Early in the 1970s a few intrepid accident and health carriers introduced case management services to coordinate the care of the catastrophically injured individual. This was also to facilitate communication between the physician, provider, and payor. One of the early models of case management was built on the following premises:

1. Only a physician can practice medicine.
2. Case management is an ancillary support system to facilitate communication between the provider, the patient, and the payor.
3. The physician is the ultimate case manager.

The term “case management” is used today to describe a wide range of disparate activities. Confusion exists regarding case management as an entity and as a profession because there is little consensus on the definition.

In the author’s opinion, case management is the coordination and facilitation of services to achieve quality care. Effective case management can be a very positive adjunctive service between the physician, the patient, and the payor. The physician and the case manager can develop a collaborative relationship that can expedite the treatment of the patient. Timely intervention will achieve the best outcomes in the shortest amount of time.

This article will identify roles of the case manager, distinguished by the setting which employs them; give suggestions for qualifications of a case manager; and discuss the effect case management can have on outcomes. Using case examples, the author will attempt to describe how case management can contribute to the effective delivery of health care.

**Historical Overview**

As advancements in medical technology have enhanced the survival of catastrophically injured individuals, some of the payors (especially, those responsible for the injured worker) began looking at alternative treatment options. They looked for quality rehabilitation programs that could foster independence. These payors determined that certain programs were able to achieve better outcomes and maximize functional gains.

These payors realized that long-term financial benefits were possible when patients who received appropriate services gained maximal functional independence. Achieving maximal independence reduced the probability of potential complication and rehospitalizations. Individuals who achieved a higher quality of life were also more likely to reach the goal of returning to work.

The accident and health industry had noted the success of case management services by the workers compensation carriers. Their potential liability had increased significantly so these accident and health payors began to explore the utilization of case management services. They too, realized not all programs were alike and saw that utilization of case management services enhanced the outcome and quality of life of their clients.

The early 1980s saw the rehabilitation industry in a state of rapid growth. New programs and alternative treatment approaches were opening around the country. Some of these developments significantly enhanced the outcome of catastrophically injured individuals. Policy language was not written to encompass these new developments. Some of these payors found it necessary to make extra contractual arrangements to accommodate their clients and the providers.

The early “case managers” essentially facilitated and coordinated care. Working closely with the physician, receiving recommendations, the case manager was able to facilitate entry into the appropriate program. The case manager would meet with the patient and family to assist in obtaining the durable medical equipment and home modifications.

Efforts of the case manager enhanced communication between the patient, the physician, the provider, and the payor. Case managers prevented unnecessary delays in treatment authorization, thus expediting achievement of outcomes for the patient. Costly complications and rehospitalizations were reduced.

**Roles of Case Managers**

*The Independent Contractor*

Usually this is a health care professional who has worked as a clinician in rehabilitation (it is acknowledged that some individuals who do not have a clinical background can do an excellent job of case management). The independent contractor may work alone or be an employee of a national case management company.

These individuals or companies are hired by payors to provide case management services. One of the case manager’s primary functions is to assist the payor in identifying appropriate programs for cost-effective treatment. In addition to the title of “Case Manager,” this group may also use the title “Rehabilitation Specialist” or “Rehabilitation Coordinator.”
The Payor’s Employee

The carrier usually hires a clinician to provide the essential coordination and facilitation functions. The case manager may facilitate the patient’s care needs by telephone or they may do on-site visits. Instead of, or in addition to, their own employees, the payors may hire independent case managers to do on-site evaluations and monitor the progress of the patient.

When working with a case manager who represents the payor, it is essential to clarify whether they are an employee of the payor or an independent contractor. This distinction might have implications regarding the case manager’s level of authority to authorize recommended treatment.

Some of these payor-based employees are actually doing utilization review. A distinction must be established between case management and utilization review. “Utilization review is the process of evaluating the necessity, quality, effectiveness or efficiency of medical services, procedures and facilities.”

Utilization review, then, normally authorizes length of stay or treatment in accordance with national norms. The author feels that the functions of utilization review and case management vary significantly. While utilization review can be effective for many diagnoses, catastrophic and high-risk cases need individualized case management to maximize outcomes.

The Provider’s Employee

The provider, i.e., a hospital, hires a case manager to provide a link to the payor, and to facilitate communication between the physician and the family. In addition, they may be doing internal utilization review and coordinating patient benefits. Facility case managers may be responsible for discharge planning, which can include coordinating outpatient and home health treatments and assisting the patient and the family with financial matters.

Qualifications of a Case Manager

As the physician and the case manager begin their collaboration for the patient’s benefit, both may have certain assumptions that need to be verified. The physician is assumed to have a greater knowledge of the pathophysiology of the disease and disability. The case manager is assumed to know how to facilitate access to needed care. The physician and the case manager can act as vital resources for each other.

If the case manager has a basic understanding of the disease entity, that is an added benefit for the provider, the patient, and the payor. The case manager should be aware of the state-of-the-art treatment, including criteria for referral to all available levels of care. If the case manager lacks the necessary, specific knowledge, they should be aware of how to access the resources necessary to determine the appropriate level of care.

The case manager must be aware of the benefit limitations of the individual’s policy. Alternative resources, i.e., public and private sector, as well as other not-for-profit organizations, can be helpful. Knowledge of eligibility requirements are very important in order to access this alternative funding. The case manager can assist the individual in accessing this funding.

Criteria for qualifications, screening, and training of case managers is unknown, thus the level of knowledge and expertise of any individual case manager can vary greatly. The case manager should possess the coordination and facilitation skills to access services. They must be able to communicate with the physician, the payor, the facility, and the patient to effectively move the patient through the health care system.

Accessing Case Management Services

The physician can be proactive by initiating contact with the payor requesting case management services for the catastrophically injured individual. Early contact demonstrates the physician’s understanding of the benefits of case management for the patient, the payor, and the physician.

At times, it can be difficult to determine if a patient’s benefits include case management services. Experience has demonstrated that it is useful to communicate with a supervisory-level person to determine how to access case management services.

The Cost of Care

Initially, cost containment—the process of saving dollars—was part of the impetus for case management services. Presently, the focus is more on cost effectiveness—the process of achieving savings by focusing on the whole spectrum of recovery and understanding that high initial costs may produce long-term savings. As case management evolves, perhaps the focus should become cost benefit—the process of focusing on results, outcome, to determine what the cost is to the patient, the payor, and society.

Alvin H. Arakaki, CIKS, a noted expert in the field of case management, has said, “Appropriate medical care in and of itself is cost effective.” The role of case management is to assist the physician to facilitate appropriate medical care for their patient. This is the most effective way to achieve cost savings.

Utilizing the most beneficial program may cost more initially. The greatest savings can come from avoiding readmissions or complications. Computation of costs of care for the catastrophically injured is complicated. Consideration for the entire treatment costs must be calculated. The reader is referred to the article “Centers of Excellence: Choosing the Appropriate Rehabilitation Center” to help understand the potential financial savings that are derived from such centers.

Case Examples

Case examples are provided to demonstrate how case management can be effective or costly depending upon a wide range of factors including the knowledge and skill of the case manager. While these are individual examples, the principles can be applied globally to improve case management.

Examples of Effective Case Management

Case Number 1

The discharge plan, for a recent onset paraplegic, was for him to return home and live with his spouse. The spouse brought in a floor plan of the home for the facility’s team to make suggestions to improve wheelchair accessibility. From the floor plan, it appeared that only minor modifications would be necessary to provide doorway access, plus ramping the entry.

The case manager visited the home and informed the team that the patient would be returning to his mobile home. Modification of mobile homes can be cost prohibitive. Prompt commu-
The case manager for this paraplegic patient was responsible for obtaining durable medical equipment. The wheelchair specifications were given to the case manager and the discharge date was estimated. Contact was made with the case manager when the wheelchair had not arrived two days prior to discharge.

The case manager’s failure to order the equipment in a timely manner resulted in the discharge being delayed two weeks. No adequate alternative could be arranged because the local vendor would not provide a wheelchair on loan inasmuch as purchase of the new wheelchair was from a vendor several states away.

This case was costly for the payor due to the failure of the case manager to coordinate the equipment needs. The case management company in this instance had a purchase arrangement with a dealer very distant from the patient and provider. Had they purchased the equipment from the local vendor, it is likely the local vendor would have loaned the needed equipment and discharge could have taken place as scheduled.

Case B
A four-month delay in the transfer of benefits prevented a patient with a severe traumatic brain injury from being transferred to a sub-acute rehabilitation program for more appropriate and less costly care. Because the primary insured was killed in the accident, provisions established by the employer necessitated the transfer of benefits to the surviving spouse.

The case manager was unable to establish alternative benefit arrangements which would have made it possible to transfer the patient from the acute hospital to the sub-acute rehabilitation program. The four-month delay was extremely costly for the payor. The extension of benefit clause would have facilitated this transfer.

This example demonstrates the importance of the case manager understanding the patient’s benefits and how to cut through the bureaucracy to effect appropriate treatment and cost savings. Utilizing knowledge of the benefits can provide the case manager with the opportunity to educate the payor of the long-term liabilities and risks when appropriate care is not facilitated.

Example of Conflict between Case Management and Utilization Review

Case 1
The payor for the patient used a cost containment company with separate departments for utilization review and case management. The catastrophic nature of the case required the use of case management. However, the utilization review department continued to be involved with the case. The provider was required to contact both utilization review and case management to provide information on the patient’s progress and obtain authorizations for continued length of stay.

Not only was this time consuming and costly for the provider, it was costly for the payor as well. Lack of communication between utilization review and the case manager resulted in the reviewer denying days approved by the case manager, creating potential for a costly appeal.

Consolidation of the case management and utilization review functions for catastrophic injury cases improves communica-
tion and reduces confusion. The potential for delaying necessary treatment is also diminished when the case manager performs both roles. Do not forget that everyone's time is being billed to the payor.

Conclusion

Case management for the catastrophically injured individual is complex and requires a wide range of knowledge and abilities. It is essential to understand the disease and to have the expertise in identifying appropriate treatment options. Coordination and facilitation skills along with the ability to communicate with the physician, the facility, the payor, the patient, and the family are crucial.

The variations in hiring and training practices and the lack of a standard definition of case management can cause confusion and lead to disappointment and increased costs when expectations are not met. It is not safe to assume that an individual called “case manager” has all of the necessary qualifications and expertise to effectively assist the physician in managing the patient’s care.

The title of “case manager” is probably a misnomer. The physician should be the “case manager.” Assistance and suggestions from case management services can facilitate and help in the coordination of care. This allows the patient to receive the most appropriate care, in the most appropriate setting, in a timely manner. By utilizing this process, the best outcomes can be achieved in a minimum amount of time while decreasing the risk for complications and rehospitalizations.

The provider must be aware that not all payors have case management services. It has been experienced by the author that the claims person is not always aware that the company they worked for also provides case management services. When dealing with a catastrophic case, the provider should ask the payor if they have case management services and request that they expedite this service. If the claims person is unaware of case management services, the provider should utilize resources to determine if anyone knows a representative from the particular company. The author has found that many of the payors are willing to establish case management services once they realized the magnitude of the injury and their potential liability.

Physicians, providers, and case managers must work together to maximize the patient’s outcome in the most timely manner. Close communication and a willingness to educate each other is essential. No individual can know everything.

REFERENCES