to patients). He should ensure that all physicians are performing his/her responsibilities in a timely manner to help provide appropriate patient care.

#### *Charges Denied as Medically Unnecessary*

During detail testing, we noted that a bill to Medicaid was completely denied as being "medically unnecessary" based on Interqual criteria. This has a direct negative impact on UMC's fee revenue. This particular patient's stay totaled 51 days and approximately \$84,400. We noted other Medicaid bills where charges were denied as they did not meet emergency Medicaid criteria. Per the Medicaid Services Manual, a medical emergency is a situation whereby a delay of 24 hours in treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self or bodily harm to others. This designation requires a physician's determination criteria.

To minimize these occurrences, better coordination and communication between a physician, nurse and case manager to consistently review each case for medical necessity should be implemented. We previously recommended the creation of a Utilization Review Committee. We believe implementation of that committee would address this finding by giving Case Managers a mechanism to challenge physicians who admit patients without medical necessity.

#### *Excess Observation Days*

Per discussions with Case Management and Managed Care personnel, as well as guidelines set forth by Medicaid, Medicare and other insurance carriers, typically observation hour charges will only be reimbursed for up to the first two days of a patient's stay (depending on the payor). In reviewing a MedSeries 4 report listing observation activity, we noted 306 out of 8,886 (3.45 percent) patients stayed for more than two days, resulting in excessive cost to UMC without related reimbursement. In performing detail testing and as discussed in other areas of this report, we noted gaps in Case Management, Social Services, nurses and physicians notes. We also



noted issues with delays in discharging patients. Patients should be assessed and processed within the applicable guidelines required by insurance carriers. Within these directives, a patient should either be justifiably converted to inpatient status, or considered stable and healthy enough to be discharged from the hospital.

We recommend that the Manager of Case Management and the Medical Director of Case Management implement a process to work with physicians and encourage the discharge or admission of patients prior to exceeding applicable guidelines in observation status unless special circumstances exist.

## **Back-End Processing**

### *Coding Issues*

We noted during detail testing that 2 of the 81 claims we tested were incorrectly coded. This may have contributed to the delay in billing to the insurance carriers. In addition, the insurance carrier denied a portion of a claim due to certain line items not being recognized on Magellan's (formerly known as First Health's "FH") fee schedule. FH also denied part of another claim where observation hours and dialysis charges were simultaneously billed. There should be proper procedures in place to ensure that all claims are properly coded. Errors in coding may affect the timely billing of charges to insurance carriers. This may lead to claims being denied, stale-dated, and/or ultimately written off as untimely follow-up. This could also result in false claims act violations that could result in fines of up to \$10,000 per item plus treble damages, and potential exclusion from federally funded healthcare programs.

We recommend that the Director of Medical Records amend its current self monitoring process to better ensure that claims are coded correctly. Additionally, we recommend that errors identified during the audit are corrected and re-billed as necessary.

### *Charging Issues*

For each of the selections made, billable charges were compared between the information on the charts and billed charges per MedSeries 4 and the claim (UB04). Billing practice dictates that patients are billed a room charge when they have an overnight "inpatient" (IP) status stay. We noted charging issues in several of the selections. On 24 of 81 of the bills, we noted no observation hours being billed, where observation expenditures were incurred. In one case, the appropriate observation hours were not billed, but rather a room charge was assessed for the first five days of the patient's stay.

In addition to these charging issues, we also noted incidences where Condition 44 was applied to a patient. When this occurs, a patient's status changes from inpatient to observation (as Interqual criteria is not being met). Per Centers for Medicare and Medicaid (CMS) guidelines, billing for observation charges should start at the time a physician's orders changes a patient's status to observation. In 1 of the 5 Condition 44 patients we reviewed, UMC billed observation charges retroactively to when a patient was first admitted. This resulted in an overbilling of observation charges.



Patient charges billed should reflect the actual expenditures incurred during a patient's stay. In addition, charges on claims should be billed in accordance with CMS and all managed contract guidelines. These charging issues may result in the under/overbilling of patient charges and the under/over collecting of fee revenue. In addition, charging discrepancies may delay the reimbursement process, and may lead to charges being disallowed (as untimely or inappropriate). This could also result in false claims act violations that could result in fines of up to \$10,000 per item plus treble damages, and potential exclusion from federally funded healthcare programs.

UMC should make sure that all the departments that affect the billing process have controls in place to ensure that all billable charges are being identified and processed in a timely and appropriate basis. We also recommend that the Revenue Cycle Director correct the incorrect accounts and refund or re-bill as necessary. NOTE: Subsequent to this audit, automatic system charging of observation hours was implemented.

## **Other**

### *Outdated Interqual Manuals*

Case Management uses Interqual manuals and on-line referencing to assist in determining whether a patient meets the criteria for hospital admittance. Currently, there are approximately 30 case managers in Case Management utilizing five manuals. In addition, the manuals are the 2007 edition which makes them somewhat outdated. Furthermore, it appears that the on-line "Interqual" referencing is not as detailed as obtaining information per the manual. These issues increase the possibility of patients being admitted that do not meet criteria for admittance, which may lead to lost revenue.

The Case Management Manager should purchase additional (more current) manuals making them more accessible for referencing and to help ensure that the most recent admission criteria are being used. In addition, case management could meet with the Interqual consultants to discuss the feasibility of obtaining additional features from the Interqual program to facilitate the easier use of on-line referencing.

### *Skilled Nursing Facility Transfer Delays*

In numerous instances, there were patients at UMC that required transfers to skilled nursing facilities (SNF). Some of these patients originally presented at the Emergency Room requiring medical attention. Others were transferred from a SNF due to medical necessity, only to find out that the bed they previously occupied at the SNF had been reassigned to another patient. Moreover, other patients either refused to go to a SNF or were denied from several facilities due to behavioral issues or a lack of pay source. In all 19 cases of patients waiting to be transferred to a SNF that we reviewed, there were delays in transferring the patient to a skilled nursing facility.

Patients needing skilled nursing facility services should be transferred in a timelier basis. Improving patient placement to SNF should help reduce un-reimbursed charges by insurance carriers. In addition, overall medical charges may be reduced as the daily rate for a SNF (\$175)



is lower than a daily bed rate at UMC (\$237). Furthermore, efficient patient transfers will help free up bed space at the hospital for more acute patients requiring medical treatment at UMC.

UMC administration should attempt to coordinate with all local SNF for these facilities to hold patient beds available for existing patients that are temporarily receiving medical treatment at UMC and other hospitals. UMC may also want to work with County Social Services to potentially get these patients moved to a cost efficient SNF. In addition, there may be areas of possible improvement in the coordinated effort between Case Management, Social Services, physicians and nurses, to help ensure that discharge planning on all patients is processed in a timelier manner.

#### *Mental Health Facility Transfer Delays*

During detail testing, we noted several patients that required transfers to mental health facilities (MHF). Some of these patients originally presented at the Emergency Room requiring medical attention. Others were transferred from a MHF requiring medical attention, only to find out that the bed they previously occupied at the MHF had been reassigned to another patient. In each of these cases, there were delays in transferring the patient to a mental health facility. In addition, UMC is not a licensed psychiatric facility, and may not be reimbursed by Medicaid for these expenditures.

Improving patient placement to MHF should help reduce un-reimbursed charges by insurance carriers. In addition, efficient patient transfers will help free up bed space at the hospital for more acute patients requiring medical treatment at UMC.

UMC administration should attempt to coordinate with all local MHF for these facilities to hold patient beds available for existing patients that are temporarily receiving medical treatment at UMC and other hospitals. UMC administration should also explore any legislative options available through the State. In addition, there may be areas of possible improvement in the coordinated effort between Case Management, Social Services, physicians and nurses, to help ensure that discharge planning on all patients is processed in a timelier manner.

#### *Repeat Undocumented Patients*

In analyzing repeat patients, we noted several instances where a patient presented on numerous occasions. Specifically, repeat, undocumented patients are presenting at UMC for periodic and related visits (such as kidney dialysis treatments). Many of these undocumented patients are uninsured, and periodically provide incomplete information to the Admitting department. When this occurs, UMC is unable to bill or successfully seek and receive payment for services it provides these patients. Consequently, these charges are absorbed by UMC.

Although it is UMC's lawful duty and responsibility to stabilize each patient that presents at the hospital, there should be a formal process in place to address this issue of repeat, undocumented and uninsured patients so their healthcare needs can be met in the proper setting.



We recommend the UMC COO investigate legislative avenues to deal with the increase in repeat, undocumented, uninsured patients that present at the hospital, while still maintaining patient safety and appropriate level of care.

## **Medicaid**

### *Case Management Utilization Review Timeframes*

A utilization review (UR) is performed on all cases where a patient is admitted to the hospital (UMC). This review is conducted to ensure that patients meet the medical criteria for admission.

For patients with current Medicaid benefits, UMC must provide Magellan (Medicaid Administrator) with a completed utilization review within 24 hours of a patient's admission. With patients where Medicaid is approved during the patient's stay at the hospital, UMC has 5 days (from the date of decision for the approved Medicaid benefits) to complete and submit a UR to Magellan for review. In either case, if the UR is not provided to Magellan within the specified timeframe, Magellan will deny the claim. This becomes more of an issue when a patient's stay at the hospital is lengthy, and the amount of information to compile and review by Case Management is voluminous. In these cases, the UR may take more than the allowed time to complete. As such, the shorter time guidelines for UMC utilization reviews results in cases being denied due to untimely completion and submission of URs to Magellan. This leads to increased write-offs of claims by UMC.

For patients where a date of decision for approved Medicaid benefits occurs after a patient is discharged, the UR is performed by Magellan. In comparison, Magellan has 30 days to complete its utilization review.

Utilization review time constraints should be applied consistently between UMC and Magellan. We recommend that the UMC COO meet with the Nevada Department of Welfare to discuss amending the utilization review timelines currently set for UMC to reflect the same time constraints currently being imposed on Magellan.

## **Information Technology**

### *Improving and Creating MedSeries 4 Reports*

On a daily basis, a case manager will print a report for her assigned area from MedSeries 4 called "Census Report for Case Management". The census report shows all the patients currently occupying the rooms in her area. It also shows other information such as a patient's status (I=inpatient, V=observation), admit date, gender, age, insurance type, attending physician and length of stay (LOS). The case manager uses this report to monitor the cases in her area. However, this report may also be used for analytical purposes. If the report could be generated by month, quarterly or by year, with additional information to include discharge date and a diagnosis related group (DRG), the manager and director of Case Management could use this report to perform assessments on its case managers and to conduct overall analyses on the information to identify trends and to compare statistics with information from other hospitals.



The current report format does not allow for the department manager to assess the performance and progress of case managers. It also limits how much monitoring can be done. The report had not been reviewed to determine whether changes could provide more beneficial information.

We recommend that the Case Management Manager meet with the Information Technology (IT) department and discuss the feasibility of enhancing the existing MedSeries 4 “Census Report for Case Management”, or creating a new report that will include additional information and with the capability of running reports for various timeframes. This may help Case Management better monitor its cases and caseloads, and provide a tool for trending this information and comparing UMC performance to national or industry averages. These reports could also help department management assess case manager productivity.



## **APPENDIX**

### **Management's Response**

## Case Management Response to the Case Management Audit for January 2011

[Page 7 Line 15] On going

[Page 17 Line 19] On going

**IT** – Currently Case Management in conjunction with Social Services, is in the RFP process to determine what software solution would best suit the needs of the department. The requirements include patient tracking, E-Fax, Interqual interaction, post acute planning, and tracking for avoidable days, delay in service, and related concerns for utilization (resource management). The latest version of Interqual (CERMe) is due to be installed and accessible to Case Management by the second week of April, 2011. Access to a workstation is also of critical importance. We are engaged with IT to determine what mobile device will best meet the needs of each case manager.

[Page 7 Line 19] Closed

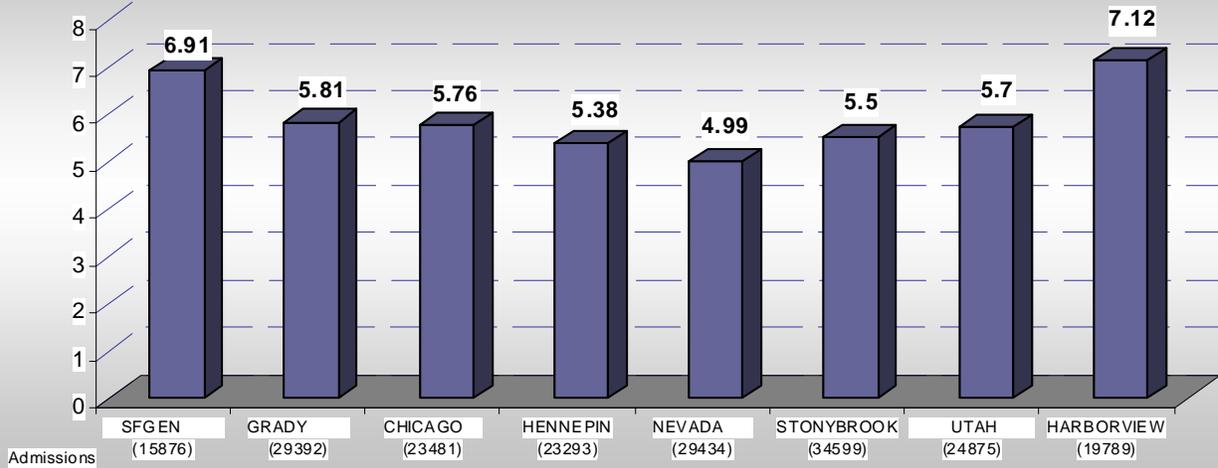
**Training** - All case managers are now cross trained and educated in the principles of unit base case management. These principles include, but are not limited to Admission Assessment, Concurrent Review (utilization review), Discharge Planning, and Retro-Eligible case review. In addition, the Manager for Case Management personally mentors each new hire on the Magellan portal (FFS Medicaid) for utilization review, retro eligible teams, and Interqual during their course of orientation. This serves several important concerns by ensuring standardization within the UR process and evaluating the skills of each newly hired employee during the probationary period.

[Page 8 Line 4] Informational

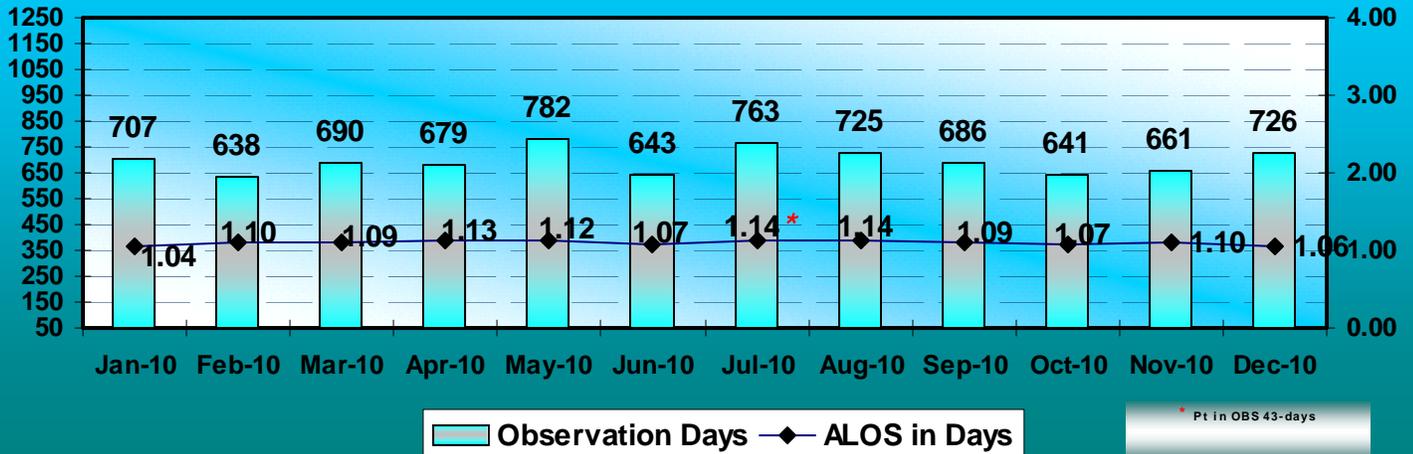
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**Statistical Information** – Presented in the Audit were that Observation days are statistically higher for UMC (from the UNLV Center for Health Information Analysis website). Observation status is for patients who are ill, but do not meet evidence based criteria (Interqual) for acute in-patient admission. Information gathered by Case Management from UMC's Siemens Med Series data for all patients admitted and discharged in Observation status (Pt Type V) demonstrate average length of stay for 2009 and 2010 at 824 patient days and 695 respectively. Overall the median time in Observation status for 2009 and 2010 was 29 hours and 26 hours respectively. The embedded graphs serve to demonstrate the efforts put forth by the Case Managers, Social Workers, Physicians, Staff Nurses, and the Imaging department to focus on this group of patients and expedite a disposition consistent with their reason for being hospitalized.

## Public Hospital Comparison



## Observation Hours In Patient Days & ALOS 2010 Patient Type V

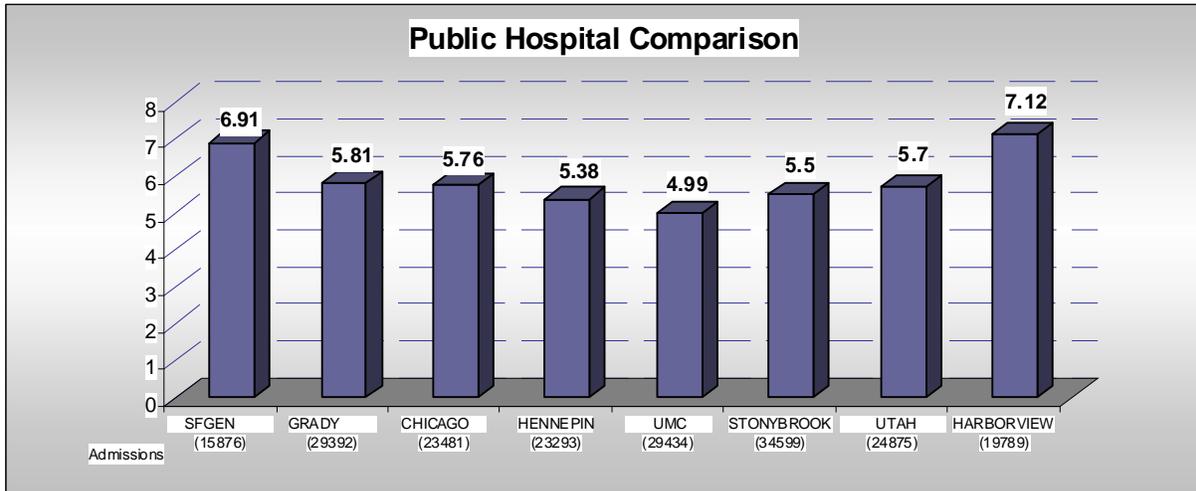


Of note in this data are:

- Psychiatric patients, who have medical issues that are addressed and medically cleared, but still remain in the hospital pending placement at Rawson-Neal Psychiatric Facility.
- Social displacement concerns.
- Certain Chest Pain Center patients admitted as Observation.
- Pediatric patients.

[Page 10 Line 2] On going

Also embedded in this response is the Average LOS for Inpatient, as trended against similar hospitals from the Lewin Report, presented to the Commission in April, 2007. This data comes from the UHC Clinical Database and serves to compare UMC with similar public hospitals in the consortium.



[Page 13 Line 12] On going

The process of changing patients from Observation to In-Patient has improved through increased attention to detail, the addition of a dedicated Fax Server, and collaboration between the Nursing Floors, Case Management, and Patient Access Services (PAS). Currently Case Management has near 24 hour coverage of the Adult Emergency department. There are two days of 20 hour coverage. The initial assessment and determination of Observation vs In-Patient status is accomplished by the ED case manager in conjunction with the ED physician and if possible the Attending Physician or their designee. We feel that additional opportunity for dramatic improvement lies in this process through the implementation of Case Management Assignment Protocol, CMAP.

- Recognizes that the Hospital, through established protocols and approval from the Medical Executive Committee (MEC), determine the admission status of the patient. This is accomplished in the first 6-8 hours of the admission and is based in Case Management review of the Attending Physicians initial Impression and Plan of Care by a Case Manager.
- Requires more coverage per 24 hours by Case Management. Estimate 2 FTE's.
- IT support through patient tracking and electronic documentation.
- Provides the potential for better patient directed healthcare through patient enhanced awareness of deductibles, co-pays, and outpatient procedures.

[Page 16 Line 1] On going

Conversely, when patients are found to not meet Interqual criteria for an acute inpatient stay and the order is written as inpatient, the case manager is required to notify the Attending physician or designee and well as the Medical Director for Case Management [UM committee]. By a process called Condition 44, the order will be changed to Observation and a note placed in the record documenting why. This process must occur before discharge and Medicare/Medicaid not billed for the in-patient stay. This is true of any Third Party Payer not just Medicare or Medicaid. However, significant problems are encountered with the identification of the actual order for Observation. They include:

- Orders for observation written without the case manager aware.
- Orders for Observation are written after the Case Managers perform their initial admission assessment and determine inpatient criteria exists. These orders too are not communicated to the case manager before discharge and result in lost revenue.
- Poor understanding of inpatient criteria and Observation status by Medical and Nursing Staff including the Residents.

Case Management believes that this issue of inappropriate status changes both Observation to Inpatient and Inpatient to Observation would be eliminated by Case Management Assignment Protocol, CMAP.

[Page 13 Line 18] Closed

[Page 28 Line 6] Closed

**Interqual Manuals** – Case Management has purchased sufficient and up to date Interqual manuals for the individual case managers. In addition the on-line Interqual will be installed in early April 2011 and be available to all case managers as workstation access allows. Again, we are working with IT to identify and implement mobile access for them.

[Page 13 Line 20] On going

[Page 19 Line 2] On going

**Inconsistent Charting/Documentation** – The policy is that every patient receives an initial assessment and 48 hour review on each acute stay. Documentation requirements have been reinforced to the staff during monthly staff meeting and through emails. The Manager and Director will randomly audit patient charts during patient stays, retro-eligible reviews, and in Roadblock. This documentation by each case manager is hindered by lack of consistent access to the chart and should resolve with electronic medical records and specific case management software. In the meantime performance improvement measures will be implemented when consistent trends are discovered.

[Page 14 Line 11]Closed

[Page 18 Line 2 through Page 19 Line 2] Closed

**Utilization Management Committee/Plan** – UMC has established a Utilization Management Committee that is consistent with CMS guidelines. The Committee will focus on several resource management concerns such as Observations times, LOS, Avoidable Days, Delay in Service, Re-Admission rates, RAC Audit findings, continuity of care, but is not limited to those issues. The Committee will meet monthly and be chaired by a physician. Members include the COO, the CNO, the Administrator for Quality and Patient Safety, a physician Hospitalist, an ED physician, and stakeholder Directors and Managers. Overall the goal of this Committee is to better improve Patient Transition and Throughput as it relates to Resource Management, Professional Services, and Revenue. This is to be accomplished through data trending, intense focus on outliers, revenue review, and clinical documentation improvement. The 2011 Utilization Management Plan has been approved by the Medical Executive Committee.

[Page 21 and 22] On going

**Procedural Delays** – Procedural delays or Delay in Service are recognized by Case Management as one of UMC's best opportunity to improve Throughput and enhance Revenue. The Case Management process will improve significantly with the addition of software solutions (automation) and IT access that greatly enhance the ability of the case managers to track and assign Delay in Service. This data will be reported through the UM Committee to appropriate departments and physicians so that organizationally UMC will have the ability to develop strategies, implement action plans, and evaluate the effectiveness of those strategies. Again, this process must be reported through the UM Committee to Senior Administration, Medical Executive Committee and key stakeholder departments such as Imaging, Surgery, Patient Access Services, etc.

[Page 24 Line 10] On going

**Charges Denied as Not Medically Necessary** – represent patient stays that:

- Lack evidence based acute inpatient criteria (Interqual) and clinical documentation to substantiate an inpatient admission.
- Require timely peer to peer interaction provide medical discussion to substantiate the reason for admissions that do not meet evidence based criteria (Interqual).
- Are seen repeatedly in the Retro-Eligible Medicaid process that substantiate UMC's inability to provide for post acute or ambulatory services due to the lack of the patient's financial resources.

It is Case Management's intention to utilize the UM Committee, (as stated in the County Audit), to *"give Case Managers a mechanism to challenge physicians who admit patients without medical necessity."* Thereby allowing the process of Peer Review to mitigate concerns over liability (litigation) and require

clear definitions for admission when evidence based criteria is absent. Additionally, the UM Committee with documented cases of “Not Medically Necessary,” will move forward to Administration strategies to manage uninsured and underinsured patients in the existing framework of our outpatient clinics rather than the inpatient setting.

[Page 25 Line 4] On going

**Excess Observation days** – As demonstrated earlier, the overall median time in Observation falls well within the 48 hours discussed in CMS guidelines. [However, the guidelines if read carefully, state “, *the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours*] UMC has challenged this limit and follows its own goal of 24 hours. Using the median stay allows for the filtering of outliers. Case Management feels that it is incumbent on us, and in collaboration with Social Services and physicians, to manage outliers on a daily basis. This process is in place and evident in our daily prioritizing of patients by:

1. Observation Review
2. Medicaid UR
3. Commercial UR
4. Self Pay UR
5. Medicare Review

As Case Management moves to embrace Case Management Assignment Protocol, CMAP, we suspect UMC may initially see an increase in observations days, but an overall decrease in denials, specifically the Retro-Eligible Medicaid denials. If CMAP is accomplished in our projected time frame of one year and the UM Committee can provide the direction and motivate applicable stakeholders, then UMC may not see a rise in Observation stays. In deed we suspect that UMC will see an overall decrease in Observation stays and decrease in Retro-Eligible denials due to:

- Patients will not be admitted as much into Observation status, but rather referred to the ambulatory setting directly from the ED.
- Denials will decrease as uninsured patients are admitted into the appropriate status of Observation rather than Inpatient and then managed by our current process challenging the 26 hour LOS we currently have for Observation (Pt Type V).

Critical to this intense scrutiny is the addition of electronic medical records and software solutions for Case Management and Social Services.

**Information Technology** – Case Management currently has daily reports for case managers. They include Observation and Census by Insurance which allows us to focus on our priorities as defined earlier. In addition, and since reviewing the County Audit, we have discovered additional information contained in the ALOS and Flash reports that have relevant information for us. Unfortunately we have been unable to find a solution to specifically monitor certified days, opportunity days, delay in service, etc that would allow us to better monitor productivity. As stated earlier on line Interqual will be installed in April, 2011. We will be able to query patient reviews for those that meet inpatient criteria or not, more easily produce forms to identify delays, print HINN letters (Hospital Issued Notice of Non-Coverage), request secondary reviews, etc. However overall workflow still must be accomplished by a time consuming paper chart audit which may or may not be accessible to the case manager at the time they are on the patient care unit.

**Summary:**

Case Management appreciates this opportunity to respond to the County Audit of our practice. It identifies areas for improvement and provides support for concerns we already had such as IT and the establishment of a UM Committee. It has afforded us a forum to review and explain our workflow as well as the expectations the County has for us as we move forward. Case Management is very motivated and embraces the need to improve this aspect of the Revenue stream for UMC.