Case Managers: Friend or Therapists and case managers are struggling to understand one another and still provide the best treatment and equipment for their clients.

By Lisa Nicolaysen

The diversity of assistive technology and rehab therapy is matched by a population of former nurses, clinicians and administrators who have accepted the role of managing client cases for insurance companies, hospitals, managed care organizations and rehab centers.

With such a diverse background, the case manager’s role on the rehab team can vary depending on whom they represent and their rehab experience.

Some therapists and case managers have formed adversarial relationships. Therapists charge that discounts and cost containment rank high on case managers’ lists of priorities. Case managers have their own frustrations in working with therapist, particularly regarding what they consider a breakdown in communication.

Despite all this, the ranks of case managers who are working closely with therapists to bring functional independence to their clients continue to grow. And therapists are being forced to cast aside their misconceptions about case managers to form working relationships with them.

Reaching Out to Educate

The biggest challenge in working with case managers is their limited familiarity with rehab technology, says Janice Hunt Herman, M.S., P.T., a private contractor based in Scottsdale, Ariz., who performs assistive technology evaluations. “I recognize that a case manager was never intended to be trained to do the work of a therapist and I don’t expect them to understand what I’m doing,” she says. “I go into it expecting them not to understand and that it’s my job to educate them.”

Herman commits a lot of her time to educating case managers about equipment, its usage and clinical outcomes. In her experience, most are eager to learn about the industry. She also encourages case managers to attend seating evaluations and rehab meetings so that she can explain the process step-by-step.

But the challenge of working with case managers is better than working for a client who has no case manager to oversee all follow-up care, Herman says. “My biggest frustration is when there is no case manager and there’s nobody to pick up that ball and run with it,” she explains.

Without case managers, many clients can fall through the cracks without the proper training. Says Herman: “Unless all these pieces fit together and [clients] receive ongoing training, the equipment just sits there and gets dusty and it’s a big waste of money. It’s the case manager who makes sure all that follow-up happens.”

In one instance, she says, a case manager considering a client’s request for a standing chair came to her with concerns that the client’s arthritis was too severe for the device. In the end, Herman and the case manager arranged for a physical exam, which determined that the client could not have supported herself in the standing position and might have suffered leg fractures.

“The case manager had the sense to wonder about the medical problems,” Herman says. “If that had gone through, the client would have ended up in the hospital.”

Finding a receptive audience can vary from case manager to case manager, according to John Komuda, president of CNY Medical Products, a rehab technology supplier in Syracuse, N.Y. “Their concept of the equipment dates back to when they were nurses,” he says. “Everybody is looking at the dollar signs as opposed to bringing people back to a level of useful and constructive activity.”

In Komuda’s experience, many external case managers who work for insurance companies push for discounts on equipment without considering the intensive service that is involved in rehab. He recalls a client who was prescribed a high-tech power wheel-
The case manager would not approve the chair and the insurance company’s review board took five months to approve the equipment. By that time, the client had passed away after developing decubitus ulcers. Says Komuda: “These people have got to realize that they’re playing with people’s lives.”

But Komuda has also had positive experiences. When his company hosted a seating symposium, it invited local external case managers to attend. After the event, the 15 case managers who had attended and learned about the benefits of rehab technology called CNY Medical Products to find out about its rehab services.

“When we’ve found case managers who are willing to spend the time and learn what we do, we develop a close working relationship,” Komuda says. “They want to be involved in the care and that has definitely helped.”

The challenge of confronting case managers’ demands for discounts, however, also is a problem for Barb Ketcham, O.T.R., Rehab Designs of Southern California, Woodland Hills. She has had requests for 30 to 40 percent discounts off manufacturers’ suggested retail prices, usually from case managers who work for the client’s insurance company.

But case managers with a clinical background are usually responsive to the inservice presentations Ketcham provides to explain the service component of rehab therapy.

**Additional Assets**

Despite the problems that surface in working with case managers, some therapists welcome the additional member to the team because of the benefits for clients. Susan Johnson Taylor, an occupational therapist at Shepherd Center in Atlanta, considers the case manager a vital part of the rehab team. “The good case manager is actually going to be able to make sure that many different aspects of a client’s care are addressed so that they fit all together,” she explains.

Although many case managers whom she comes into contact with are former rehab nurses, Taylor goes into every relationship with case managers expecting to educate them about rehab technology. “They have to understand that the reason [clients] have come to a seating clinic is because we can’t just glibly make these decisions,” she explains. “It’s an evaluation process and it should involve trying out the equipment. That process it’s just the beginning.”

After a client receives equipment, Taylor agrees that it’s then...
up to the case manager to coordinate all follow-up care.

More often than not, she comes across case managers who want to learn about the rehab industry. Shepherd Center conducts educational sessions on rehab and assistive technology for case managers. “Most are willing to work for the client and go to bat and get equipment approved,” she says.

However, Taylor notes that some case managers attend these sessions with an adversarial attitude, hoping to prove that the prescribed equipment and therapy are not medically necessary in an effort to save money.

“There are a certain number of case managers who are just interested in the least expensive price,” agrees Adrienne Bergen, P.T., with rehab technology supplier Dynamic Medical, Westbury, N.Y. “That usually happens with simple orders.”

For the more high-tech cases, case managers are willing to sit through inservices to get a better understanding of the equipment. “As long as you have an opportunity to speak to them about the process and value of the service, they negotiate accordingly,” she notes.

The biggest stumbling block is trying to explain the difference between durable medical equipment and rehab technology, Bergen says. Some case managers are not aware of the hours that go into sizing equipment for clients, particularly the time spent with clients to properly seat them.

Without a clear understanding of the service related to rehab, the approval process can take a long time, according to many therapists. “There have been some [case managers] who have really put the client first and been very supportive of what technology can do for their patient,” says Beth Waite, an augmentative communications specialist and speech/language pathologist for Crossroads Rehabilitation Center, Indianapolis. “But there are others who drag their feet and want to try every other possibility.”

As the case manager becomes a vital member of the rehab team, other frustrations surface. A high turnover rate among case managers complicates the commitment to provide inservices and other education, according to Pay Seay, a unit liaison for the Institute on Disability and Human Development, the University of Illinois, Chicago.

Given the ranks of case managers new to rehab technology, Seay says, it’s necessary to periodically offer educational services. “After a period of time, we find that it’s useful to ask to allow us to explain our services for the new personnel who don’t have a thorough understanding of rehab.”

Because of their limited rehab background, case managers have a hard time seeing the broader picture for their clients, notes Seay. “If they are going to refer a person for multiple evaluations, it would be in the best interest of their client to bring those entities together and discuss the equipment,” she explains. “I don’t think they understand that there is overlap and tie-in between these different divisions and that they can advocate in a holistic way.”

The Case Manager’s Perspective
Case managers, too, have their own frustrations as they struggle to play catch-up in learning about rehab. Many say they are called upon to understand all aspects of health care depending on the cases they are working on.

Seay, who is a former case manager, says that being able to consult a panel of experts in a variety of fields would have helped her in working for her clients as a case manager. “I was more frustrated by the fact that some of the cases were very involved,” she explains. “You really need a level of expertise that’s beyond your scope. There is a lot of responsibility that rests on the case manager’s shoulders. If you are going into waters that are foreign to you, it would be quite helpful to have experts whom you could call on.”

But most case managers don’t have a panel of experts to turn to for each case they are working on and are instead forced to learn as they go. “Something that could have taken a month or two may take years,” Seay says. “It’s a much longer, slower, tedious process trying to sift through everything. Even though the case manager can be a very astute person, he or she is working with a handicap in having to work in such a broad area.”

Other case managers agree that the challenge is being able to look at the broad picture to advocate for clients. “You just have to deal with having a lot of different resources at your fingertips,” says Lois Thompson, a case manager for catastrophic injuries for PacifiCare, Oklahoma City. Thompson has a bachelor’s degree in nursing and experience in utilization review, quality improvement and workers’ comp case management. Using the Internet, as well as industry seminars and inservices, Thompson says she is constantly learning about the industry. Rehab centers that offer critical pathways also make it easier for her because they offer a more concrete timeline of client care.
Price comes into it, but that’s

Despite complaints that case managers are concerned only with cost, Thompson says she and her colleagues are more interested in their clients’ long-term health. “Case management is no longer looking at cost issues,” she says. “It is looking at the overall patient care and what’s better for the patient. There is a real shift now to look at disease management before [cases] become catastrophic.”

Thompson admits that cost does factor into her client decisions, but she recognizes that spending more now could save the insurer money in the future. “If it costs more, it is going to wind up being more beneficial for the patient and will end up saving us more,” she explains.

Because no two case managers are identical, a need for consistency in their role as client advocates has surfaced, according to Margaret St. Coeur, administrator of case management for Aetna Health Plans in Hartford, Conn. Aetna has been working on case manager guidelines with the Individual Case Managers Association. At press time, those guidelines were slated to be released this month.

Therapists have been among the health care providers anxiously awaiting case manager guidelines, St. Coeur says. “That says to me that historically, case managers have confused providers because we’ve not been consistent in what we’ve been looking for.” Part of the problem, she adds, is that case managers have received no formal training to take on the role of client advocate.

Open Communication

With a caseload of about 25 clients, Thompson says the more difficult part of her job is keeping the communication lines open between herself and the rehab team. Most frustrating for her is the therapist who does not communicate clients’ problems. For example, it wasn’t until Thompson had made her monthly follow-up telephone call to a therapist that she discovered one of her clients had not been to therapy in three weeks.

Norma Huizenga, R.N., C.C.M., a senior case manager for Kemper National Services in Sunrise, Fla., has had similar problems with therapists. “A lot of times we go in and find a prescription for strengthening is not being completed or [therapists] are just giving modalities or the patient is not cooperating,” she says. “We have to make sure they’re asking the patient to do alternatives.”

Most of Huizenga’s 20 to 30 cases a month are workers compensation cases. She is also on call 24 hours a day and is sometimes flown across the country to advocate for her clients. The former rehab nurse relies on therapists to educate her on the changing industry, as well as seminars, conventions and conferences for case managers.

Despite a heavy workload, Huizenga considers herself part of the rehab team and regularly attends team conferences to discuss a client’s therapy. “The main job of all of us is to get the person back to the best that he can be,” she says. “A team effort is really what’s needed. You need to be open and informative if there’s a problem.”

As part of that team, Huizenga helps determine what equipment will be acquired for her client, where the equipment is purchased, and how the client’s home or office needs to be modified to suit the equipment. She also works with the client’s family members to train them on the equipment.

Case management has reemerged today for entirely different and altogether economic reasons. U.S. health care costs have risen dramatically—until very recently by 8 to 10 percent per year. Prompted by the desire of large commercial employers to control their employee health care costs, payers have responded by implementing case management as the central element of their managed care programs.

Beginning in the late 1960s and early 1970s the traditional indemnity insurance companies brought in or contracted with two-year degreed, registered nurses to function as case managers and vocational rehabilitation counselors, first to manage workers’ compensation cases. Their role was to limit the duration and level of attendant care, using licensed visiting nurses and aides wherever possible, and to decrease the total dollars spent over enrollees’ lifetime coverage without creating adversarial situations that could invite lawsuits.

In response, independent case management firms grew by contracting with the insurance companies to perform these tasks. Simultaneously, other insurance companies hired their own case managers.

Dominance of MCOs

The use of case managers has intensified in the past few years, with the dramatic conversion of indemnity plans to the managed care plans of health maintenance organizations and preferred provider organizations.

As the number of case managers has grown, their responsibilities have expanded. Their functions grew to include health plan benefits management, prior approvals for high-dollar equipment, utilization review and cost-benefit reporting. Increasingly, managed care organizations (MCOs) brought this function in-house, resulting in a decrease in the number of independent case management firms.

As the MCOs centralized this function within their organizations, they demanded a centralized contact point within the provider facilities. Thus the development of “internal” or facility-based case managers, whose positions were first created to respond to the needs and questions of the MCOs’ “external” case managers. These internal professionals began to ask questions about the medical necessity of equipment and the client’s long-term plan.

Managing Rehabilitation

Casa Colina Centers for Rehabilitation in Pomona, Calif., was one of the first rehab facilities in the country to set up an internal case management system, initiating its program in 1985-86. Betsy Desimone, M.S.W., who was Casa Colina’s vice president of marketing and patient services from April 1985 to August 1995, was the key individual behind the program’s conceptualization and implementation.

According to Desimone, before 1985, “the philosophy was to do whatever it took to get the patient to his or her maximum rehabilitation potential—no matter what the price tag.”

Because of the increasing trend in the mid-1980s by insurance companies to question medical necessity, cost and long-term plans, Desimone brought in a nurse with experience in the insurance industry to assume the duties of an internal case manager, with the title of assistant director of patient services.

Most rehab centers today have case managers, whether or not...
they hold that specific title. The role of internal case managers has expanded to include intake issues, coordinating with other members of the rehab team on the treatment plan, financial issues regarding coverage, equipment and services approval by the payer source, identifying the most appropriate venue for placement after discharge, and working with the family to educate and ensure proper follow-up treatment and support.

These case managers have become an integral part of the rehabilitation process, with varying degrees of acceptance on the part of traditional rehab team members. They, along with the external case managers, are lightning rods in the storm of managed care upheaval. Often blamed as the perpetrators of unwanted change, they are the clinician-executors of a national goal whose responsibilities will inevitably be shared by all members of the rehab team.

**Internal Case Manager Responsibilities**

The roles of facility-based case managers are diverse and ill-defined. These professionals often end up doing everything from the clerical tasks of verifying benefits and maintaining reporting schedules to developing care plans, negotiating rates and lengths of stay with external case managers, marketing facility services, and managing care plans.

Internal case managers are required to be versed in all major diagnostic categories, to be experts in community and facility resources, and to be knowledgeable of the roles of all members of the rehab team. They also need to be skilled communicators, negotiators, educators, managers, coordinators and initiators.

Janet Mott, Ph.D., president of Mott Rehabilitation Services, Edmonds, Wash., believes that there are some tasks in the never-ending list that should not be part of case manager responsibilities, such as marketing.

She also believes that having case managers perform clerical tasks is inappropriate. “Knowing the available resources in the community and making the final selection are appropriate roles,” she notes. “But making the 49 phone calls to gather information about the resources could be delegated to someone else.”

**Adjusting to Change**

Physical therapists, occupational therapists and other traditional rehab team members are responding in different ways to the new paradigm of rehab care. Some are resisting the intrusion of cost considerations and the individuals with the major responsibilities in this area. They believe that anything short of a care plan that works toward a client’s achievement of maximum rehabilitation and independence potential is incongruent with their professional and moral responsibilities.

Yet others point out that someone has to pay—or may have to be open-minded,” she says. Ranta handles about nine client cases a month, helping them return to work.

The realists are saying that there is a middle ground to be met. On one hand, care must be appropriate and not standard to the need of each client on a case-by-case basis. On the other hand, cost is always a factor and options must be evaluated in light of both short- and long-term costs. Maximum rehabilitation at all costs is as misguided as minimum short-term cost as a blanket rule.

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"The good case manager is actually going to be able to make sure that many aspects of a client's care are addressed so that they fit all together." - Susan Johnson Taylor, O.T.R./L.

Huizenga admits that a case manager who is concerned only with price can be a disservice to the client. “Case managers can make or break a case,” she says. “A lot of times people think case managers want to save money. Price comes into it, but that’s not our main objective at all; it never has been.”

Some internal case managers say their hands are tied by insurance companies that are resistant to their recommendations. Della Noyes, R.N., an internal case manager for the Lorien Medical Specialty Unit in Columbia, Md., often comes up against the insurer’s own case manager. For her, frustration surfaces when a client’s benefits run out but the client needs further therapy or equipment.

Recently, Noyes spent the day fighting an insurer over a client’s transportation home from Lorien, until she threatened to pay for it herself. In the end, the insurer picked up the bill.

“I wanted what was best for my patient,” Noyes said. “That’s the frustrating part: fighting insurance companies over what the team feels is a necessary piece of equipment.”

In advocating for the 38 clients she handles at any given time, Noyes tries to attend their therapy sessions and weekly rehab meetings. “If you see what therapists are doing, you can get a feeling face-to-face on how the client is progressing,” she explains. And although she sometimes works 10 to 12 hours a day, Noyes sits through inservices and seminars to get a better picture of the rehab industry.

In fact, most case managers recognize the importance of continuing education. Carey Ranta, a case manager for Mentor Clinical Care, Woburn, Mass., receives much of her education from the therapists and providers whom she works with. “You have to be open-minded,” she says. Ranta handles about nine client cases a month, helping them return to work.

**Understanding Rehab**

In addition to inservices, sensitivity training workshops-in which the staff uses a piece of equipment for a day-are part of the continuing education for case managers at the Central California Rehab Hospital in Modesto, according to Paul O’Connell, director of case management. He serves as liaison between the clinical team, the client and family, and the insurance company. His monthly workload includes five to 10 cases and he attends the weekly rehab team meetings to discuss clients’ cases.

Although O’Connell is the first to admit that he has no clinical background, he says he has something even more valuable: a conceptual knowledge about the equipment that allows him to see the broader picture. “No one discipline
External Case Managers
The role of external case managers is changing as payers become more sophisticated about managing the health care dollar. Some of the large MCOs are dividing their enrollee populations into groups by proportion of dollar expenditures.

High-risk rehab groups, such as brain and spinal cord injury, are managed on an individual case basis by specialized case managers. Groups that are at lower risk such as people with controlled chronic conditions but could move into the higher risk categories are managed under a disease-state approach. However, a major complaint by rehab professionals is the lack of understanding and education that many external case managers have of the involved rehab cases requiring complex assistive technology. Most external case managers are RNs with little background in long-term rehabilitation. They don’t understand the different needs of, for example, someone with a left hemi stroke and someone with quadriplegia, or the products appropriate for each condition.

Impact on Care
Many rehab professionals see both good and bad effects of the impact of managed care and case management as its primary implementation tool. Rehab professionals have learned to do in two months what used to take six. There is much more attention placed on the long-term implications of short-term decisions and the weighing of various care and equipment options to determine which are the most effective and efficient. And there is more focus on preparing the client and family to take on responsibilities and provide the education for them to do so.

On the other hand, some people feel the pendulum has swung too far in the other direction. They say that case managers are becoming “restrictors of care” rather than “managers of care.” Desimone says: “Some MCOs look solely at bed days per thousand and don’t understand that catastrophic injuries do not fit the average.”

Families are being forced to take on a large share of the burden of continuing rehabilitation care, where they encounter a fragmented jumble of programs with no idea of the range and structure of services available.

Rehab’s Future
The optimistic view of the future is that a reasonable middle ground will be reached. Unfortunately, many rehab professionals believe that things will get worse before they get better. Some clients will suffer as a result of inadequate care; undoubtedly, a few lawsuits will result.

Ultimately, the prevailing rehab professional view must encompass the following components:
- a long-term perspective
- treatment protocols based on a foundation of sound statistical data that demonstrate effective results for diagnostic categories
- the reality of financial constraints
- the concept and wisdom of strategic dollars spent in the short-term, eliminating the need for bigger dollars down the line.

This research, including extensive one-on-one interviews and a literature search, was conducted and written for TeamRehab Report by Elaine Nesterick, M.B.A., vice president/chief operating officer of Miramar Communications Inc. Previously, she was an independent marketing and business consultant, her clients including several health care companies.

“There is a real shift now to look at disease management before [cases] become catastrophic.”

-Lois Thompson

can have all the knowledge needed to provide adequate services,” he explains. “I feel that I have much more broad-based knowledge than a nurse working as a case manager for an insurance company. They have training as a nurse, but they don’t have overall concepts that you would see on the front lines.”

Because his work sometimes pits him against the insurer’s case manager, O’Connell has seen the effects of placing a high importance on cost issues. “They don’t fully understand how a facility like this can enhance someone’s quality of life,” he says. “They tend to be bottom-line people. In order to save a few days in a facility, they put people at risk.”

O’Connell once had a client who needed a wheelchair ramp in his home, but the insurance case manager would not approve the equipment. Without the ramp, the client was forced to stay in the hospital, running up thousands of dollars more than the ramp would have cost, O’Connell says.

Michael LeBlank, a quality control reviewer for Louisiana’s Medicaid program, Baton Rouge, La., shares similar frustrations. LeBlank reviews medical records for correct reimbursement for Medicaid. “When we’re shown a vast array of medical equipment, we’re looking at it from the wrong end in terms of paying for the machine,” he says. “I believe that we’re getting away from hands-on experience and helping individuals that are handicapped. The focal point is just not the person.”

Given that case managers share many of the concerns of therapists that cost has taken on more significance than quality services, some therapists are trying to effect change in the industry. “There is an investment to justify,” concludes therapist Seay, who understands both sides of the coin. Rather than work against the case manager, she has launched an inservice program in the hopes of bridging the gap between the two sides.

“I don’t know yet what the verdict is going to be because I’m just starting the process,” Seay says. “Some will allow me to do [inservices] and some will decide they don’t have a need for it. But I would hope that the entities that employ the case managers will see the need to give as much training as possible.”

Other therapists see credentialing programs and outcomes measurements as keys to proving to case managers the quality of services that they provide. “This industry is in a quandary,” says Rehab Designs’ Ketcham. “It needs credentialed providers to ... gain recognition from payers.” Until the value of every dollar spent on rehab therapy can be proven by the industry, Ketcham concludes that case managers will be resistant to spending money on high-tech services and equipment.